North Cumbria University Hospitals NHS Trust

Cumberland Infirmary

Quality Report

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Date of inspection visit: 6 – 9 and 21 December 2016
Date of publication: 29/03/2017

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out a follow up inspection between 6 and 9 December 2016 to confirm whether North Cumbria University Hospitals NHS Trust (NCUH) had made improvements to its services since our last comprehensive inspection, in April 2015. We also undertook an unannounced inspection on 21 December 2016.

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

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

At Cumbria Infirmary in Carlisle (CIC) we rated services overall as 'requires improvement'. We rated surgery, critical care and services for children and young people as 'good', with all other services rated as 'requires improvement'.

There were three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations at this hospital. These were in relation to staffing, person centred care, and assessing and monitoring the quality of service provision.

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

We found that the trust had improved in some areas. However, Cumberland Infirmary (CIC) remained rated as 'requires improvement' overall, with caring and effective rated as 'good' and safe, responsive, and well-led rated as 'requires improvement'.

Our key findings were as follows:

- Nursing and medical staffing had improved in some areas since the last inspection. However, there were still a number of nursing and medical staffing vacancies throughout the hospital, especially in medical care, surgical services, and services for children and young people, including the special care baby unit.
- The trust had systems in place to manage staffing shortfall as well as escalation processes to maintain safe patient care. However, a number of registered nurse shifts remained unfilled despite these escalation processes. The 'floor working' initiative within medical care should be reviewed in order to support safer nurse staffing.
- Despite ongoing recruitment campaigns the trust had struggled to recruit appropriate clinicians in some specialities.
- Compliance against mandatory training targets was an issue in some services.
- Access and flow across the emergency department, medical care, surgical services, and outpatients remained a significant challenge.
- For an extended period, the hospital had failed to meet the target to see and treat 95% of emergency patients within four hours of arrival and the hospital was failing to meet a locally agreed trajectory to see and treat emergency patients within the standard agreed with regulators and commissioners.
- We found patients experienced overnight delays in the emergency department whilst waiting for beds to become available in the hospital.
- Between 2015 and 2016 the trust cancelled 1,410 elective surgeries. Of these, 12% were not treated within 28 days.
- For the period November 2015 to November 2016 CIC cancelled 573 elective surgeries for non-clinical reasons.
- Referral to treatment time (RTT) data varied across specialities, particularly in surgical services.

Summary of findings

- Within the outpatients department, across the trust, several clinics had been cancelled within six weeks of the scheduled clinic date, and there were no plans in place to address this issue. Turnaround times for inpatient plain film radiology reporting did not meet Keogh standards, which require inpatient images to be reported on the same day.
- Delays in obtaining suitable community care placements were causing access and flow difficulties, particularly in medical care services.
- There had been an improvement in record-keeping standards throughout the hospital, however, we identified some ongoing areas for improvement around accurate completion of fluid and food charts, risk assessments, and completion of DNACPR forms, some of which did not provide evidence of a best interest decision or mental capacity assessment being undertaken and recorded where appropriate.
- There was some improvement in strengthening of governance processes across the hospital, however, within some services, particularly medical care and maternity, there were gaps in effective capturing of risk issues, and in how outcomes and actions from audit of clinical practice were used to monitor quality.
- Due to the review of the Cumbria-wide healthcare provision there remained no clear vision nor any formal strategy for the future of maternity or of services for children and young people.

However:

- Staff knew the process for reporting and investigating incidents using the trust's reporting system. They received feedback from reported incidents and felt supported by managers when considering lessons learned.
- The policy and activity around the transfer of critical care patients, including children and babies, to other hospitals were good.
- The hospital had infection prevention and control policies in place, which were accessible, understood, and used by staff. Patients received care in a clean, hygienic, and suitably maintained environment.
- There were no cases of Methicillin Resistant Staphylococcus Aureus infection (MRSA) reported between November 2015 and October 2016. Trusts have a target of preventing all MRSA infections, so the hospital met this target within this period. The trust reported nine MSSA infections and 23 C. Difficile infections over the same period.
- Safeguarding processes were embedded throughout the hospital.
- We saw that patients were assessed using a nutritional screening tool, had access to a range of dietary options, and were supported to eat and drink.
- Patients were positive about the care they received. Staff were committed to delivering high quality care. Staff interactions with patients were compassionate, kind, and thoughtful. Patient privacy and dignity was maintained at all times.
- Patient feedback was routinely collected using a variety of measures, including real time patient experience.

We saw several areas of outstanding practice including:

- The trust was a National Patient Safety Awards finalist for 'Better Outcomes in Orthopaedics'.
- The trust had the only surgeon between Leeds and Glasgow doing a meniscal augment in the knee.
- A University of Cumbria Honorary Professorship had been received by a consultant for work on applying digital technologies in health care for an elderly population in a rural setting; a part of CACHET.
- The trust had set up a multinational, multicentre prospective study in the use of intramedullary nail in varus malalignment of the knee. It had the largest international experience of this technology for this application.
- CIC was one of only 18 Hospitals in England and Wales referred to in the first NELA audit for contributing examples of best practice in care of patients undergoing emergency laparotomy.
- There was evidence of real strength in multidisciplinary team (MDT) working across stroke, neurorehabilitation, and older person's services;
- An 'expert patient programme' and a 'shared care initiative' had been set up to promote patient empowerment and involvement in care;
- A variety of data capture measures were used to monitor 'real-time' patient experience and collate patient feedback;

Summary of findings

- The trust operated innovative and progressive Frailty Unit projects;
- There had been growth, expansion, and development of the MPU service; and
- The trust had implemented dance-related activities for vulnerable patient groups, to stimulate social interaction, patient involvement, family partnerships, and exercise.

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

Importantly, the trust must:

In urgent and emergency services

- Meet the target to see and treat 95% of emergency patients within four hours of arrival linked to meeting the locally agreed trajectory to see and treat emergency patients within the standard agreed with regulators and commissioners.
- Ensure medical and nursing staff use the computer system fully as intended so that patient real time events are recorded accurately and this is demonstrated through audit.
- Take further steps to resolve the flow of patients into and out of the hospital.

In Medicine

- Ensure that systems and processes are established and operated effectively to assess, monitor, and improve the quality and safety of the services provided, and evaluate and improve practice to meet this requirement. Specifically, review the escalation process involving 'floor working' to ensure the quality and safety of services are maintained; and
- Ensure that sufficient numbers of suitably qualified, competent, skilled, and experienced persons are deployed across all divisional wards. Specifically, ensure safe staffing levels of registered nurses are maintained, especially in areas of increased patient acuity, such as NIV care and thrombolysis.

In Surgery

- Must ensure the peri-operative improvement plan is thoroughly embedded and that all debrief sessions are undertaken as part of the WHO checklist to reduce the risk of Never Events.
- Improve compliance with 18 week referral to treatment (RTT) standards for admitted patients for oral surgery, trauma and orthopaedics, urology, and ophthalmology;
- Improve the rate of short notice cancellations of operations for non-clinical reasons, specifically for ENT, orthopaedic, and general surgery; and
- Ensure that patients whose operations are cancelled are treated within the following 28 days.

In Maternity and Gynaecology

- Review staffing levels, out of hours consultant paediatric cover, and surgical cover to ensure they meet the Royal College of Obstetricians and Gynaecologists (RCOG) guidelines (including 'safe childbirth: minimum standards for the organisation and delivery of care in labour'); and
- Ensure that systems are in place so that governance arrangements, risk management, and quality measures are effective.

In Services for Children and Young People

- Ensure that children and young people's services meet all Royal College of Paediatrics and Child Health (RCPCH) - Facing the Future: Standards for Acute General Paediatric Services (2015 as amended); and
- Ensure that nurse staffing levels on SCBU adhere to establishment and meet recognised national standards.

In End of Life Care

- Ensure that DNACPR forms are fully completed in terms of best interest assessments, in line with the Mental Capacity Act.

In Outpatients and Diagnostic Imaging

- Address the number of cancelled clinics in outpatient services; and
- Ensure that referral to treat (RTT) indicators are met across outpatient services.

In addition the trust should:

- Ensure that levels of staff training continue to improve in the hospital, so that the hospital meets the trust's targets by 31st March 2017;

In urgent and emergency services

- Increase the complement of medical consultant staff as identified in the accident and emergency service review
- Achieve quantified improvements in response to the trauma audit and research network (TARN) audit and the NICE clinical guideline self-harm audit (CG16), and demonstrate progress achieved through audit.
- Take steps to ensure patient confidentiality can be maintained in the accident and emergency reception area.
- Extend the scope and consistency of staff engagement

In Medicine

- Continue to progress patient harm reduction initiatives;
- Revisit the 'floor working' initiative, particularly across Elm wards;
- Revisit thrombolysis cubicle bed utilisation to reduce potential unnecessary, inappropriate, or inconvenient bed moves;
- Ensure infection prevention and control (IPC) compliance improvement and consistency in standards, in particular regarding catheter and cannula care;
- Ensure that best practice guidelines for medicines-related documentation is reinforced to all prescribers;
- Ensure that care and treatment of service users is appropriate, meets their needs, and reflects their preferences. Specifically, ensure the endoscopy pathway design meets service user preferences and care or treatment needs;
- Ensure that oxygen prescribing is recorded and signed for accordingly;
- Ensure that medicines management training compliance improves in line with trust target;
- Ensure that NEWS trigger levels are adhered to (or document deviation/individual baseline triggers in the clinical records);
- Ensure that fluid and food chart documentation is accurate, to reflect nutritional and hydration status;
- Ensure that staff are given time to complete all necessary mandatory training modules and an accurate record is kept;
- Ensure that all equipment checks are completed in line with local guidance;
- Continue to proactively recruit nursing and medical staff, considering alternate ways to attract, such as utilising social media;
- Ensure that measures are put in place to support units where pending staffing departures will temporarily increase vulnerability;
- Ensure that food satisfaction standards are maintained and, where relevant, improved;
- Develop an action plan to detail objectives to improve and progress diabetes care across the division;
- Evidence improvements in patient outcomes for respiratory patients around time to senior review and oxygen prescribing;
- Ensure that all staff can access development opportunities in line with organisational/staff appraisal objectives, protecting/negotiating study time where required;
- Ensure that appraisal rate data recorded at trust level coincides with figures at divisional/ward level;
- Revisit the patient journey, booking, and listing procedures at the endoscopy suite at CIC;

Summary of findings

- Continue to minimise patient moves after 10 pm;
- Continue to work with community colleagues to develop strategies to minimise delayed transfer of care (DTOC) and unnecessarily lengthy hospital stays for patients medically fit for discharge;
- Reinforce the benefits of dementia initiatives to ensure consistency of practice;
- Ensure that the risk register is current and reflects actual risks with corresponding, accurate risk rating;
- Ensure that all actions and reviews of risk ratings are documented;
- Ensure that progress continues against its Quality Improvement Plan (QIP), and realign completion dates and account for deadline breaches;
- Revisit medical rota management processes for junior doctors;
- Revisit modes of communications with staff to ensure efficiency whilst avoiding duplication;
- Ensure that staff involved in change management projects are fully informed of the aims and objectives of the proposal, and these are implemented and concluded in appropriate timeframes; and
- Ensure that divisional leads and trust leaders promote their visibility when visiting wards and clinical areas.

In Surgery

- Ensure that robust recruitment and retention policies continue, to improve staff and skill shortages;
- Continue to embed the perioperative quality improvement plan;
- Improve debrief in theatres post-surgery;
- Improve the proportion of patients having hip fracture surgery on the day or day after admission;
- Improve the rate of patients receiving a (VTE) re-assessment within 24 hours of admission;
- Improve cancellation rates;
- Ensure that all mandatory training is completed by 31st March 2017;
- Reduce the management of medical patients on surgical wards; and
- Ensure that bullying allegations in theatres are addressed.

In Critical Care

- The trust should take action to improve pharmacy staffing in line with GPICS (2015);
- The clinical educator should provide a full time role in the CIC unit in order to meet GPICS (2015) standards for a unit of this size;
- The role of the clinical coordinator should be protected as per GPICS (2015) standards. and
- Staff should not be moved to cover ward shortages if this compromises safe nurse to patient ratios of care in the critical care unit. Senior staff at trust and unit level should offer continued support and monitor this issue closely, to reduce the need for the frequency of unplanned staff movement to reduce risk of compromising patient safety and to improve morale amongst nursing staff in the unit.

In Maternity and Gynaecology

- Ensure that processes are in place for midwives to receive safeguarding supervision in line with national recommendations;
- Continue to improve mandatory training rates to ensure that trust targets are met by the end of March 2017;
- Ensure that there are processes so that record-keeping, medicine management, and checking of equipment is consistent across all areas; and
- Review the culture in obstetrics to ensure there is cohesive working across hospital sites and improved clinical engagement.

In Services for Children and Young People

- Ensure that staff adhere to and update the cleaning schedule and cleaning log in the children's outpatient department as appropriate;

Summary of findings

- Ensure that medical staff sign all signature sheets, and print their names and designations against all entries on all patient notes;
- Ensure that all staff have completed the required mandatory training, and the trust should ensure that its systems accurately reflect this data;
- Ensure that all staff are trained in the use of the flagging system on the patient database system in A&E for children and young people who have multiple attendances at A&E, children who are looked after, and children subject to a child protection plan'; and
- Ensure that the new paediatric anaesthetist lead (when appointed) receives an appropriate amount of professional leave time to develop a specialist skill base for this highly specialised role. This should include robust training and support, including time spent at specialist centres for paediatric surgery.

In End of Life Care

- Arrange formal contract meetings with members of the Cumbria Healthcare Alliance to monitor the service being commissioned and provided, and ensure it is of an appropriate standard in terms of quality and meeting patient need;
- Ensure that it is aware of the number of referrals to the Specialist Palliative Care Team (SPCT) within its hospitals;
- Ensure that it is aware of how many patients are supported to die in their preferred location, and there is regular audit of the Care of the Dying Plan to demonstrate this; and
- Produce an action plan to address areas in national audits where performance was lower than the England average, with key responsibilities and timelines for completion.

It is apparent that the trust is on a journey of improvement and progress is being made clinically, in the trust's governance structures and in the implementation of a credible clinical strategy. I am therefore happy to recommend that North Cumbria University Hospitals NHS Trust is now taken out of special measures.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Good	At our previous inspection in April 2015, we rated this service as 'requires improvement'. In December 2016 we rated the service as 'good' because: • Risks to the delivery of care and treatment for patients were mitigated and a risk register for accident and emergency reflected key risks. Safeguarding procedures were in place. • Patient care and treatment followed evidence based guidance and recognised best practice standards. Sepsis screening and management and other clinical guidelines were used effectively. • Staff provided considerate and compassionate care for patients and treated them with dignity and respect. Staff interacted with patients empathetically and responses to their needs were prompt. Care and treatment was explained to patients in a way they understood. Patients were consulted and involved in decisions about their care and treatment and received emotional support. • Patients with a learning disability, patients with dementia, and bariatric patients accessed emergency services appropriately and their needs were supported. Patients with mental health needs could access services in a joined up way. • Patient's consent to care and treatment was documented and the requirements of the Mental Capacity Act were followed. Patients' nutrition and hydration needs were provided for and pain was managed effectively. • Incident reporting had increased and serious incidents had reduced. Learning from the investigation of incidents was shared and duty of candour requirements were followed. Emergency preparedness arrangements were in place to respond to major incidents.

Summary of findings

- Public engagement included consultation events about changes to services and although few complaints were received they were investigated and learning was shared with staff.
- Staffing had improved and staff were deployed in the department effectively so that staffing levels were sufficient to meet patients' needs. Mandatory training had been completed by most staff. The learning and development of medical and nursing staff was supported and staff received an annual appraisal. Multidisciplinary teams operated effectively. An improved, positive culture was apparent in the emergency department and staff worked well together.
- The hospital was taking steps to address performance as part of its improvement plan for emergency care and the accident and emergency service undertook a strategic service review during 2016. A frailty assessment unit and an ambulatory care unit recently opened. Seven day working was operated 24 hours a day throughout the year including key support services, for example radiology.
- Cleanliness, infection control and hygiene procedures were followed and standards were monitored. Equipment and medicines stocks were managed effectively.
- The department participated in relevant national audits and undertook regular local audits which supported consistent improvements in care and treatment for patients.
- Local clinical leadership was visible and approachable; governance of the emergency department was more embedded and the vision and strategy for emergency care was understood. The department implemented innovation to benefit patients.

However:

- For an extended period, the hospital has failed to meet the target to see and treat 95% of emergency patients within four hours of arrival and the hospital was failing to meet a locally agreed trajectory to see and treat emergency patients within the standard agreed with regulators and commissioners.

Summary of findings

- Emergency department waiting time data was incorrect. Staff were not fully utilising the computer system as intended so that the times recorded were not accurate.
- Material issues remained with patient flow into the hospital. The accident and emergency service review had identified a shortfall of two whole time equivalent consultant staff due to increasing patient demand. This was only partially filled by locum consultant staff.
- Paediatric nursing resource was limited, although the department was taking steps to address this shortfall.
- Changes in the operational nursing structure for the emergency department needed to become embedded.
- Although the service had made improvements in its responses to the trauma audit and research network (TARN) audit and the NICE clinical guideline self-harm audit (CG16), work to achieve further improvements remained in progress.
- Patient confidentiality was not always maintained in the reception area.
- Staff engagement needed to be extended.

Medical care (including older people's care)

Requires improvement

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

- medical staffing levels;
- Increase numbers of trained nurses;
- Improve safety thermometer results;
- Improve performance for the care of patients with diabetes;
- Reduce the pressures on the availability of medical beds;
- Stop moving patients during the night without a medical reason for doing so; and
- Provide effective leadership for nurse practitioners.

During this inspection, we found the service had made some improvements:

Summary of findings

- While medical staffing was not at full substantive compliment at CIC, there had been recruitment in cardiology, respiratory, and older person's services. Network support had been strengthened in oncology and haematology services. There was a composite workforce strategy being reviewed, a number of senior interviews were pending, and the division had a clearer recruitment picture;
- Registered nurse vacancies remained at CIC; however, all wards reported an improved picture since the 2015 inspection. This division had reconfigured wards and there were improved fill rates;
- There had been a reduction in patient harms aligned to safety thermometer key performance indicators;
- The division worked with a partner trust to provide diabetes services. A joint diabetologist appointment had been made, and specific programmed activities were in place to develop diabetic foot services;
- There had been a reduction in the number of medical outliers on the CIC site. The division had developed a number of initiatives to improve access and flow.
- Moves after 10 pm continued at CIC, however, we were assured staff only effected such a move when clinical demand and patient need necessitated this; and
- All nurse practitioners were brought into the divisional management structure to provide clinical supervision, and senior nursing support was available to this cohort of staff.

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

- Nurse staffing requirement had not been formally revalidated following recent ward reconfigurations. Registered nurse staffing shortfalls and registered nurse vacancies persisted on all divisional wards. A number of registered nurse shifts remained unfilled despite escalation processes. The 'floor working' initiative within medical care should be reviewed in order to support safer nurse staffing. There

Summary of findings

was a continuing number of patient related harms around pressure ulcers and falls. Some IPC audit outcomes highlighted a variance in compliance with cannula and catheter care key performance measures. Auditors identified some medicines-related documentation that required improvement, and deviation from National Early Warning Score (NEWS) triggers needed further consideration. Mandatory training figures were inconsistent and, overall, were below trust target.

- Patient outcomes in some national audits were static or worse than the national averages. These were around key performance indicators in diabetes and two domains within myocardial infarction data. Completion of fluid and food charts required improvement and the temperature of some patient meals was not optimal. Staff confirmed that learning opportunities and access to professional development were variable, and appraisal rates provided by the division were inconsistent with those reported at ward level. The division had not fully embedded seven day working across all areas.
- Staff considered the endoscopy suite at CIC was not fully meeting the needs of the local population due to changes in the booking and list preparation processes. This had led to increased numbers of patients failing to attend. There remained a number of medical outliers being cared for on non-medical wards, and care progression for those patients assessed as medically fit for discharge stalled due to multi-factorial difficulties. Some dementia initiatives to support vulnerable patient cohorts were not fully embedded.
- The divisional risk register did not correlate with top risks identified by divisional leads. Risk ratings were confusing and details of actions taken against the risks were limited. Divisional progress against the QIP objectives was incomplete and slow. Staff morale was variable and junior doctors resented the perceived shift

of onus onto them to take responsibility for covering gaps in the junior doctor medical rota. Staff considered the rate of change to be hurried and difficult. Senior leaders lacked visibility.

However:

- Staff confidently reported incidents and the division had made considerable efforts to reduce harms to patients from falls and pressure ulcers. Ward environments were clean, and staff used personal protective equipment appropriately to protect themselves and their patients from infection exposure. Overall, medicines management was good and clinical documentation, in particular risk assessments and safety bundles, were completed thoroughly. Medical staffing establishment had improved and the division considered alternative initiatives to bolster medical staffing.
- The division was actively involved in local and national audit, which provided a strong evidence-base for care and treatment. Patient outcomes in a number of national audits were good and there had been some reported improvements in others. Patients reported pain management to be good and considered their nutritional needs to be met. MDT working across the divisional wards was integrated, inclusive, and progressive. Staff had an understanding and awareness of consent issues and Mental Capacity Act and Deprivation of Liberty Safeguards, and capacity assessments were completed.
- Patients were positive about the care they received. Staff were committed to delivering high quality care. Staff interactions with patients were compassionate, kind, and thoughtful. Patient privacy and dignity was maintained at all times. Staff proactively involved family and considered all aspects of holistic wellbeing.
- The division supported the trust in service-planning to meet the needs of the local population, acknowledging the internal and external demands upon it. The division had developed new services, extended the remit of existing services, appointed specialist

Summary of findings

practitioners, and collaborated with neighbouring trusts in service development. There were good 18 week standards reported. Access and flow was monitored, and the division worked to minimise obstacles. The division provided additional services to redirect flow and avoid unnecessary admissions. The management of medical outliers had improved. The division had made reasonable adjustments to reduce environmental conflict for vulnerable patient groups, and complaint numbers were low on divisional wards at CIC.

- The division had a clearly defined strategy and vision, which was aligned to organisational aims and wider healthcare economy goals. Divisional leads had an understanding of the pressures and risks the service faced. Governance processes across the division were clinician-driven, and quality measures were monitored. There were defined leadership structures, and staff confirmed there was a strong clinical leadership presence across the division. Cultural improvements had been made in the preceding 18 months, evident by greater openness. Public engagement was good and utilised a variety of mechanisms to capture opinion. The staff engagement agenda had increased, in particular around health and well-being. The division was involved in a number of improvement projects.

Surgery

Requires improvement

The overall surgery rating from the 2015 inspection was 'good'. During the December 2016 inspection we rated surgical services as 'requires improvement' because:

- The trust had reported its staffing numbers as at August 2016. These numbers showed that the majority of surgical wards were below nursing establishment levels. The data showed that Beech B required 14.4 whole time equivalent (WTE) members of staff, but had only 11.72 WTE in post. Similarly, Beech D was 2.24 short and Maple D was 6.49 WTE short.

Summary of findings

- As of September 2016 the trust reported a vacancy rate of 8.9% in surgical staff at Cumberland Infirmary with a turnover rate of 23.6% between April 2015 and March 2016.
- There had been seven Never Events for Surgery between June 2015 and February 2016.
- We saw that, in November 2016, 26% of patients were re-assessed for VTE within 24 hours of admission. This was a decrease from October 2016, when 72% of patients were re-assessed with 24 hours of admission. September 2016 figures were 37%. The target is 95%.
- Surgical debrief, as part of 'five steps to safer surgery', was undertaken 14% of the time. A trust audit recommended further work on encouraging the team debrief through business unit governance meetings and dissemination of learning by governance leads.
- We found that training rates, in areas such as fire safety (58%), hygiene for clinical staff (67%), trust doctors' patient safety programme (31%), and duty of candour (45%) were below the trust target of 95%.
- The proportion of patients having hip fracture surgery on the day or day after admission was 68.3%, which does not meet the national standard of 85%. The 2015 figure was 75.1%.
- Between March 2015 and April 2016 patients at the trust had a higher than expected risk of readmission for both elective and non-elective admissions. Relative risk of readmission for general surgery and trauma and orthopaedics were both similar to the trust level.
- For the period Q2 2014/15 to Q1 2016/17 the trust cancelled 1,438 operations on the day of surgery. Of these, 12% were not rescheduled and treated within 28 days. The overall trend for this was that the trust's percentage was much higher than the England average. Performance improved from Q1 2015/16 to Q3 2015/16; however, performance deteriorated again from Q4 2015/16 and was showing signs of deteriorating further.
- Cancelled operations as a percentage of elective admissions includes all cancellations rather than just short notice cancellations. Cancelled

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operations as a percentage of elective admissions for the period Q2 2014/15 to Q1 2016/17 at the trust were consistently greater than the England average. The trust trend had followed a similar pattern to the England average, although the peaks and troughs were far more pronounced, particularly the increase in Q3 2015/16, although it should be noted that junior doctor strikes were planned during this period and may have contributed to the sharp rise.

- For the period November 2015 to November 2016 CIC cancelled 573 surgeries for non-clinical reasons.
- Four surgical specialties were below the England average for admitted RTT (percentage within 18 weeks).
- An action in the QIP stated that the division aimed to achieve compliance with 18 week RTT for the incomplete pathway standard by September 2016. The status of this action remained 'in progress' as of December 2016.
- At trust level general surgery had a longer average length of stay than the England average for both elective and non-elective admissions.
- At the time of inspection the perioperative improvement plan was in the early stages of implementation, thus impacting upon some areas but not yet fully embedded within the division.
- Staff morale was variable on the wards, in theatres, and in recovery areas. Morale was affected by working in difficult circumstances during the preceding 18 months to cover staff and skill shortages.
- We were advised that there were ongoing bullying allegations within the theatre departments.

However:

- The division held regular emergency surgery and elective care business unit meetings, at which serious incidents were discussed, investigations analysed, and changes to practice identified.
- Senior nursing staff had daily responsibility for safe and effective nurse staffing levels. Staffing

guidelines with clear escalation procedures were in place. Site cover was provided out-of-hours 24 hours per day, seven days per week, by a team of senior nurses with access to an on-call manager. Numbers of staff on duty were displayed clearly at ward entrances.

- A 'red flag' and safer staffing system had been introduced to identify when lower than optimal staff numbers may impact upon patient care and so to initiate mitigation. Escalation processes were in place through the matron, service manager, and chief matron. Capacity bed meetings were held twice daily to monitor bed availability, review planned discharges, and assess bed availability throughout the trust.
- All wards participated in the NHS safety thermometer approach, displaying consistent data to assure people using the service that the ward was improving practice based on experience and information. This tool was used to measure, monitor, and analyse patient 'harm free' care.
- We looked at medical records across wards and saw that they were appropriately completed, legible, and organised consistently. All documentation checked was signed and dated, clearly stating details of the named nurse and clinician.
- Patients were treated in accordance with national guidance, and enhanced recovery (fast track) pathways were used. Local policies were written in line with national guidelines. A range of standardised, documented pathways and agreed care plans was in place across surgery.
- During 2015/16 the surgical business unit participated in 12 out of 14 national clinical audits covering a range of specialties and completed 122 local audits. Outcomes from each audit were reported to the Business Unit Governance Board (BUG Board).
- The perioperative surgical assessment rate was 92.4%, which does not meet the national standard of 100%. However, the 2015 figure had been 62.4%, so the 2016 figure did show considerable improvement.

Summary of findings

- CIC was one of only 18 Hospitals in England and Wales referred to in the first NELA audit for contributing examples of Best Practice in Care of Patients Undergoing Emergency Laparotomy.
- Patients admitted with a fractured neck of femur had their pain assessed immediately upon presentation at hospital and within 30 minutes of administering initial analgesia, then hourly until settled on the ward and regularly as part of routine nursing observations throughout admission.
- A dedicated pain team was accessible to support with analgesia as required. The pain team visited patients when baseline pain relief was ineffective. Anaesthetists provided support with pain relief out-of-hours.
- The Friends and Family Test (FFT) response rate for surgery at the trust was 38%, which was better than the England average of 29%, between November 2015 and October 2016. Ward level recommendation rates were variable, although recommendation rates were generally high, being between 70 and 100% for the overall period across all participating wards.
- We observed the treatment of patients to be compassionate, dignified, and respectful throughout our inspection. Ward managers and matrons were available on the wards so that relatives and patients could speak with them if necessary.
- The trust was actively working with commissioners to provide an appropriate level of service based on demand, complexity, and commissioning requirements.
- The division had an escalation policy and procedure to deal with busy times, and matrons and ward managers held capacity bed meetings to monitor bed availability.
- Complaints were handled in line with the trust's policy and discussed at all monthly staff meetings. Patients or relatives making an informal complaint were able to speak to individual members of staff or the ward manager. Wherever possible the patient Advice Liaison Service (PALS) would look to resolve complaints at a local level.

Summary of findings

- We met with senior trust and divisional managers, who had a clear vision and strategy for the division and identified actions for addressing issues within the division. The divisional leadership team detailed its understanding of the challenges associated with providing good quality care, and it identified actions needed.
- The trust had developed a quality improvement plan (QIP) and had identified specific objectives to improve the management of the deteriorating patient, the recognition of, and initiation of treatment for, patients with sepsis, and ongoing development of the Mortality and Morbidity Framework.
- The division had also developed a Perioperative Improvement Plan in response to then recent issues identified within surgery. This aimed to enhance governance through learning from events and incidents, to develop the workforce through a positive learning environment, and to initiate external assessment and compliance.
- There was a systematic programme of clinical and internal audit, which was used to monitor quality and systems to identify when action should be taken. Monthly audits were undertaken and audit outcomes were published quarterly.
- The division's risk register was updated following Safety and Quality meetings, with risks discussed, controls identified, progress against mitigation, risk grading, assurance sources, and gaps in control documented.

Critical care

Good

During our previous inspection of CIC, in July 2015, we rated critical care services as 'good' overall, with safe as 'requires improvement', due to concerns about nurse and medical staffing levels. Effective, caring, responsive and well-led were rated as 'good'. We rated the service as 'good' overall, after our comprehensive announced and unannounced inspection visit in December 2016, with evidence of ongoing improvement in the unit:

- There was ongoing progress towards a harm free culture. Incident reporting was understood by the staff we spoke with and improvements in

reporting culture had been noted by the critical care team. There was a proactive approach to the assessment and management of patient-centred risks and staff had a good understanding of the trust position related to learning from incidents, serious incidents, and Never Events.

- There had been no Never Events in critical care and no reportable serious incidents at the CIC site. There had been ten NRLS reported incidents, and themes were monitored closely by grade and seriousness of harm.
- A 24/7 Critical Care Outreach Team (CCOR) was well established. We observed good practice for recognition and treatment of the deteriorating patient. One hundred percent of patients received follow-up care once discharged from the unit. Practice was in line with GPICS (2015), NICE CG50 and against the seven core elements of Comprehensive Critical Care Outreach, (C3O 2011) 'PREPARE'; 1. Patients track and trigger, 2. Rapid response, 3. Education and Training, 4. Patient safety and governance, 5. Audit and evaluation (monitoring patient outcome), 6. Rehabilitation after critical illness and 7. Enhancing service delivery.
- Nurse staffing was good with sufficient staffing levels for provision of critical care. There was provision of a supernumerary coordinator and practice educator in line with Guidelines for the Provision of Intensive Care Services (GPICS) (2015).
- Supernumerary induction for new nursing staff was good with an organised approach to nurse appraisal and nursing achievement of competence in critical care skills.
- Medical staff we spoke with described good anaesthetic staffing levels and continuity for rotas and out-of-hours cover, however, this was achieved with 35% use of locum consultant staff at CIC, as sickness and vacancy rates for anaesthetic cover were greater than average for 2015/16.
- The policy and activity around critical care patient transfer to other hospitals when required were good. The arrangements for the small

Summary of findings

numbers (17 in 2015/16) of paediatric admissions for stabilisation for hours prior to transfer were also good, this included levels of staff training and competence and storage and checking of essential equipment. The unit was part of the 'North East Children's Transport and Retrieval' (NECTAR) new transport service.

- The emergency resuscitation equipment and patient transfer bags for both adults and children were checked daily with a good system in place as per trust policy. There was good provision of equipment in critical care, good storage, and robust systems for medical device training.
- The unit was visibly clean; standards of IPC were in line with trust policy. One isolation room was available with a ventilated lobby area, in line with Health Building Note HBN 04-02. Staff we spoke with told us that isolation of patients was risk assessed and documented. Liaison with the infection control team supported assurance that patients with infections received best practice.
- The team in the unit had invested in and implemented an electronic patient record and prescription system specific to intensive care, which we observed to be comprehensive and well understood by staff. All records checked in the system were complete, and the risk assessment and patient review process was good.
- Patients were at the centre of decisions about care and treatment. We reviewed consistent positive survey feedback and comments, which gave evidence of a caring and compassionate team. The team had established a memorial service for relatives of patients who had died in the unit, and this was well attended in the local community. There was evidence of well-attended support groups for patients in the local community. Staff whom we observed and spoke with were positive and motivated and delivered care that was kind and promoted dignity, and that focused on the individual needs of people. The improvements made towards the rehabilitation of patients after critical illness since our last inspection were comprehensive.

Summary of findings

- The team members in critical care services spoke highly of their local leadership and felt supported by matrons, consultants, and senior matrons. A culture of listening, learning, and improvement was evident amongst staff we spoke with in the unit. Staff we spoke with across the team were positive about their roles and clear about governance arrangements, despite frequent changes in the senior team over the preceding five years. Staff expressed desire for a period of stability in the senior and executive team.
- We found that Intensive Care National Audit and Research Centre (ICNARC) data showed that patient outcomes were comparable or better than expected when compared with other units nationally, this included unit mortality. ICNARC data had been collected and submitted consistently at CIC for around three years, since the appointment of a dedicated member of the team. The data was available to the team and, during our inspection, we were able to review consistent annual reports. However, we reported to the critical care team that, although its data was published on the ICNARC website, this was only for one unit. Staff we spoke with were not aware of this and could not explain why data for the other unit was not published.
- Plans were in place to provide multidisciplinary follow-up clinics across both units for rehabilitation of patients after critical illness, as recommended by NICE CG83 and GPICS (2015). These were for those patients who had experienced a stay in critical care of longer than four days. A small, dedicated team was being recruited to deliver this standard, and progress was good. Support groups had been well attended in the local community, with staff organising a range of supportive and educational opportunities. The use of patient diaries had been embedded in practice.
- Patients received timely access to critical care treatment and consultant-led care was delivered 24/7. Readmissions to the unit were monitored closely by the consultant and CCOR team and

were below national average. Patients were not transferred out of the unit for non-clinical reasons. We found that patients were not cared for outside of the critical care unit when Level 2 or 3 care was required, and we did not see examples of critical care outliers in theatre recovery or ward areas.

- Patients in the critical care unit were discharged to the wards within eight hours once a decision to discharge was made, as per GPICS (2015). ICNARC data indicated a position that was much better than national performance against this target. Almost all patients were discharged within four hours of being ready for discharge. There were no single sex breaches and low numbers of out-of-hours discharges (0.8%).

However:

- Although substantive and establishment nurse staffing were good in critical care, with low vacancies and sickness rates, staff (including members of the CCOR team) were moved frequently to support shortfalls in staffing in other wards and departments. We spoke with staff who felt that this affected the morale of nursing staff in the unit. Nonetheless, patient safety was not compromised, and we did not see evidence that patient-to-nurse ratios were compromised, as we had found that they had been during previous inspections. We also noted that it was not possible to protect the supernumerary coordinator role when staff were moved.
- The role of the supernumerary clinical educator was embedded and valued. However, this role was provided in a 0.8 WTE post, and the post-holder had commitments to deliver nasogastric (NG) education across the trust in response to trust-wide serious incidents. Although this training was valuable it meant that the clinical educator was only able to provide a part time service in the CIC unit and was unable to provide a service across the trust.

Summary of findings

- The number of pressure sores recorded in the incident reporting system had not shown improvement since our previous inspection, and staff reporting of pressure ulcer grading and level of harm was inconsistent.
- The critical care pharmacist provision was well below GPICS (2015) standards. We spoke with staff in the unit who did not report any issues with management of medicines and pharmacy support. However, pharmacists were not able to fulfil the critical care role, join ward rounds, or deliver improvements in practice, with only 0.2 WTE dedicated hours.
- In 2015 we reported that the unit had limits in storage and patient bed space, and, during this inspection, we noted again that, although the unit was modern in design, it would not meet current national standards for new buildings and environment. (HBN 04-02). The senior team had submitted proposals which outlined plans for unit upgrade and expansion.

Maternity and gynaecology

Requires improvement

During our previous inspection, in April 2015, the service was rated as 'requires improvement' for being safe, effective, and well-led. This was because of a lack of dedicated medical staff cover, no epidural service, mandatory training levels not being met, ineffective medicines management, insufficient governance and audit processes, staff not following guidelines, and a lack of cohesive working across hospital sites.
At this inspection, although some improvements had been made, the service remained as 'requires improvement' for being safe and well-led because:

- Some of the risks identified were still in place and sufficient actions to mitigate the risks had not yet been implemented, particularly the lack of senior paediatric medical cover out-of-hours to manage advanced neonatal resuscitation. Although there was no evidence of adverse outcomes this still presented a risk to patients.
- There remained no clear vision or formal strategy for the future of maternity services, due to a review of Cumbria-wide provision and managers awaiting the outcome of this consultation.

Summary of findings

- Although there was some improvement in cross site working the cohesiveness of the two hospital sites for maternity services was not fully embedded.
- There was some improvement in strengthening of governance processes but there were no indicators to ensure performance and understanding of risk or governance roles. There continued to be gaps in how outcomes and actions from audit of clinical practice were used to monitor quality and systems to identify when action should be taken.
- The checking of equipment and medicines was not consistent across all areas. The quality of record-keeping was variable particularly for ante-natal information.

However:

- Staff understood their responsibilities to raise concerns and to record safety incidents and near misses.
- Medical and midwifery staffing levels were similar to the national recommendations for the number of babies delivered on the unit each year.
- Care outcomes were meeting expectations in most areas, and, where improvements were required, the service had identified action.
- Women were positive about their treatment by clinical staff and the standard of care they had received. They were treated with dignity and respect.
- Services were planned, delivered, and co-ordinated to take account of women with complex needs, and there was access to specialist support and expertise. An epidural service was available.
- Midwifery and medical staff worked together ensuring women received care which met their needs.

Services for children and young people

Good

- The leadership, governance, and culture promoted the delivery of high quality person-centred care. Staff were competent and had the skills they needed to carry out their roles effectively and in line with best practice.

Summary of findings

Managers were visible, and there was a real strength, passion, and resilience across medical and nursing teams to deliver high quality care to children, young people, and their families.

- Staff told us that they were proud to work for the trust and promoted a patient-centred culture. Children, young people, and parents felt that medical staff communicated with them effectively, kept them involved and informed about care and treatment, promoted the values of dignity and respect, and were kind and compassionate.
- Staff protected children and young people from harm and abuse. Medical and nursing staff understood and fulfilled their responsibilities to raise concerns and report incidents, and managers took appropriate action to investigate and share learning.
- Medical and nursing staff followed appropriate processes and procedures to safeguard children and young people. The trust was represented at local safeguarding children board meetings and other sub-groups. Clinicians shared learning from serious case reviews, and care records showed staff provided very good standards of care.
- Children and young people received effective care and treatment, planned and delivered in line with current evidence-based practice and legislation. Children's services participated in national and local audits and other monitoring activities, including service reviews and accreditation schemes. Managers shared outcomes from audits, and actions plans were developed to address areas of concern.
- Children's services were organised to meet the needs of children and young people. Managers and healthcare professionals from the team worked collaboratively with partner organisations and other agencies to ensure services provided choice, flexibility, and continuity of care.

However:

- The unit did not meet all Royal College of Paediatric and Child Health (RCPCH) – Facing the

Summary of findings

Future: Standards for Acute General Paediatric Services (2015 as amended) within contracted hours. Despite ongoing recruitment campaigns, the trust had struggled to recruit appropriate clinicians. The current paediatric consultant team members voluntarily worked in excess of their programmed activities to ensure that children and young people were safe. However staffing constraints meant that this was done in their own time. In a letter to CQC the trust formally acknowledged our concerns and outlined actions taken to address the current shortfall, which included robust handovers and ward rounds, and on-site consultant presence, plus out-of-hours support.

- Due to staff shortages in the special care baby unit (SCBU), the trust could not provide a qualified in specialty (QIS) senior nurse on every shift. Paediatric consultants supported the nurse-led unit, which mitigated the risk to babies, however, this also contributed to their own increasing workload. The trust formally acknowledged our concerns in the aforementioned letter, highlighting the mitigating actions taken to ensure babies received safe care. In addition to senior QIS nurses working extra shifts, the trust planned to support less experienced neonate nurses to complete advanced neonatal nurse practitioner courses, and to ensure that all senior staff completed neonatal life support training.

End of life care

Good

During our previous inspection of End of Life Care Services at Cumberland Infirmary, in April 2015, we rated the service as 'requires improvement' overall. During this inspection there was evidence of ongoing improvement. We have rated the service as 'good' overall, with effective as 'requires improvement' because:

- Staff delivering end of life and specialist palliative care understood their responsibilities with regard to reporting incidents. Staff we spoke with told us that when an incident occurred it would be recorded on an electronic system for reporting incidents.

Summary of findings

- We viewed mortuary protocols and spoke with mortuary and porter staff about the transfer of the deceased. Staff told us that the equipment available for the transfer of the deceased was adequate, and we saw that this included bariatric equipment.
- The trust had developed a care of the dying patient (CDP) care plan that provided prompts and guidance for ward-based staff when caring for someone at the end of life. We observed the use of these and saw that information was recorded and shared appropriately and that the plans were completed.
- We saw that specialist palliative care nurses worked closely with medical staff on the wards to support the prescription of anticipatory medicines. The guidance that the specialist nurses provided was in line with end of life care guidelines and was delivered in a way that focused on developing practice and confidence in junior doctors around prescribing anticipatory medicines.
- The palliative care end of life communication training (Sage and Thyme) was part of the mandatory training for all staff at CIC.
- We observed the use of McKinley syringe drivers on the wards and saw that regular administration safety checks were being recorded. Ward staff told us that syringe drivers were available when they needed them.
- The trust had also introduced a “Care after Death” document. The document provided a standard operating procedure for healthcare staff to understand that end of life care extends beyond death, to provide care for the deceased person and support to their family and carers.
- An early warning scoring system was in use throughout the trust to alert staff to deteriorations in a patient’s condition. Patients recognised as being at the end of life had their care plan transferred to the CDP framework when they were expected to die within a few days.

Summary of findings

- The Trust had an organ donation policy which adhered to national guidelines. The framework process made reference to specialist nurses, clinicians, and nursing staff supporting the family throughout the process.
- Staffs were able to demonstrate compassion, respect, and an understanding of preserving the dignity and privacy of patients following death. Mortuary staff told us there was always a member of staff on call out-of-hours. This service was available for families who wanted to visit during an evening or a weekend.
- Porters had face-to-face mortuary training that included the transfer of the deceased, promoting dignity and respect, and an understanding of bereavement.
- The chaplaincy service provided spiritual support for patients and their families, together with the Bereavement Nurse Specialist
- The trust ensured that there was timely identification of patients requiring end of life care on admission. Systems were in place so that when a patient who was known to the palliative care team was admitted that team would be alerted.
- We observed staff caring for patients in a way that respected their individual choices and beliefs, and we saw that records included sections to record patient choices and beliefs so that these were widely communicated between the teams.
- An Integrated End of Life and Bereavement group was in operation. This was headed by the Deputy Director of Nursing, and the members of the group included the SPCT, the chaplaincy, the bereavement lead, education and training staff, and consultant medical staff.
- The trust had developed “Welcome to Hospice at Home – West Cumbria” initiative. This service included the provision of daytime and night nursing care, respite care during the day, evening, or night, and volunteer support in the home The service could also refer patients to other services within the organisation, including complementary therapies for patients, carers,

Summary of findings

and those bereaved, one-to-one or group support, bereavement support, and Lymphedema support. All services provided were free of charge

- The SPCT had developed a care pathway tool for patients in all areas of the hospital. This was to ensure that patients who required end of life care were identified at the earliest opportunity, and to facilitate the most appropriate care in the most appropriate place for each patient.
- A clear vision had been established, providing that 'All people who die in Cumbria are treated with dignity, respect and compassion at the end of their lives, and that, regardless of age, gender, disease, or care setting they will have access to integrated, person-centred, needs-based services to minimise pain and suffering and optimise quality of life'.
- The vision's aim was to provide a framework for the delivery of services allowing all adults in Cumbria who were approaching the end of their lives, "to live as well as possible until they die," in accordance with their own wishes and preferences.
- The lead bereavement nurse and the chaplain had leadership roles in terms of end of life care and raising awareness of aspects of their service across the trust. This involved attending meetings and working collaboratively across services and departments to raise awareness of end of life care issues.
- There was a commitment at all levels within the trust to raise the profile of death, dying, and end of life care. This included improving ways in which conversations about dying were held and engaging with patients and their families to ensure their choices and wishes were achieved.
- Discharge coordinators were available to support the process of rapid discharge at the end of life, and the trust had recently implemented a community service where patients could be supported by trust staff in their own homes should care packages be difficult to access in the community.

However:

Summary of findings

- For patients who did not have mental capacity, DNACPR forms we viewed at this inspection were inconsistently completed. We saw DNACPR forms that did not provide evidence of a best interest decision or a mental capacity assessment being undertaken and recorded. In a letter to CQC the trust formally acknowledged our concerns and outlined actions to be taken to address this issue.
- The trust had not achieved two clinical indicators and three organisational indicators in the End of Life Care Audit: Dying in Hospital in 2016.
- The trust had not produced an action plan with key responsibilities and timelines for achievement to address areas where performance was lower than the England average at the time of our inspection.
- The trust could not provide us with the number of referrals to the SPCT.
- Both the SPCT and staff on general wards supported patients in their endeavours to die in their preferred location. However, the trust did not collate or hold the data that would demonstrate the percentage of patients who had done so. This information was held by the Clinical Commissioning Group and could not be provided by the trust.
- There was no regular audit of the CDP.
- Specialist palliative care was not provided across a seven day service.
- The trust did not have formal contract meetings with members of the Cumbria Healthcare Alliance to monitor the service being commissioned and provided, and so could not demonstrate that the service was of an appropriate standard in terms of quality and meeting patient need.

Outpatients and diagnostic imaging

Good

We rated this service as 'good' because:

- An electronic incident reporting system was in place. Staff we spoke with could describe how they would report incidents.

Summary of findings

- The environment was suitable, clean, and tidy. Hand gel dispensers were available for use in all areas visited, and staff adhered to the 'bare below the elbow' policy in services that we visited.
- We found that equipment had been checked appropriately, and medicines that we checked were found to be in date and securely stored. Medical records availability had been identified as an issue at previous inspections, and we found improvements had generally been maintained.
- Staffing levels and skill mix were ascertained by the department managers. Actual staffing levels were mostly in line with the planned staffing levels in most areas.
- Staff used evidence-based guidance and followed national guidance. We found that a number of staff members had undertaken additional courses and training to enhance their competency. Staff had access to the systems and information they required for their role.
- 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.
- Staff provided compassionate care and ensured patient privacy and dignity was respected whilst using the services. Patient feedback was positive about the services. Diagnostic services were delivered by caring, committed, and compassionate staff.
- The service offered clinics throughout the week and on weekends to ensure that patients were seen and to meet demand. Additional clinics were added to manage demand for the services. Interpreter services were accessible and available if required.
- Management could describe the risks to the service and the ways in which they were mitigating these risks. However, we found that not all risks identified were on the risk register.

Summary of findings

- Staff were mostly positive about their roles, local leadership, and team work. Daily huddles in the outpatient department had increased information sharing between staff and were found to be useful.

However:

- Mandatory training completions had not achieved the trust target of 95%.
- There were staff shortages in the orthopaedic practitioner staff group and oncology outpatients.
- There was no formal clinical supervision in main outpatients or ophthalmology outpatients.
- There was no current strategy for outpatients. However, staff told us that they were developing one.
- Performance measurement information was limited.
- The trust did not measure how many patients waited over 30 minutes to see a clinician in outpatient departments.
- Turnaround times for inpatient plain film radiology reporting did not meet Keogh standards, which require inpatient images to be reported on the same day.

Cumberland Infirmary

Detailed findings

Services we looked at:
Urgent & emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and Gynaecology; Services for children and young people;End of life care; Outpatients & Diagnostic Imaging

Detailed findings

Contents

Background to Cumberland Infirmary

Cumberland Infirmary (CIC) is part of North Cumbria University Hospitals NHS Trust (hereafter referred to as the trust), which was created in 2001 by the merger of Carlisle Hospitals NHS Trust and West Cumberland NHS Trust and became a University Hospital Trust in September 2008.

The trust is not a Foundation Trust. Its main commissioner is Cumbria Clinical Commissioning Group (CCG), which commissions around 85% of its services, with NHS England commissioning a further 13%.

CIC is a provider of acute hospital services serving mainly the Carlisle and North Cumbria areas. It is a general hospital providing 24-hour A&E with Trauma Unit status, consultant-led maternity services and special care baby unit, a range of specialist clinical services, and outpatient clinics. It has 500 beds (410 of which are inpatient).

The consultant-led emergency department at Cumberland Infirmary, Carlisle is open 24 hours a day, seven days a week to provide an accident and emergency service for children and adults. Separate entrances were used for walk-in patients and patients arriving by ambulance and there was a reception and waiting area for walk-in patients. Of the 19 bays in the department, 10 in the majors' area were available for isolation of patients. A separately equipped cubicle was available for ophthalmic treatment. A separate area of the department was designated for children, with a children's waiting area and a children's treatment room. A designated room for psychiatric assessment was available for patients with mental health needs with some safety features fitted. The resuscitation area comprised three bays which included one equipped for paediatric patients.

At the time of this inspection the trust provided 334 medical inpatient beds and 50 day-case beds located across 16 wards covering 14 medical specialities. The medical service accounted for over 50% of the overall trust inpatient bed capacity.

CIC provided surgical services for general surgery, head and neck, ENT, orthopaedics, gynaecology, and ophthalmology. There were six wards, an operating suite, a day-case unit, an assessment unit, and a ward which had a mix of medical and surgical patients. In total the surgical division had 80 day-case and 157 inpatient beds.

The trust had a total of 15 adult critical care beds and the Intensive Care National Audit and Research Centre (ICNARC) data indicated that there were around 1150 admissions a year, with 850 at the CIC site. Across two sites there were eleven 'intensive care' (ITU) beds for complex level 3 patients who require advanced respiratory support or at least support for two organ systems, and four 'high dependency' (HDU) beds for level 2 patients who require very close observation, pre-operative optimisation, extended post-operative

care, or single organ support. This also included care for those 'stepping down' from level 3 care. Beds were used flexibly, with the resources to increase and decrease the numbers of either ITU or HDU admissions.

CIC provided care and treatment for maternity and gynaecology patients in Carlisle and the surrounding rural areas of North Cumbria. The maternity services comprised outpatient clinics, post-natal and ante-natal ward, and a delivery suite. Community midwifery services were provided by midwives employed by the trust. For gynaecology patients there was a women's outpatients department and inpatient beds on a surgical ward. There was a termination of pregnancy service, which operated as part of surgical services. There were 10 maternity beds. The gynaecology ward had eight inpatient beds (shared with surgery).

Services for children and young people at CIC included a 16-bed children's ward and an eight-bed short stay assessment unit. A children's outpatient department was adjacent to the children's ward and there was a special care baby unit (SCBU) with 12 commissioned cots.

The Specialist Palliative Care Team (SPCT) service at NCUH Palliative care was commissioned by the Clinical Commissioning Group and delivered in the trust by staff from Cumbria Partnership Trust. The SPCT at CIC comprised one 0.8 WTE consultant post shared with the community and the Loweswater Suite, with two sessions per week of hospital support, one 0.8 WTE staff grade doctor who mainly worked in the Loweswater Suite, and two WTE Macmillan nurses. An End of Life Care team was established at NCUH and consisted of a lead bereavement nurse, a chaplain and a bereavement officer.

The outpatient departments held clinics for various specialities throughout the trust across the different hospital sites. Diagnostic imaging was available at CIC and West Cumberland Hospital. Clinics were held in the main outpatient department and departments such as ophthalmology.

Diagnostic imaging services were mainly provided from two locations – CIC and West Cumberland Hospital – with limited services at Workington Community Hospital, Penrith Hospital, and Cockermouth Community Hospital. Diagnostic imaging at CIC provided plain film x-rays, ultrasound, CT, MRI, and interventional treatments. Acute clinical work, including fluoroscopy, was concentrated at CIC and West Cumberland Hospital. The service offered a range of diagnostic imaging, image intensifiers in theatres, and interventional procedures. The trust provided diagnostic imaging figures for all sites for each modality.

Our inspection team

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

Head of Hospital Inspections: Amanda Stanford, Care Quality Commission

The team included two CQC Inspection Managers, nine CQC inspectors, an Expert by Experience, and a variety of specialists, including consultant medical staff, senior nurses, allied health professionals, and governance experts.

How we carried out this inspection

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

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

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

- Accident and emergency;
- Medical care (including older people's care);

Detailed findings

- Surgery;
- Critical care;
- Maternity and gynaecology;
- Services for children and young people;
- End of life care;
- Outpatients.

Prior to the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These organisations included Cumbria CCG, Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges, Overview and Scrutiny Committees, and the local Healthwatch.

We interviewed members of staff and talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment. We used all of this information to help us decide which aspects of care and treatment to look at as part of the inspection.

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

Facts and data about Cumberland Infirmary

In the year September 2015 to August 2016 53,746 patients attended the accident and emergency department at Cumberland Infirmary, Carlisle. Paediatric attendances (children age 0 to16) represented 18% of these patients.

The trust had 38,352 medical admissions between April 2015 and March 2016. Emergency admissions accounted for 19,658 (51%), 1,248 (3%) were elective, and the remaining 17,626 (46%) were day-case. Of these admissions, 24,614 (64%) were reported from CIC. Admissions for the top three medical specialties were: General Medicine: 18,487; Gastroenterology: 8,294; and Clinical Oncology: 4,259.

Across the surgical division the trust had 24,171 surgical admissions between April 2015 and March 2016. Emergency admissions accounted for 6,469 (26.8%), 13,210 (54.7%) were day operations, and the remaining 4,492 (18.6%) were elective.

Intensive Care National Audit and Research Centre (ICNARC) data indicates that there were around 1150 admissions in the preceding year, with 850 at the CIC site.

Between April 2015 and March 2016, there were 1,759 births at CIC. Across the trust the percentage of births to mothers aged 20-34 and percentage of births to mothers aged 20 and under were slightly higher than the England average.

Patients at the end of life were nursed on general hospital wards. Between April 2015 and March 2016 there had been 1,185 inpatient deaths across the three hospital sites within the trust as a whole.

The trust had 488,353 outpatient appointments between April 2015 and March 2016. Of these, 321,336 appointments were held at CIC and 124,856 appointments were held at West Cumberland Infirmary. All other appointments were held at other trust hospitals: Workington Community Hospital; Penrith Hospital; and Cockermouth Community Hospital.

Staff at CIC had carried out 15,508 CT scans, 7,971 MRI Scans, 14,915 non-obstetric ultrasound scans, 9,857 obstetric scans, 2,425 nuclear medicine procedures, 3,101 fluoroscopy procedures, and 65,850 plain film x-rays in the preceding year.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Notes

Urgent and emergency services

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

Information about the service

Urgent and emergency services were provided at two hospitals within North Cumbria University Hospitals NHS Trust. The consultant-led emergency department at Cumberland Infirmary, Carlisle was open 24 hours a day, seven days a week, to provide an accident and emergency service for children and adults. In the year September 2015 to August 2016 53,746 patients attended the accident and emergency department at Cumberland Infirmary, Carlisle, paediatric attendances (children age 0 to16) represented 18% of these patients.

Separate entrances were used for walk-in patients and patients arriving by ambulance, and there was a reception and waiting area for walk-in patients. Of the 19 bays in the department, 10 in the majors' area were available for isolation of patients. A separately equipped cubicle was available for ophthalmic treatment. A separate area of the department was designated for children, with a children's waiting area and a children's treatment room. A designated room for psychiatric assessment was available for patients with mental health needs, with some safety features fitted.

The resuscitation area comprised three bays, which included one equipped for paediatric patients. The emergency department was a designated trauma unit. The radiology department was adjacent and easily accessible from the emergency department. A relatives' room with comfortable chairs was available.

During our inspection in December 2016 we visited the accident and emergency department at Cumberland hospital on 6, 8, and 9 December. We spoke with 22 members of staff, including managers, doctors, nurses, therapists, non-clinical, and student staff, as well as ambulance staff and volunteers. We reviewed 12 patient records. Inspectors met with 15 patients and relatives, observed the interaction of staff with patients, and observed team meetings in progress. We reviewed comments from people who contacted us to tell us about their experiences, and we reviewed performance information for the hospital.

Urgent and emergency services

Summary of findings

At our previous inspection in April 2015, we rated this service as 'requires improvement'. In December 2016 we rated the service as 'good' because:

- Risks to the delivery of care and treatment for patients were mitigated and a risk register for accident and emergency reflected key risks. Safeguarding procedures were in place.
- Patient care and treatment followed evidence based guidance and recognised best practice standards. Sepsis screening and management and other clinical guidelines were used effectively.
- Staff provided considerate and compassionate care for patients and treated them with dignity and respect. Staff interacted with patients empathetically and responses to their needs were prompt. Care and treatment was explained to patients in a way they understood. Patients were consulted and involved in decisions about their care and treatment and received emotional support.
- Patients with a learning disability, patients with dementia, and bariatric patients accessed emergency services appropriately and their needs were supported. Patients with mental health needs could access services in a joined up way.
- Patient's consent to care and treatment was documented and the requirements of the Mental Capacity Act were followed. Patients' nutrition and hydration needs were provided for and pain was managed effectively.
- Incident reporting had increased and serious incidents had reduced. Learning from the investigation of incidents was shared and duty of candour requirements were followed. Emergency preparedness arrangements were in place to respond to major incidents.
- Public engagement included consultation events about changes to services and although few complaints were received they were investigated and learning was shared with staff.
- Staffing had improved and staff were deployed in the department effectively so that staffing levels were sufficient to meet patients' needs. Mandatory training had been completed by most staff. The learning and development of medical and nursing staff was supported and staff received an annual appraisal. Multidisciplinary teams operated effectively. An improved, positive culture was apparent in the emergency department and staff worked well together.
- The hospital was taking steps to address performance as part of its improvement plan for emergency care and the accident and emergency service undertook a strategic service review during 2016. A frailty assessment unit and an ambulatory care unit recently opened. Seven day working was operated 24 hours a day throughout the year including key support services, for example radiology.
- Cleanliness, infection control and hygiene procedures were followed and standards were monitored. Equipment and medicines stocks were managed effectively.
- The department participated in relevant national audits and undertook regular local audits which supported consistent improvements in care and treatment for patients.
- Local clinical leadership was visible and approachable; governance of the emergency department was more embedded and the vision and strategy for emergency care was understood. The department implemented innovation to benefit patients.
- Although CQC identified incorrect waiting time data at the inspection, the trust responded promptly and robustly to the issues identified and put in place an action plan to have addressed these issues by March 2017 which included arrangements to audit the accuracy of data.

However:

- For an extended period, the hospital has failed to meet the target to see and treat 95% of emergency patients within four hours of arrival and the hospital was failing to meet a locally agreed trajectory to see and treat emergency patients within the standard agreed with regulators and commissioners.

Urgent and emergency services

- Emergency department waiting time data was incorrect. Staff were not fully utilising the computer system as intended so that the times recorded were not accurate.
- Material issues remained with patient flow into the hospital. The accident and emergency service review had identified a shortfall of two whole time equivalent consultant staff due to increasing patient demand. This was only partially filled by locum consultant staff.
- Paediatric nursing resource was limited, although the department was taking steps to address this shortfall.
- Changes in the operational nursing structure for the emergency department needed to become embedded.
- Although the service had made improvements in its responses to the trauma audit and research network (TARN) audit and the NICE clinical guideline self-harm audit (CG16), work to achieve further improvements remained in progress.
- Patient confidentiality was not always maintained in the reception area.
- Staff engagement needed to be extended.

Are urgent and emergency services safe?

Good

At our previous inspection in April 2015, we rated safe as 'requires improvement'. In December 2016 we rated safe as 'good' because:

- Incident reporting had increased and serious incidents had reduced. Staff knew how to report an incident and could describe the action they took following an incident. Learning from the investigation of incidents was shared. Emergency care staff were conversant with the duty of candour requirements.
- Risks to patients in the department were kept under review by medical and nursing staff working together and children were prioritised. The "Home First" initiative applied to patients mainly over 75 years with a frailty condition and a full assessment of their needs was undertaken by therapy staff.
- Safeguarding procedures were in place and there were no open safeguarding alerts. Patient records were maintained.
- Medical and nursing staffing had significantly improved and staff shortages were managed proactively. Staff were deployed in the department effectively and staffing levels were sufficient to meet patients' needs. The department was recruiting more staff, including paramedics in development roles and generic workers. A twilight shift supported the department when it was busiest. Mandatory training had been completed by most staff.
- Cleanliness, infection control and hygiene procedures were followed and standards were monitored. Marginal improvements had been made to the environment and equipment was in order. Medicines management was in order including controlled medicines.
- Emergency preparedness arrangements were in place to respond to major incidents.

However:

- The accident and emergency service review had identified a shortfall of two whole time equivalent consultant staff due to increasing patient demand. This was only partially filled by locum consultant staff.
- Paediatric nursing resource was limited, although the department was taking steps to address this shortfall.

Urgent and emergency services

Incidents

- Following our 2015 inspection, the trust was required to improve the rate of incident reporting. For emergency care, we found there had been an increase in incident reporting and a reduction in the number of serious incidents. Staff knew how to report an incident and could describe the action they took following an incident. Staff reported incidents readily and provided examples of incidents they reported, which included staffing shortages, patients delayed in the department and other risks to patients.
- Reportable incidents in emergency care were recorded using an electronic reporting system widely used in the NHS. Incidents were graded according to risk rating and severity of harm in accordance with the trust incident management policy (including the management of serious incidents) published in February 2016.
- Incidents were categorised according to severity ranging from no injury, low, moderate, major or catastrophic. Managers and the patient safety panel reviewed submitted incidents and grading of harm. Staff escalated serious incidents.
- Incident trends and themes were monitored. In accordance with the Serious Incident Framework 2015, the trust reported 16 serious incidents (SIs) in emergency care between October 2015 and September 2016, which met the reporting criteria set by NHS England Seven of these incidents, were reported for Cumberland Infirmary. Of these, the most common type of incident reported was treatment delay.
- Never events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. Between October 2015 and September 2016, the trust reported no incidents which were classified as Never Events for urgent and emergency care. However, one Never Event involving a medication error occurred in A&E at Cumberland Infirmary, Carlisle in November, 2016. We found operational changes were introduced following the incident and emergency care staff had received a medicines update.
- Investigation reports provided a full summary of the investigation process, the background leading to the investigation, a checklist of critical concerns, a detailed timeline of events, organisational factors, care and service delivery issues, involvement of the patient or family and areas of good practice. The reports detailed action plans, feedback mechanisms and processes in which lessons learnt could be embedded.
- Learning from the investigation of incidents was shared. Managers discussed the outcomes of investigations at divisional meetings, incidents were discussed at weekly sister's meetings and learning was shared with staff at team meetings. The safety newsletter was re-launched in November 2016 and the division proposed holding safety summits on a monthly basis. The division had appointed a safety clinical director who led on programmes to improve clinical safety and learning methods. Learning from incidents was included in a monthly safety newsletter which set out what worked well and what went wrong, so that learning was shared.
- The patient safety thermometer was used to record the prevalence of patient harm, and to provide immediate information and analysis for teams to monitor their performance in delivering harm free care. Data collection took place one day each month.
- Data from the patient safety thermometer showed that between September 2015 and September 2016 for emergency care the service reported eight pressure ulcers, 12 falls with harm and six catheter urinary tract infections. There was an increase in pressure ulcers in February 2016 and June 2016. There was an increase in falls with harm in March 2016. There was an increase in catheter urinary tract infections in March 2016 and June 2016. During our visit the emergency department reported three days without a falls incident.
- We were informed that following an independent audit of duty of candour during 2016, the trust introduced a new policy for duty of candour. Emergency care staff were conversant with the duty of candour requirements and of the trust being open policy. Staff understood that this involved being open and honest with patients. Managers were aware of the duty of candour and some staff explained to us that they had been involved in investigating and responding to patients and families under this duty.
- The division held monthly mortality and morbidity review meetings. The meeting considered case summaries, reviewed outcomes and identified key lessons.

Cleanliness, infection control and hygiene

- The emergency department was visibly clean and tidy. Cleaning rotas were in place for both clinical and non-clinical areas and equipment was visibly clean, although items of equipment did not have a label to indicate it was clean and ready for use. We observed that equipment was cleaned between patients. Clean utility areas and treatment rooms were visibly clean and tidy. We observed clinical waste and sharps were disposed of appropriately, although two cubicles had full sharps bins.
- Staff used personal protective equipment including disposable gloves and aprons. Staff washed their hands between patients and followed the bare below the elbow policy.
- Emergency care followed infection control procedures. The trust healthcare associated infection prevention and control strategy followed national guidelines and infection prevention and control policies to manage and monitor infection essential for patient and staff safety.
- Emergency care was involved in monthly infection prevention and control audits to monitor compliance against quality measures including hand hygiene and cleanliness of equipment. The audit results displayed in the emergency department during our visit were 100% for hand hygiene, 97% for cleanliness, and 73% to 100% for equipment. Managers confirmed best practice was confirmed following infection prevention and control audits and where findings were below standard; action was taken to improve compliance in follow-up audits.
- The division provided data for the Quarterly Reports on Clostridium Difficile Infections in Cumbria published by Public Health England. Infection prevention and control staff investigated all c.difficile cases through root cause analysis. Themes, trends and learning outcomes were disseminated. Staff reviewed confirmed cases at weekly HCAI meetings and at IPC and Safety and Quality groups.
- The trust reported eight c.difficile cases between August and October 2016, of which six (75%) originated from the medical division. The division also completed audits of methicillin resistant staphylococcus aureus (MRSA) screening, although no MRSA cases were reported in the previous 12 months and no infection was attributed to emergency care. Two isolation rooms were available to care for c.difficile positive patients or patients with other conditions requiring isolation. We found staff received training annually in isolation procedures.
- Infection prevention and control training was mandatory and 70% of staff in the medical division had completed this training in the last 12 months.
- Ahead of the inspection we received information about a complaint as to lack of cleanliness in the accident and emergency department at the Cumberland Infirmary, Carlisle. We found that action had been taken to address the concern. The emergency department achieved high scores in patient survey questions about the cleanliness of the department.
- The emergency department contributed to a monthly environmental audit. Monthly audit scores achieved in 2016 for Cumberland Infirmary, Carlisle were consistently 100%, except in one month when the score was 73%. We observed cleaning staff in the emergency department and found that action was taken if any deterioration in cleaning standards was observed.
- We observed a nursing support worker in the emergency department undertaking monitoring of infection control procedures and the cleaning of equipment. The support worker undertook monthly the 15 steps challenge programme from the NHS Institute for Innovation and Improvement. They discussed with staff in the department any infringements of standards they observed.

Environment and equipment

- Separate entrances were used for walk-in patients and patients arriving by ambulance and a reception and waiting area for walk-in patients. Of the 19 bays in the department, 10 in the major's area were available for isolation of patients. A separately equipped cubicle was available for ophthalmic treatment which could also be used for other patients. A separate area of the department was designated for children, with a children's waiting area with toys and TV and a children's treatment room. A designated room for psychiatric assessment was available for patients with mental health needs with some safety features fitted.
- The resuscitation area comprised three bays which included one equipped for paediatric patients. The resuscitation bays could also be used for overflow from the main department. The emergency department was a designated trauma unit. The radiology department was adjacent and easily accessible from the emergency

department. A separate room was available in the department for reviewing x-rays. A separate relative's room with comfortable chairs was available. Designated rooms were also provided for medical and nursing staff.

- Since our 2015 inspection the department had reviewed its storage arrangements to release space for an additional treatment cubicle for "see and treat." Two further cubicles were also designated for see and treat and a step-down seating area for patients when awaiting a bed elsewhere in the hospital.
- We reviewed the storage of items in the stock room. The department had reviewed the storage arrangements for equipment and supplies. Adequate stocks of sterile single use equipment were available and within date. A trolley fitted with an x-ray plate had been obtained for the use of bariatric patients.
- Checklists of the equipment on the resuscitation trolleys and in cubicles were completed for a daily, weekly and monthly cycle of checks. We checked equipment in the resuscitation and paediatric areas. A separate equipment checklist was used for the paediatric resuscitation bay. Equipment checklists for the current and previous months were completed although we found two or three days over a three month period where the checklists were unsigned. In the resuscitation area labels to indicate individual items of equipment had been checked were not used.
- Electrical and mechanical equipment was maintained appropriately and faulty equipment was repaired or replaced. We reviewed evidence that planned preventative maintenance for the department was fully completed over the previous two years. We reviewed the minutes of the medical devices committee for September 2016 which confirmed the action taken if the planned preventative maintenance schedule fell behind and after root cause analysis of accidental damage to medical devices, the department was incentivised to minimise causes of damage. Items of equipment we checked were within their maintenance dates and clearly labelled. Trolleys were clean and labelled ready for use. Electrical equipment was portable appliance tested and within date.
- The medicines division had recently opened additional facilities which were available for patients who may have attended the emergency department and required further observation or treatment. An ambulatory care unit with three treatment rooms and a surgical assessment unit had opened. The division had also recently designated a frailty unit for patients who required a short stay in hospital.
- The division contributed to the trust Patient-Led Assessments of the Care Environment ("PLACE") 2016 audit. Performance improved in all four aspects of PLACE from 2015 to 2016. The greatest performance improvement in 2016 compared to 2015 was related to facilities which improved by 19%.

Medicines

- Emergency department staff were aware of local policy, professional standards for medicine management and for the storage and administration of controlled drugs. Staff we spoke with knew how to report incidents involving medicines. A dedicated clinical pharmacy service was available to the department. Pharmacy staff maintained stock levels and checked medicine expiry dates.
- Medicines were appropriately stored and access was restricted to authorised staff. Medicines which required refrigeration were stored appropriately. Staff completed daily checks of fridge temperatures and an audit of fridge temperatures was completed weekly. Staff informed us when a temperature reading was outside the upper or lower limit, they contacted the pharmacy department for guidance.
- Staff managed controlled drugs securely and maintained accurate records in accordance with trust policy, including regular balance checks. We undertook a random check of controlled medicines in the resuscitation area and found medicines were within their expiry date and was securely stored and disposed of appropriately. .
- The department participated in an audit of controlled medicines for the medicines division in September 2016. The division's overall reported compliance was 94%. Some improvements to documentation were identified from the audit.
- One Never Event involving a medication error occurred in the emergency department at Cumberland Infirmary, Carlisle in November, 2016. We found operational changes were introduced following the incident and emergency care staff had received a medicines update.
- The department received quarterly medicines safety data to identify individual actions and to encourage learning. Reports included medicine safety results,

reconciliation figures, allergy status compliance, medication omission rates, controlled drug audits, antibiotic audits, patient experience, education and training and discussed key incidents to share wider learning from other hospital areas.

Records

- An electronic patient record system used elsewhere in the NHS was used in the department. Since our 2015 inspection we were informed the electronic patient record system had been updated to improve data entry.
- Staff used the system in conjunction with the completion of paper records. The record followed the patient through the department. The initial set of patient observations were recorded using the electronic system. Paper records were printed from the system in the form of an emergency department card. The patient cards and supporting assessment records were subsequently scanned onto the electronic system. Records were kept securely and confidentially.
- We reviewed the records for seven patients in the department. The records were kept up-to-date with details completed of their assessment, risk review, diagnosis, plans for care and treatment and the involvement of the patient. Multi-disciplinary team involvement was documented. We found the paper records were well completed and collated consistently with the exception of minor inconsistencies related to the recording of allergies, where these were also recorded in the electronic system. In a small number of instances we did not find evidence of ongoing nursing assessment being recorded.
- The division completed annual case note audits for the NHS Litigation Authority. The key clinical content indicators were mainly in place however the audit identified some issues with legibility of entries, fully completed patient details on all pages and some signatory omissions.

Safeguarding

- The trust had designated an executive lead and organisation level staff team with responsibility for safeguarding. The division and department were represented by senior staff who attended safeguarding board meetings.
- Staff we spoke with in the emergency department were aware of the trust's safeguarding policy. Staff were confident in identifying concerns and escalating these where appropriate, both within and out-of-hours. Safeguarding records were well documented. The emergency department had no open safeguarding alerts at the time of our inspection.
- Staff completed a safeguarding key in the patient's clinical assessment record for each child who attended the emergency department. The electronic patient record system alerted staff to any previous safeguarding issues. Records contained the appropriate triggers and a safeguarding referral file was also available in the department. We observed with consent two paediatric patient safeguarding assessments, which we found followed the recognised safeguarding process.
- Safeguarding policies and procedures we observed were displayed in designated staff areas. Safeguarding information included guidance as to where to seek specialist advice and provided key contact details for escalation. Staff also accessed safeguarding information and guidance on the trust intranet.
- For the division which included emergency medicine, the trust had in place a target of 95% for completion of mandatory safeguarding training by the end of March 2017. Prior to our inspection we found the medical staff group in emergency services had not reached the trust target for any of the safeguarding training courses. Training compliance for nursing and health care assistant staff in emergency services achieved the trust target for safeguarding adult's level 1 and safeguarding children level 2. Managers confirmed that for staff who had not attended their refresh training, a date was arranged before the end of the year.

Mandatory training

- Mandatory training modules covered core subjects including information governance, fire safety, equality and diversity, infection control, health and safety and basic life support. For staff in emergency care, a range of additional training modules in specialist clinical competencies was included in mandatory training. Staff in the department received training in basic and advanced life support covering adults and paediatrics, advanced and immediate and paediatric immediate life support.
- The division including emergency medicine adhered to the trust mandatory training target of 95% by the end of March 2017. As of August 2016, compliance for medical staff ranged from 83% for equality and diversity and 50% for basic life support. Nursing staff compliance rates

were better ranging from 97% for equality and diversity to 59% for fire safety. Managers confirmed that where shortfalls in training compliance were identified, staff were arranged to attend the relevant session.

- At our inspection we saw evidence displayed in the emergency department that 83% of staff had completed their mandatory training. Staff in a focus group confirmed that the trust had placed an emphasis on their completion of mandatory training. Staff were allocated time to compete mandatory training. Staff in the focus group confirmed they had completed their training.

Assessing and responding to patient risk

- Patients were prioritised in order to see the sickest patients first. Walk-in patients with mainly minor injuries arrived at the emergency department reception and were seen promptly by a member of reception staff to receive initial signposting. We observed the initial assessment of patients on arrival. The receptionist used recently revised guidance to direct the patient depending on the apparent seriousness of their condition, so that more urgent patients were seen first, rather than in the order they arrived. Patients under 18 years were directed to a separate paediatric waiting room. Patients arriving by ambulance used a separate entrance and were seen promptly on arrival.
- In the triage area, children were seen first of all, and then adult patients were called from the main waiting room. A triage system widely used in the NHS was used. A qualified triage nurse undertook observational screening and discussed their history with the patient to assess their condition. The triage nurse offered the patient pain relief if this was indicated, and other minor treatment needs could be dealt with directly by the triage nurse. The triage nurse may request initial blood tests or x-rays immediately so that the patient's results were available when they were seen by a doctor. The triage nurse recorded the patient's details on the electronic system.
- Following their triage the patient was allocated to a red, yellow or green category depending on the initial assessment of their risk. Patients were directed or escorted to minors, majors or another department in the hospital. We observed that a child was taken to the paediatric department for further assessment.
- The electronic admissions system alerted staff when patients had previously attended the hospital and the emergency department. The system indicated if the patient was assigned to a specialist team, for example oncology, so that staff could signpost appropriate care for the patient.
- Since our 2015 inspection the "Home First" initiative had started. For patients over 75 years who lived alone with a frailty condition, a full assessment of their needs was commenced on their arrival in the emergency department, undertaken by a physiotherapist and occupational therapist. These members of staff then liaised with the patient's family and with the hospital frailty ward.
- We found that since our 2015 inspection the senior nurse and doctor worked closely together in managing the flow of patients through the department so that the most unwell patients were prioritised. When significant patient delays in the department were experienced which risked patients waiting more than one hour, medical staff commenced assessment and treatment so that the patient by-passed the nurse triage. The medical intervention was used to ensure risks to patients were managed, and was operated for a variable length of time. This approach was also used when there were no medical beds available in the hospital.
- Every two hours the nurse in charge undertook rounding of the department to review the risks to patients. Staff described this as trouble shooting.
- Emergency department staff used a range of tools to assess, monitor and respond to patient risk. The emergency department completed the national early warning score (NEWS) for each patient treated in the majors area of the department. NEWS scores the patient's vital signs and was used for identifying patients who were deteriorating clinically. NEWS was part of the patient record and included directions for escalation.
- Since our 2015 inspection, the emergency department had held a NEWS rapid improvement workshop which aimed to improve NEWS compliance. The quality of care board in the department included actions for the week and we observed that NEWS was identified for improvement. We observed the information board in the department which identified patients and indicated whether a NEWS score had been completed. A NEWS sticker was fixed to the patient's name if they had a NEWS score of five or more, with the date and time of the next observation.
- Since our 2015 inspection the emergency department had also introduced a nursing assessment based on the

situation, background, assessment and recommendation (SBAR) technique. SBAR was not completed for each patient, but for patients identified for admission to hospital. We were informed SBAR had been developed as a result of audit, with the objective of improvements in handover and in consistency of care. We saw some evidence that audits had been undertaken which demonstrated this.

- Since our 2015 inspection the emergency department had introduced a recognised (ROSIER) triage score for suspected stroke patients, with the objective of improved stroke recognition and treatment.
- The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust met the standard for 12 months over the period August 2015 to July 2016.
- At the December 2016 inspection we were informed that changes to the triage process since our previous inspection had increased the number of patients triaged within 15 minutes. The improvement was evidenced by performance information in the emergency care dashboard for 2016-17. The quality of care display in the department showed that 98% of patients were being triaged within 15 minutes.
- The department undertook a daily audit to check that patients were being triaged within 15 minutes. We saw evidence that 80% of patients were being triaged within this time. We observed that at some times no triage nurse was present in the triage room even though there were patients in the waiting room who had not been triaged. We confirmed there were delays in triage from conversations with patients.
- An escalation policy was in place for the emergency department. Bed management meetings were held regularly to review and escalate risks that could impact on patient safety, including staffing, bed capacity and patient flow in the hospital. The emergency department matron was able to escalate concerns. The emergency department operations policy included guidance on how to escalate patient pathway delays or other concerns in order to meet the needs of patients.
- The hospital was a designated trauma unit. A major trauma bypass protocol was in place as part of the northern trauma system with the local ambulance provider to ensure patients were directed to the correct site within and outside of the trust. Trauma procedures identified pathways for both adults and children which specified the treatment each location was able to carry out and when a transfer should take pace for severe trauma. Where patients were sent to another site (for example a major trauma centre: the nearest is Newcastle) the receiving hospital could prepare appropriately to receive the patient.

Nursing staffing

- We found the trust had made progress with its emergency department nursing staffing compared with our 2015 visit. Since our 2015 inspection the trust had obtained approval to recruit staff to an agreed level and the emergency department had improved staffing levels. Shift patterns had been changed to increase staffing levels at times of high patient demand. A paramedic had been deployed on the nursing rota to work in resuscitation and triage roles.
- The emergency department did not use a recognised staffing acuity tool to determine the nursing establishment. Departmental data was analysed and local knowledge and clinical experience was used to take account of fluctuations in attendances to inform staffing numbers. Staffing levels met these criteria except when the department was very busy.
- Qualified and unqualified nursing staff of different grades were assigned to each of the patient areas within the emergency department. The department had in place planned nurse to patient ratios for the minors, majors and resuscitation areas. In resuscitation and majors, two registered nurses were allocated to six patients for the early and night shifts, with three registered nurses to six patients for the late shift. In minors and paediatrics, one registered nurse and two health care assistants were allocated to 15 patients on the early shift, one registered nurse and two healthcare assistants were allocate to seven-and-a-half patients on the late shift, with one registered nurse and one health care assistant allocated to seven-and-a-half patients on the night shift. Other qualified and senior staff were allocated to triage and nursing supervision of the department. Two generic workers were in post who undertook a variety of roles supporting the practical needs of patients.
- During our inspection we observed the quality of care display board in the department which was completed daily, and showed planned and actual levels of staffing. For registered nurses, actual staffing matched planned staffing in the morning, but was operating with one

nurse short in the afternoon and at night. Health care assistants were as planned. On a second day, the department was also operating with one nurse less than planned in the morning. Senior staff confirmed that the department had regularly operated with less staff than planned, particularly at night, which was confirmed by a comparison of actual and planned qualified nurse staffing for four months during 2016.

- The department had recently introduced a twilight shift to provide support when the department was busiest. Despite nurse staffing shortfalls, we obtained evidence from the emergency department to confirm that a process was followed for managing staffing levels and escalating staff shortages. Staff confirmed patients were safe and not at risk.
- Since our 2015 inspection the staffing duty rota was managed using an e-roster system introduced in May 2016. Staff told us this system provided improved monitoring of nursing staff resource.
- We were informed that three daily nursing handover meetings took place in emergency medicine. A daily multidisciplinary meeting was held which included medical and reception staff. Because of different shift change times for medical and nursing staff, separate handovers were also held where staffing requirements were reviewed. Handover information was recorded by the nurse in charge for those staff not present.
- Between April 2015 and March 2016, the trust reported for emergency care an average turnover rate of 31%, and a sickness rate of 5%. We reviewed evidence that the turnover rate had decreased substantially. As at September 2016, the trust reported a vacancy rate of 2.6% in emergency care.
- At the time of inspection the emergency department were recruiting a full time paediatric charge nurse to replace a member of staff who had left the service. The service were also recruiting a senior clinical lead, a paramedic and two registered nurses for emergency care. Senior managers in a focus group told us the trust reviewed each vacancy in emergency care to check whether there was a more efficient way of replacing staff who had left. The service was working with the university to co-ordinate nursing recruitment.
- Cover for staff absences at short notice was provided by bank staff from the existing nursing team or by agency nursing staff. Agency staff were subject to vetting checks and received training in delivering emergency care before working in the department. Between April 2015 and March 2016, Cumberland Infirmary reported a bank and agency usage rate of 1.02% in urgency care.

Medical staffing

- We found medical staffing for the division which included emergency medicine had improved since our inspection in 2015. Senior and medical staff in a focus group gave examples of progress since the last inspection. Medical rotas were more resilient to change and some medical consultant staff had returned to the trust and gave positive feedback about the progress achieved. The organisation had a high retention rate for existing medical staff.
- Medical staffing in the emergency department consisted of three substantive consultants of which one was on maternity leave at our inspection. The vacancies for three further consultants were held by locum consultants, one of whom was long-term. The accident and emergency service review had identified a shortfall of two whole time equivalent consultant staff due to increasing patient demand. This was only partially filled by locum consultant staff.
- A dedicated consultant worked on the emergency floor all day and also middle grade medical staff. No paediatric consultant was in post in the department. A paediatric consultant was on-call from the paediatric department in the hospital.
- Between April 2015 and March 2016, the trust reported a bank and locum usage rate of 20% in emergency care. The emergency department locums were seen as stable and well embedded in the role. The department had found it difficult to recruit to substantive consultant posts. Existing vacancies and shortfalls were covered by locum, bank or agency staff when required. All agency and locum staff received a local induction before they were permitted to work in the department. Locum consultants required current advanced life support training and were required to support the consultant staff rota.
- Consultants held handovers between medical staff at their change of shift, and in the morning a multidisciplinary meeting was also held with senior nursing staff. When we observed a medical handover we saw that staffing arrangements to cover shortages were included in the discussion.

Urgent and emergency services

- At our 2015 inspection we required the trust to ensure that medical staffing was sufficient to provide appropriate and timely treatment and review of patients at all times including out-of-hours and that medical staffing was appropriate at all times including medical trainees, long-term locums, middle grade doctors and consultants.
- At this inspection, for the emergency department we found consultant medical staff worked a series of staggered shifts with the first being from 8am to 4pm, the second from 9am to 5pm and the third from 1pm to 10pm. A consultant was on call through the night until 8am. Middle grade medical cover was provided 24 hours and day seven days a week and included acute clinical practitioners. Junior doctors also provided cover 24 hours an day seven days a week. This meant that four members of medical staff worked through the night. Consultant cover during the week was available from 8am to 10pm weekdays. Each member of medical staff covered shortfalls in rotas over a 24 hour period and was on call during out-of-hours and weekends. Medical staff confirmed that colleagues were ready to support them with clinical advice during the night if required.
- Between April 2015 and March 2016, the trust reported a sickness rate of 0.01% in emergency care, with 0.02% reported for Cumberland infirmary.

Major incident awareness and training

- Emergency care was included in trust arrangements for major incident planning and business continuity and we found an emergency preparedness policy was in place. Staff we spoke with were familiar with the major incident policies and were able to access guidance on the trust intranet which included key risks that could affect the provision of care and treatment. The resilience team for the trust undertook exercises to challenge emergency response procedures and communications from the team were shared with staff.
- The department had in place decontamination facilities and equipment to deal with patients who may be contaminated or otherwise exposed to hazardous substances. Staff undertook simulated chemical, biological, and radiological training and were familiar with procedures to follow in the event of a major incident alert. Senior staff confirmed they had undertaken the major incident training. A member of nursing staff in the emergency department was in charge of training and upkeep of equipment.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

At our previous inspection, in April 2015, we rated effective as 'requires improvement'. In December 2016 we rated effective as 'good' because:

- Patient care and treatment followed evidence based guidance and recognised best practice standards. Clinical audits were used to assess how well NICE and other guidelines were followed. Sepsis screening and management and other clinical guidelines were used effectively.
- The department contributed to the Royal College of Emergency Medicine's (RCEM) clinical audit programme, participating in most national audits for which it was eligible. The department also undertook regular local audits which supported consistent improvements in care and treatment for patients.
- The service supported the learning and development of both medical and nursing staff. All staff new to the department received an induction and all staff received an annual appraisal.
- Staff collaborated effectively within multidisciplinary teams to support the planning and delivery of care.
- Patient's consent to care and treatment was documented in their records. The requirements of the Mental Capacity Act were followed where this was appropriate.
- Patients' nutrition and hydration needs were monitored and provided for and their pain symptoms were managed promptly and effectively.
- Information supported the coordination of services for patients and was exchanged readily with other departments in the hospital.
- Seven day working was operated 24 hours a day throughout the year including key support services, for example radiology.

However:

- Although the service had made improvements in its response to the trauma audit and research network (TARN) audit, work to improve the readiness of consultant-led trauma teams was ongoing
- Although the service had made improvements in its response to the NICE clinical guideline self-harm audit (CG16) work to increase the number of patients who received a clear risk assessment was ongoing.

Evidence-based care and treatment

- Since our inspection in 2015 we found improvements in evidence based care in the emergency department. The introduction of new nursing documentation had improved clinical indicators. An external tool to support the collection and reporting of electronic data for local audit had been used in the department.
- We found care and treatment in the emergency department was evidence-based and followed recognised national guidelines including the National Institute for Health and Care Excellence (NICE) and College of Emergency Medicine (CEM) guidelines. Local policies reflected up-to-date clinical guidelines and were available on the trust intranet. Staff referred to a range of NICE, CEM guidelines and patient group directions to support best practice in the provision of care and treatment provided for patients.
- The division including emergency medicine had in place a range of evidence based condition specific care pathways to enable standardised and improved patient care and service flow. The department used clinical guidelines including trauma, stroke, pneumonia and fractured neck of femur which were developed for local use alongside recognised national and international standards.
- The division including emergency medicine had adapted guidance for sepsis screening and management. For patients with symptoms of sepsis, the department followed the sepsis care bundle. The sepsis care pathway flowchart provided guidance in treating severe sepsis. We observed the display for staff on the department's quality of care board which included sepsis amongst the actions for the week.
- The clinical guidance group for the hospital oversaw the development of the clinical guideline policy and the preparation and revision of clinical guidelines. We found clinical guidance was discussed at governance meetings where the impact that guidance made to staff practice was considered.
- The division which included emergency medicine had developed a range of evidence based condition specific care pathways to standardise and improve patient care and service flow. For example, we saw an abscess referral flowchart for an abscess referral pathway for the hospital which was used in the department to support referrals to ambulatory care. We observed that operational rules for resuscitation and other procedures were displayed in the department
- The emergency department undertook clinical audits to assess how well NICE and other guidelines were followed. The clinical audit plan for 2016-17 showed that national audits of violence and aggression and of assessment of transient loss of consciousness were in progress in emergency care and aimed to check practice in relation to NICE guidelines. Examples of other audits current in emergency medicine at our inspection included vital signs in children and procedural sedation in adults.
- The hospital's clinical effectiveness and improvement programme was supported by continuous data collection for national audit. An external tool to support the collection and reporting of electronic data for local audit was used in the department. The audit of NICE guidance and 10 national audits were supported, which included for example sepsis, asthma and consultant sign-off. A consultant was assigned to each audit with responsibility for monitoring actions taken. The division used national audit findings to develop action plans which supported compliance with evidence-based care and treatment. Audits resulted in changes in practice to improve patient care in staff training.

Pain relief

- In the CQC accident and emergency survey, the trust scored 5.82 for the question "How many minutes after you requested pain relief medication did it take before you got it?" This was about the same as other trusts. The trust scored 8.09 for the question "Do you think the hospital staff did everything they could to help control your pain?" This was also about the same as other trusts.
- The division which included emergency medicine participated in the trust wide pain management audit. The audit considered four clinical indicators (pain

assessment, care plan, analgesia administration and pain reassessment) with a benchmarking compliance of 95%. Between September and November 2016, the division reported overall compliance at 96%.

- We observed staff in their care and treatment of patients who required pain relief. Patients were assessed for pain relief as they entered the emergency department. During the initial assessment, the patient was asked about their level of pain and whether they required medicine to relieve their pain symptoms. We observed that a pain scoring system was used and if the patient scored zero, this was also recorded in their assessment.
- Of the seven patients we reviewed who needed pain relief, medication was mainly given very promptly. For example, we saw that the triage nurse ensured patients were given relief for pain symptoms. However in two instances patients required and were administered pain relief although their pain score was recorded as zero. Patients we spoke with confirmed they had been given medicine for pain relief if they required it.

Nutrition and hydration

- In the CQC accident and emergency survey, the trust scored 6.91 for the question "Were you able to get suitable food or drinks when you were in the emergency department?" This result was about the same as other trusts.
- We observed that housekeeping staff checked with patients about their needs for food and drink and ensured they were served hot drinks and food. Staff checked whether patients were not permitted refreshments for medical reasons before offering them. Nurses checked patients had received food and drink appropriate for their needs during the two hourly intentional rounding. We observed a display board with details of patients in the department where staff had recorded whether the patient had received food and drink. We were informed that it could be more difficult for patients to obtain food and drink out-of-hours.
- The emergency department had some facilities to make drinks and snacks and staff had access to a fridge where sandwiches could be stored for patients. However, there was not a separate fridge for patients' use.
- The division contributed to the Patient Led Assessment of the Care Environment (PLACE) 2016 survey. In the food category, the hospital achieved an 83% satisfaction rate, which was worse than national average of 88%.

Patient outcomes

- At our 2015 inspection we reviewed the hospital's performance in the trauma audit and research network (TARN) audit for admissions between January 2014 and December 2014. Data showed consultant led trauma teams had only been ready for patients with an injury severity score greater than 15 on arrival for 17 patients out of 42 (41%). We required the trust to improve the rates for consultant led trauma teams being ready for patients with an injury severity score greater than 15 on arrival.
- At this inspection we reviewed the trust's quality improvement programme to check the progress it had made against this requirement. The trust reported that improvements had been achieved and a re-audit in 2016 found an improved level of consultant attendance at trauma calls and improved documentation of the event by medical staff. The rate of improvement was not specified and the action remained in progress in the quality improvement programme.
- At our 2015 inspection we also reviewed the hospital's performance in the audit in relation to NICE clinical guideline CG16 (Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care) which looked at 52 patients in the emergency department. Results showed only 22% had a clear risk assessment and 92% were seen by the mental health team within an hour. We required the trust to increase the number of patients who received a clear risk assessment.
- At this inspection we reviewed the trust's quality improvement programme to check the progress it had made against this requirement. The trust reported that improvements had been achieved which included training for staff and raising awareness of self-harm. An audit was carried out during 2016 to monitor progress and a further audit was planned during 2017. The action remained in progress in the quality improvement programme.
- Since our 2015 inspection the emergency department had achieved some improvements in patient outcomes which were confirmed by national audit. The department participated in Royal College of Emergency Medicine (RCEM) audits to measure its performance against other trusts. A consultant lead was assigned for each audit in the emergency department. We observed that details of progress with current local emergency

care audits were displayed in the medical staff area of the department. Work was in progress for national audits on trauma, asthma, sepsis, dementia and consultant sign-off.

- In the 2014-15 RCEM audit for assessing cognitive impairment in older people, Cumberland Infirmary was in the upper quartile compared to other hospitals for two of the six measures and was in the lower quartile for two of the six measures. The site did not meet the fundamental standard of having an Early Warning Score documented (74%).
- In the 2014-15 RCEM audit for initial management of the fitting child, Cumberland Infirmary was in the lower quartile compared to other hospitals for four of the five measures and was in the upper quartile for none of the five measures. The site did not meet the fundamental standard of checking and documenting blood glucose for children actively fitting on arrival.
- In the 2014-15 RCEM audit for mental health in the emergency department, Cumberland Infirmary was in the upper quartile compared to other hospitals for one of the six measures and was in the lower quartile for two of the six measures. Of the two fundamental standards included in the audit, the site did not meet the fundamental standard of having a documented risk assessment taken. The site did not meet the fundamental standard of dedicated assessment room for mental health patients.
- Between August 2015 and July 2016, the trust's unplanned re-attendance rate to accident and emergency within seven days was generally worse than the national standard of 5% and generally about the same as the England average apart from in April 2016 when there was a sharp rise to 53%. In the latest period, July 2016, trust performance was 7.2% compared to an England average of 7.9%.

Competent staff

- Before they commenced work in the emergency department, staff received an induction specific to their role in accident and emergency care.
- Between April 2015 and March 2016, 43% of medical and nursing staff in accident and emergency at the hospital had received an appraisal. However, the executive confirmed that 94% of staff had received an appraisal, which compared with 48.75% in 2015-16. The performance display board in the emergency department showed that 100% of staff had received their appraisal. Staff we spoke with confirmed they had received an annual appraisal in the previous 12 months and that they received regular appraisals.
- Staff in a focus group told us they were allocated time for regular supervision. We found nursing staff met with their line manager weekly. Members of staff in emergency medicine were allocated a buddy. Staff were supported to access external mentoring.
- Nursing and medical staff we spoke with were positive as to the support they received with their learning and development. Nursing staff had been supported through the role of a practice educator in the department linked to preceptorship and the development of clinical competencies linked to mandatory and developmental training. Healthcare assistant staff were also supported to develop extended skills. Staff received mentorship and chose their own mentors.
- Staff employed by the trust and working in the division were required to meet their professional continual development obligations. A range of on-line and in-house courses were available for staff. The division also had strong links with higher education establishments, medical schools and universities. Newly qualified staff employed by the trust and working in the division were subject to a period of preceptorship and supervision which varied according to the area worked and subject to competency sign-off.
- Nursing staff confirmed they received support from the trust about their Nursing and Midwifery Council (NMC) revalidation. Medical staff told us clinical supervision was in place and adequate support was available for revalidation.

Multidisciplinary working

- Within multidisciplinary teams of medical, nursing, allied health professional and support staff we observed that staff collaborated to support the planning and delivery of care. Daily meetings took place which included medical and nursing staff and therapists to provide oversight of staffing needs in the department.
- The department liaised with medical and surgical areas of the hospital and medical and nursing staff discussed patient needs with the ward staff to support effective handover. The department liaised with a specialist crisis team to provide support for patients with mental health needs.

- Therapy staff in a focus group told us about the joint assessments they undertook in the department as part of an improvement initiative. Physiotherapists and occupational therapists supported the Home First initiative in the emergency department. For patients over 75 years who lived alone with a frailty condition, a full assessment including the patient's social needs was commenced on their arrival in the department. Therapy staff also liaised with the ambulance service, the falls service and community services and with relatives about patients with frailty needs. The Home First team also visited patients in the community.
- The division was represented on the multi-agency steering group which with adult social care supported a multi-agency discharge policy. The group were reviewing discharge procedures. However, staff in a focus group told us better liaison was needed between the accident and emergency department and other specialties.

Seven-day services

- The emergency department operated 24 hours a day throughout the year. Support services including the radiology department, which supported accident and emergency were open 24 hours a day, seven days a week. The emergency department also collaborated with the on call out-of-hours services.
- Consultant, middle grade, specialist and junior medical staff in the emergency department covered the rota 24 hours a day, 365 days a year. Consultant medical staff worked a series of shifts between 8am and 10pm and a consultant was on call through the night until 8am. Middle grade medical cover was provided 24 hours an day seven days a week and included acute clinical practitioners. Junior doctors also provided cover 24 hours an day seven days a week.
- Each member of medical staff covered shortfalls in rotas over a 24 hour period and was on call during out-of-hours and weekends. Medical staff confirmed that colleagues were ready to support them with clinical advice during the night if required.
- Reception staff worked a 12 hour shift and the receptionist rota covered 24 hours a day, seven days a week.
- Pharmacy services were not available 7 days a week, but a pharmacist was available on call out-of-hours. The department held a stock of frequently used medicines which staff could access out-of-hours.
- Ambulatory care services provided seven days services between 9am and 8pm.
- We observed that information about out of hour's services was displayed in the patient waiting area.
- The trust monitored its current working scheme against NHS services, seven days a week clinical standards. The division for medicine and emergency care provided evidence which addressed the four priority clinical standards: time to first consultant review, diagnostics, interventions and on-going review.

Access to information

- Clinical Information and guidance was available to staff through the trust intranet, which included operational policies and procedures for the emergency department. A monthly safety newsletter was published for staff by the patient safety team, linked to a monthly safety summit. The chief executive kept a weekly blog to update staff.
- The computer information system used in the department was widely used in the NHS and supported data including waiting times so that the patient's progress through the hospital could be tracked. We observed that the computer screen displayed details of all patients in the department.
- Information which supported the care and treatment of patients in the emergency department and included the patient's medical details, assessment and test results was exchanged readily with other departments in the hospital. Information was available to support the coordination of services. Staff we spoke with raised no concerns about being able to access patient information or investigation results in a timely manner.
- We observed the information board in the department which identified patients and indicated visually how their assessment and support needs were being met. Staff could see if an intervention, for example an observation, was due for the patient. A communications book was maintained by the sister in charge of the department to record information of relevance to staff, for example about the daily departmental meeting.
- A hospital arrivals screen with information about patients to support their arrival in the department was linked to the main ambulance service, but not to two other NHS ambulance services that also transported patients to the hospital. Staff told us this meant it was not always an accurate source of information.

Urgent and emergency services

- In the CQC In-Patient Survey 2015, patients rated various criteria around information sharing. Patients found information shared about continuity of care (6.8 out of 10), medications (8.1 out of 10), danger signals (5.3 out of 10) and details provided to family and friends (6.0 out of 10) to be in line with national average for similar trusts.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The emergency department used the trust policy which informed staff about the consent process. The policy included how to obtain consent where patients may have capacity issues and included guidance on the Mental Capacity Act (MCA). Staff we spoke with were aware of the safeguarding policies and procedures and had received training. We observed that staff gained the patient's consent prior to carrying out care or treatment.
- MCA and Deprivation of Liberty Safeguards (DoLS) training was part of mandatory training. The trust reported that as at August 2016 MCA level 1 training has been completed by 84% of medical, nursing and health care assistant staff in urgent and emergency care. DoLS training has been completed by 62% of staff in urgent and emergency care.
- Staff shared examples of DoLS, and explained the steps taken to support patients who may not have the capacity to consent. We saw examples of mental capacity assessments completed in patient records.

Are urgent and emergency services caring?

Good

At our previous inspection in April 2015, we rated caring as 'good'. In December 2016 we rated caring as 'good' because:

- Staff provided considerate and compassionate care for patients and treated them with dignity and respect.
- Staff interacted with patients empathetically and responses to their needs were prompt.
- Patients spoke positively about the care and treatment the department provided. Patients and their families were happy about their care and treatment. Relatives of children being seen in the paediatric area said their children had positive experiences of attending the department.
- Care and treatment was explained to patients in a way they understood. Staff explained to paediatric patients and their relatives in an easily understandable way what was to happen next about their treatment.
- Patients received emotional support to allay anxiety. Staff provided reassurance and comfort to patients who were worried, as part of their care.
- Patients were consulted and involved in decisions about their care and treatment.

However:

- Patient confidentiality was not always maintained in the reception area.

Compassionate care

- The performance in the friends and family test was positive, although the emergency department's performance was mostly worse than the England average. The friends and family test performance (% recommended) for emergency care was generally worse than the England average between September 2015 and August 2016. However there was a trend of improvement from April to July 2016. In the latest period, August 2016 trust performance was 82% compared to an England average of 87%, which showed that most patients would recommend the department.
- We spoke with several patients and their relatives to seek their views of care in the department, and observed care being delivered. We observed as staff provided considerate and compassionate care for patients. We observed that staff interacted with patients empathetically and responses to their needs were prompt.
- Patients, carers and relatives spoke positively about the care and treatment the department provided. Patients said staff treated them with patience and compassion. Patients and their families said they were happy about their care and treatment and felt relaxed about their visit to the department. We spoke with relatives of children being seen in the paediatric area who told us their children had good experiences of attending the department. Staff told us about the positive feedback they received from patients and family members.

Urgent and emergency services

- For the CQC emergency department survey 2014 response to the questions “Were you given enough privacy when discussing your condition with the receptionist?” and ”Were you given enough privacy when being examined or treated in the emergency department?” the trust scored about the same as other trusts. We saw that staff closed cubicle curtains during consultation with patients and staff spoke with patients in private to maintain confidentiality. Patients we spoke with felt their privacy and dignity was upheld. However, we observed that the reception area for walk-in patients did not always enable patient confidentiality to be maintained.

Understanding and involvement of patients and those close to them

- The results of the CQC emergency department survey 2014 showed that the trust scored about the same as other trusts in 22 of the 24 questions relevant to caring, which included the question, “While you were in the emergency department, how much information about your condition or treatment was given to you?”
- The trust scored better than other trusts in the two remaining questions relevant to caring: “If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?” and “If you needed attention, were you able to get a member of medical or nursing staff to help you?”
- Patients told us that their care and treatment was explained to them in a way they understood. Patients and their relatives who had been waiting for the results of tests in the department said they had been kept well informed about their treatment.
- In the children’s area, staff explained to patients and their relatives in an easily understandable way what was to happen next about their treatment. Relatives said they were happy with the explanations they had been given.
- We observed that patients were given information to support their care and treatment when they were discharged from the department.

Emotional support

- We observed staff as they provided emotional support. We observed staff interactions with patients to allay anxiety. Staff provided reassurance and comfort to patients who were worried. In the children's area, toys were provided.
- A relatives’ room was available for people who had experienced trauma. Information about bereavement was available. If a patient was deceased, a room was set aside to allow relatives to spend time there. Patients received emotional support from chaplaincy and bereavement services, support groups, charity workers and volunteer staff.
- Staff could access counselling services for additional support, for example after they had assisted with trauma or another distressing event.

Are urgent and emergency services responsive to people’s needs?

(for example, to feedback?)

Requires improvement

At our previous inspection, in April 2015, we rated responsive as ‘requires improvement’. In December 2016 we again rated responsive as ‘requires improvement’ because:

- For an extended period, the hospital has failed to meet the target to see and treat 95% of emergency patients within four hours of arrival
- The hospital was failing to meet a locally agreed trajectory to see and treat emergency patients within four hours of arrival which had been agreed in conjunction with regulators and commissioners.
- Emergency department waiting time data was incorrect. Staff were not fully utilising the computer system as intended so that the times recorded were not accurate.
- Material issues remained with patient flow into the hospital. We found patients experienced overnight delays in the emergency department whilst waiting for beds to become available in the hospital.

However:

- The hospital was taking steps to address performance as part of its improvement plan for emergency care and the accident and emergency service undertook a strategic service review during 2016.
- The medicine and emergency care division had reconfigured elderly care services and opened a frailty assessment unit which provided for direct referral of suitable patients. An ambulatory care unit was recently

opened which provided additional facilities for suitable patients who may have attended the emergency department and required further observation or treatment.

- The trust's system suppliers had been engaged to make changes required to the system to coincide with the completion of staff retraining in March 2017. The trust arranged to commence from February 2017 an internal audit of the actual time that the decision to admit (DTA) was recorded and the true DTA time to compare results of real-time data entry.
- An incident in December 2016 in which a patient waited longer than 12 hours for admission as an inpatient was investigated as a serious incident.
- Patients with a learning disability, patients with dementia, and bariatric patients accessed emergency services appropriately and their needs were supported. Patients with mental health needs could access services in a joined up way.
- Although few complaints were received they were investigated and learning was shared with staff.

Service planning and delivery to meet the needs of local people

- The medicine and emergency care division supported the trust in planning services to meet the needs of the people of Cumbria in collaboration with local commissioners. Divisional managers attended meetings with commissioners as part of the local health network to plan for service improvements which met the needs of local people.
- The development of emergency services within the sustainability and transformation plans was in development and consultation with commissioners and neighbouring providers of care. Divisional managers worked with partners involved in the “Success Regime” established in 2015 to review healthcare services across the region and to support the trust's longer term development of its emergency medical service pathways.
- Since our 2015 inspection the medicine and emergency care division had reconfigured elderly care services and opened a frailty assessment unit at Cumberland Infirmary. The unit provided for direct referral of suitable patients from the emergency department to consultant-led geriatric assessment.
- Also since our 2015 inspection the medicine and emergency care division had opened an ambulatory care unit at Cumberland Infirmary. The unit provided additional facilities for suitable patients who may have attended the emergency department and required further observation or treatment.
- During 2016 the accident and emergency service undertook a strategic service review in collaboration with other divisional managers of service delivery across key specialities. The review included current service configuration, activity trend, quality and workforce issues, financial position, future clinical model proposals, sustainability issues and organisational options. Business units were considering recommendations at the time of our inspection. .

Meeting people’s individual needs

- For vulnerable patients and those with complex needs, the division of medicine and emergency care took all reasonable steps to ensure the care they required was uncompromised. For example, a trust specialist link nurse was available to support patients with special needs.
- Divisional managers confirmed that in planning services, the needs of all patients, irrespective of age, disability, gender, race, religion or belief were taken into account. For non-English speaking patients, emergency department staff could access a telephone interpreter service. Staff told us translation services were easy to use. A chaplaincy service was available.
- The division used the “This is me” passport document to support patients with a learning disability. The passport was completed by the patient or their representative and included key information about the person’s preferences. Patient passports for patients with a learning disability may be completed by care providers prior to admission. Senior nursing staff in the emergency department told us they tried to prioritise patients with learning disabilities. The division had access to trust specialist nurses for patients in vulnerable groups including learning disabilities.
- The trust had in place a dementia strategy and lead nurses for patients with dementia. A dementia working group for the trust was in place. The emergency department had a lead nurse for dementia. Three members of nursing staff and a member of non-qualified staff had received additional training in caring for patients with dementia. We observed that the butterfly symbol was used to identify patients with

dementia. We observed the display board with details of patients in the department where staff had recorded whether the patient had dementia needs using a butterfly marker.
- For patients with mental health needs, staff told us they could refer patients to psychiatric liaison services. Specialist support teams were available between 8am and 8pm. The community out-of-hours crisis team provided cover at other times. Staff told us the psychiatric liaison service was effective.
- We observed staff administering care and treatment to a patient with psychiatric needs. The patient was escalated by the triage nurse when they arrived in the department. The medical and nursing team in the major's area organised the care and treatment for the patient using a pathway which supported their needs, based on the patient's previous attendance at the department.
- For bariatric patients, specialised equipment was available in the hospital. Staff explained that they could access bariatric equipment including special beds and wheelchairs from equipment storage when this was required. (Bariatric is a branch of medicine which deals with the causes, prevention and treatment of obesity).
- For patients with special visual and hearing needs, we were informed that there were no particular additional adjustments or services made available. Staff told us that the patient's visual or hearing needs were considered as part of their assessment for care and treatment.

Access and flow

- At our 2015 inspection we required the Cumberland Infirmary, Carlisle to improve performance against the Department of Health target for emergency departments to admit, transfer or discharge patients within four hours of arrival.
- At the December 2016 inspection we found the trust had agreed with regulators and commissioners an improvement trajectory target to achieve the four hour target. The hospital's performance against the four-hour target was monitored on a daily basis. Staff in a focus group told us that although the trajectory target had not been achieved consistently to date, the hospital was taking steps to address performance as part of its improvement plan for emergency care.
- At the December 2016 inspection we reviewed performance information in the emergency care dashboard for 2016-17, observed the progress of a selection of patients through the emergency department and tracked the times that patients arrived at each stage of their assessment and treatment. We compared our observed times with those recorded in the hospital's real time patient tracking computer system.
- When we compared times we had observed with recorded times, we found there were unexplained discrepancies in the data. For example, when medical or nursing staff commencing seeing a patient, a time was recorded on the system which did not coincide with the actual time they saw the patient.
- We observed that when the patient triage was undertaken and a time input to the computer system, the staff undertaking triage could change the recorded time, so that the information was not accurate. Medical and nursing staff may assign the patient to themselves as they arrived, rather than when treatment was commenced. When we revisited the computer system information later in the day to review times for doctor intervention, we found most times had changed from those displayed earlier in the day. The time to treatment taking into account all patients was not as stated. The times patients were seen was recorded manually on the patient's card.
- After discussion with the trust, a larger selection of data (for November 2016) was reviewed and the trust also conducted its own analysis of the data and of the outputs from the computer system. The trust concluded from its own analysis of emergency department waiting times that the data was incorrect. The trust deduced that staff were not fully utilising the computer system as intended so that the times recorded were not accurate.
- Following the inspection we requested the trust to explain the steps it had taken to resolve the issues identified with the computer system and its application and use in the emergency department. The trust informed us that the system configuration required review and some re-built to improve and streamline the recording of workflow. The trust's system suppliers had been engaged to make changes required to the system to coincide with the completion of staff retraining in March 2017. The trust revised its specification for some parts of the system, particularly for treatment and

decision to admit times. Changes to the recording of decision-to-treat were being made to ensure appropriate information was displayed on the tracking screen.

- The trust also arranged to deliver a programme of retraining for staff in the use of the system during February and March 2017 to address inaccuracy in recording. The emergency department medical and nursing staff teams were closely involved to ensure DTA entry was completed in real time.
- The trust arranged to commence from February 2017 an internal audit of the actual time that the decision to admit (DTA) was recorded and the true DTA time to compare results of real-time data entry.
- Between September 2015 and August 2016 there was a downward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Cumberland Infirmary. In July 2016 23% of ambulance journeys had turnaround times over 30 minutes; in August 2016 the figure was 25%. There has been a gradual overall downward trend since March 2016.
- A "black breach" occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. Between October 2015 and September 2016 the trust reported 556 black breaches. The trust reported 130 black breaches in January 2016 and 81 in February 2016. There was a downward trend in the monthly number of black breaches reported over the period since the peak in January 2016.
- At the December 2016 inspection we were informed that improvements in ambulance handover arrangements had reduced the time that ambulances waited for handover since our previous inspection. The improvement was evidenced by performance information in the emergency care dashboard for 2016-17. We ascertained anecdotally from speaking with ambulance staff that handover waits ranged from 2 minutes to one hour, dependent on the workflow in the department. The ambulance information screen displayed in the emergency department showed that 85.4% of patients were handed over within 15 minutes.
- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department. The trust breached the standard continuously between September 2015 and August 2016
- Between September 2015 and August 2016 performance against this metric showed a decline from September 2015 to January 2016. There was a general improvement from January 2016 to July2016 however this declined again in August 2016. In the latest month, August 2016, the percentage of patients, admitted, transferred or discharged within four hours was 90.1 % compared with an England average of 91.0%.
- The emergency care dashboard for 2016-17 showed the hospital's performance against the four-hour waiting time target outturn for 2015-16 was 87.9%. Emergency department performance against the four hour waiting time target for Cumberland Infirmary for September to November 2016, the three most recent completed months at our inspection was 86.1%, 84.0% and 80.6% respectively against the 95% performance standard. For December 2016 the performance against the four hour target was 82.8%, compared with the trajectory target of 91% as agreed with regulators and commissioners.
- During our inspection we observed the quality of care display board in the department which was completed daily and showed performance against the four-hour target. On the first day of our visit the performance against the four-hour target was shown as 82% and on the second day it was 86.7%. During our visit we found the maximum time a patient had waited in the department was 5hours 20 minutes. A notice in the department informed arriving patients of the approximate waiting time to see an emergency doctor, which was shown as one hour.
- The trust scored better than other trusts for the emergency department survey question, "Overall, how long did your visit to the emergency department last?
- Over 12 months, 10 patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours were in December 2015: three patients; January 2016: three patients, and March 2016: two patients.
- Following our inspection an incident occurred on 12 December 2016 in which a patient waited longer than 12 hours for admission as an inpatient at the Cumberland Infirmary. The trust investigated this as a serious incident and shared the findings of the investigation with CQC. Although a secondary finding, the

investigation concluded that decision to admit times and other additional data entries were added onto the computer system retrospectively and were therefore not being added in real time. The process the emergency department staff were following for determining the DTA and the entry of this information onto the computer system was not being consistently adhered to with data being entered retrospectively and changed.

- Whilst there were contributory factors, the root cause of the incident was determined as a failure to escalate from accident and emergency to the site co-ordinator in a timely manner a patient who was expected to breach 12 hours waiting in the department. The trust had subsequently informed CQC that a weekly operational management meeting had been established since December 2016 to review emergency department performance, specifically targeting 12 hour breaches.
- At our 2015 inspection we required the Cumberland Infirmary, Carlisle to improve patient flow throughout both hospitals to ensure patients were cared for on the appropriate ward for their needs and reduce the number of patient bed moves, particularly in the medical division.
- At our 2016 inspection we found the hospital had taken some steps to improve the flow through the provision of the frailty assessment unit and the ambulatory care unit but material issues remained with patient flow into the hospital. We found that patients experienced overnight delays in the emergency department whilst waiting for beds to become available in the hospital. On one evening during our inspection, 23 patients in the emergency department were waiting for beds and no medical or surgical beds were available. We observed some of these patients waiting in corridors, although the department had provided a seating area for some patients.
- Cross-site bed meetings were held daily to address access and flow issues. Staff identified bottlenecks to patient flow and prioritised actions to remove obstacles for patient admissions and discharges.
- Staff in a focus group told us that delays in the transfer of care had an immediate adverse effect on operation of the emergency department and the wider hospital. The organisation told it was taking steps to address access and flow issues in the local health economy in collaboration with external partners including adult social care. A daily flow meeting included patient transport, adult social care and community services to improve flow across the service.
- Between August 2015 and July 2016 the trust's monthly median percentage of patients leaving the trust's urgent and emergency care services before being seen for treatment was better than the England average. There was a slight increase in numbers in November 2015 but this was still below the England average.

Learning from complaints and concerns

- The trust reported 291 complaints between September 2015 and August 2016. During this period, 21 (7%) complaints were attributed to the medical division. Twenty of these complaints were received at Cumberland Infirmary. The majority of these (67%) related to treatment and care provided by a clinician or nurse and admission, discharge and transfer arrangements (14%).
- Ahead of the inspection we found there had been one complaint and two compliments received about the emergency department from October 2016. Staff confirmed that the department received very few complaints.
- The trust complaints policy included information about how patients could raise concerns, complaints, comments and compliments and included details of how to access the Patient Advice and Liaison Service (PALS). We found staff understood complaints procedures. We observed that leaflets and posters were displayed in the emergency department about how patients and their relatives and carers could complain about their care and treatment.
- Details of complaints were recorded on the trust computer system. Progress in the investigation of complaints was monitored and reported with performance quality indicators. The department responded to complaints according to the trust complaints policy timetable and concluded investigations within 33.9 working days at the Cumberland Infirmary.
- Staff in a focus group told us that feedback from the investigation of complaints was shared during monthly team meetings where complaints were discussed and

time allowed for reflection on things that could be done better. We observed information displayed in the department about changes that had been made as a result of investigating complaints.

Are urgent and emergency services well-led?

Good

At our previous inspection, in April 2015, we rated well-led as 'good'. In December 2016 we again rated well-led as 'good' because:

- An improved, positive culture was apparent in the emergency department which reflected a changed culture in the trust. Staff worked well together.
- Risks to the delivery of care and treatment for patients were identified, managed and action taken appropriately to mitigate them. A risk register for accident and emergency was in place and reflected key risks for the department. The risk register was reviewed monthly, and actions taken.
- Senior staff in accident and emergency understood the vision and strategy for the emergency care service and how it linked with the trust vision and strategy at hospital and organisational levels.
- Arrangements for the governance of the emergency department had become more embedded. A daily operational meeting and a weekly medical meeting were attended by medical and nursing staff and a clinical governance meeting for the emergency department was held monthly, again attended by senior medical and nursing staff at which items for escalation and other actions were agreed.
- The "Home First" initiative for patients mainly over 75 years with frailty needs and joint projects with local universities to develop different approaches to staffing were examples of innovation the department had applied to benefit patients.
- The emergency department engaged with the public through a range of methods and had held a number of public consultation events including consultation about changes to services.
- Staff were mainly consulted about changes and described local clinical leadership as visible and approachable.
- Although CQC identified incorrect waiting time data at the inspection, the trust responded promptly and robustly to the issues identified and put in place an action plan to have addressed these issues by March 2017 which included arrangements to audit the accuracy of data.

However:

- Changes in the operational nursing structure for the emergency department needed to become embedded.
- Staff engagement needed to be extended.

Vision and strategy for this service

- The medicine and emergency care division had a vision and strategic goals which reflected the aims and objectives of the trust, "To provide person centred world class quality health care services." The hospital had developed a detailed business plan which identified strategic priorities for the division aligned to trust principles and values.
- Since our 2015 inspection the service had developed its divisional strategy which included a clinical quality strategy for 2015-18 with priorities for 2016-17 linked to the trust strategy; short, medium and long term projections for performance improvement, partnership working and engagement. The divisional business unit plan 2016-17 included key strategic priorities relevant to each area.
- We found that senior staff in accident and emergency understood the vision and strategy for the emergency care service and how it linked with the trust vision and strategy at hospital and organisational levels. Staff were positive about the vision for an integrated emergency floor at Cumberland hospital, Carlisle with extended ambulatory care and about the steps already in progress to progress this vision for the service.
- Managers and senior staff in a focus group were conversant with local divisional objectives and of the impact of the wider transformation agenda for the local and regional health economy.

Governance, risk management and quality measurement

- The medicine and emergency care division had clearly defined governance channels into the trust's wider

organisational management structure. A risk register for accident and emergency was in place and reflected key risks for the department. The risk register was reviewed monthly, and actions taken.

- Since our 2015 inspection a weekly medical meeting was held, attended by the lead matron for the emergency department, the business unit manager and deputy; and general managers. The agenda included local and corporate risks, incidents and complaints, audit results, patient survey results and staffing matters including appraisal, mandatory training and recruitment. The matron for the department also chaired a weekly sister's meeting at which incidents were discussed.
- A daily operational meeting to review the previous day was attended by medical and nursing staff. Patient attendances, breaches of the four hour target, incidents, changes to policies or guidance, progress with local and national audits, medicines management, mandatory training, patient surveys and items for escalation were discussed. A record was kept in the department's communication book.
- A clinical governance meeting for the emergency department was held monthly and attended by senior medical and nursing staff. Our review of minutes showed that the accident and emergency risk register, incidents, complaints, and audit were reviewed and items for escalation and other actions were agreed.
- Divisional governance, safety and quality board meetings were held monthly. Our review of the minutes of meetings held in 2016 showed the divisional risk register, incidents, service performance, clinical audit, policy review and items for escalation were discussed.
- Staff in a focus group told us that since 2015, the governance meetings attended in the department had become more embedded. Daily meetings including medical and nursing staff was very supportive of teamwork. Staff told us they were on a trajectory in an improving situation and were taking steps to mitigate the risks.
- Although CQC identified incorrect waiting time data at the inspection, the trust responded promptly and robustly to the issues identified and put in place an action plan to have addressed these issues by March 2017 which included arrangements to audit the accuracy of data.
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Leadership of service

- The division for medicine and emergency care had in place a clear management structure defining lines of responsibility and accountability. The division was led by an associate medical director, an associate chief operating officer and a chief matron. The senior management team covered each site.
- Emergency care and acute medicine was led by a clinical director, an associate clinical director and a business manager for the Cumberland infirmary, Carlisle site. The division management structure also included three general managers and other senior management staff.
- The emergency department operational nursing structure was led by four sisters (Band 7) who operated a rota as nurse in charge of the department and reported to a matron (Band 8a) for the Cumberland infirmary, Carlisle site. In the absence of a band 7 sister two band 6 nurses may cover temporarily the nurse in charge role. Some changes in the nursing structure were planned to take effect from January 2017, with the matron covering across sites. Staff in the department told us the matron was seen as proactive although there was not enough management time in the role.
- Staff in a focus group told us that since our 2015 visit, the executive team was more engaged. Managers were supported through an in-house leadership programme which was launched during 2016. Managers were seen to be more willing to seek external help and the executive supported this approach. Staff described local clinical leadership as visible and approachable.
- Staff considered communications from the divisional leaders could be more comprehensive and succinct. This was supported in the NHS Staff Survey 2016, where 21% reported good communication between senior management and staff (versus 31% national average).

Culture within the service

- Emergency care staff represented in focus groups spoke enthusiastically about their work, about the quality of care delivered across the division and of the improvements made in the trust since our last visit in 2015. Staff described how the organisational and divisional culture was evolving. Staff told us the culture had shifted to a more transparent and open philosophy and they considered this to be work in progress.

- Medical and nursing staff told us in focus groups that the emergency department operated in a positive culture in which staff worked well together. We observed very good team working in the emergency department. Staff told us it was a nice place to work.
- Staff were still working under pressure as they had limited headroom. This view was supported by the results of the NHS Staff Survey 2016 which reported 85% of staff felt their role made a difference (lower than national average of 90%).

Public engagement

- The medicine and emergency care division participated in face-to-face and real time surveys. Patients could also leave feedback on comment cards in the accident and emergency department and through the trust website.
- The trust's urgent and emergency care friends and family test performance (% recommended) was generally worse than the England average between September 2015 and August 2016. However there was a trend of improvement from April to July 2016. In August 2016 the trust performance was 82% compared to an England average of 87%. We observed that the results of the friends and family test were displayed in the department. The quality of care display board in the department which was completed daily contained a reminder to staff to ask patients to complete the friends and family test.
- The division for medicine and emergency care used the "Two minutes of your time" survey each month to obtain the views of patients and their families on their experiences of using hospital services. Responses consistently scored above 9 out of 10. The department displayed the results of "You said, we did" survey actions taken at the department entrances to inform patients of changes made in response to patient feedback.
- The medicine and emergency care division had developed links with a range of volunteer organisations, charities and national support groups involved with patients.
- The medicine and emergency care division supported the trust and wider health community with consultation as to the future of healthcare services in the region. The future of healthcare in West, North and East Cumbria was the subject of a public consultation document current at the time of our December 2016 inspection and we were informed that 17 public consultation events had been held.

Staff engagement

- In the NHS Staff Survey 2016, the trust performed better than other trusts in nine questions, about the same as other trusts in 17 questions and worse than other trusts in six questions. The positive trends related to staff having opportunities to progress in the organisation and incident reporting. Staff engagement scores and staff contributing to work related improvements were lower than the national average.
- The executive leadership team arranged staff forums and drop-in sessions for staff. The chief executive held cross-site roadshows with recent topics including staff support, staff morale and generating cost savings. Some staff told us they were not able to attend due to clinical duties.
- Staff in a focus group told us how there had been an increased effort by divisional managers and the leadership team to engage with staff cross-site.
- Staff commented they had contributed to surveys about staff health and wellbeing. This had generated a number of action plans; in particular, organisational leaders were accessing physical activity schemes, physiotherapy services, and mental health initiatives and had appointed a health and wellbeing coordinator. Staff hoped to see this become a greater priority in the future.
- We were informed that engagement with staff in the emergency department had improved since our 2015 inspection. For example, the quality of care display board in the department which was completed daily to show arrange of operational information for staff was developed as a result of engagement with staff.
- The leadership team and divisional leads had used staff surveys to seek opinion on the transformation regime proposals. Managers recognised how unsettling changes of this kind could be for operational staff and staff attended public consultation events.

Innovation, improvement and sustainability

- The "Home First" initiative for patients mainly over 75 years had commenced since our 2015 inspection. For patients who lived alone with a frailty condition, a full assessment of their needs was commenced on their

arrival in the emergency department, undertaken by a physiotherapist and occupational therapist. These members of staff then liaised with the patient's family and with the hospital frailty ward.

- A joint project with a local university had commenced to develop and appoint allied nurse practitioners (occupational therapists) to support the nursing compliment across the division. In partnership with another university, the trust was supporting the development of a composite workforce to provide a cohort of acute care practitioners to support the medical staffing complement.

Medical care (including older people's care)

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

Information about the service

The medical care service at the trust provides care and treatment across two sites, Cumberland Infirmary (CIC) situated in Carlisle, and West Cumberland Hospital (WCH), situated in Whitehaven. At the time of our inspection the medical care service was managed by a single management team covering both sites under the division for medicine and emergency care (hereinafter referred to as 'the division').

The trust provided 334 medical inpatient beds and 50 day-case beds, located across 16 wards and covering 14 medical specialities. The medical service accounted for over 50% of the overall trust inpatient bed capacity.

The trust had 38,352 medical admissions between April 2015 and March 2016. Emergency admissions accounted for 19,658 (51%), 1,248 (3%) were elective, and the remaining 17,626 (46%) were day-case. Of these admissions, 24,614 (64%) were reported from CIC. Admissions for the top three medical specialties were:

- General Medicine: 18,487
- Gastroenterology: 8,294
- Clinical Oncology: 4,259

The present CIC was officially opened in 2000 to consolidate three city facilities into one location in Carlisle.

The division provided 234 beds, primarily located within 11 wards: Maple A; Larch A-C (the ambulatory care suite and emergency admissions unit [EAU]); Willow A-D (including the coronary care unit [CCU]), and Elm A-C. The division also provided a heart centre, an endoscopy suite, a medical procedures unit (MPU), and an on-site chemotherapy day unit facility at Reiver House.

The medical service was previously inspected between 31 March 2015 and 2 April 2015. The service was rated 'requires improvement' overall at CIC. Individual domain ratings reported safe, effective, and responsive as 'requires improvement' and caring and well-led as 'good'. The well-led rating had improved from the April 2014 inspection.

Inspectors reported insufficient medical cover, lack of leadership for junior medical staff, nurse staffing shortages, pressures on medical beds leading to high outlier numbers who were poorly reviewed, and delay to relocate as concerns.

During this inspection we spent time at CIC visiting all wards and clinical areas managed by the medical team. We spoke with 35 members of staff (including managers, doctors, nurses, therapists, pharmacists, and non-clinical staff). Where appropriate we considered care and medication records (including electronically stored information), completing 16 reviews. Our team met with 19 patients and relatives and observed shift handovers, multi-disciplinary team meetings (MDT), safety huddles, meal times, and care being delivered at various time of the day and night.

Medical care (including older people's care)

Summary of findings

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

- Improve medical staffing levels;
- Increase numbers of trained nurses;
- Improve safety thermometer results;
- Improve performance for the care of patients with diabetes;
- Reduce the pressures on the availability of medical beds;
- Stop moving patients during the night without a medical reason for doing so; and
- Provide effective leadership for nurse practitioners.

During this inspection we found that the service had made some improvements:

- While medical staffing was not at full substantive compliment at CIC, there had been recruitment in cardiology, respiratory, and older person's services. Network support had been strengthened in oncology and haematology services. There was a composite workforce strategy being reviewed, a number of senior interviews were pending, and the division had a clearer recruitment picture;
- Registered nurse vacancies remained at CIC; however, all wards reported an improved picture since the 2015 inspection. This division had reconfigured wards and there were improved fill rates;
- There had been a reduction in patient harms aligned to safety thermometer key performance indicators;
- The division worked with a partner trust to provide diabetes services. A joint diabetologist appointment had been made and specific programmed activities were in place to develop diabetic foot services;
- There had been a reduction in the number of medical outliers on the CIC site. The division had developed a number of initiatives to improve access and flow;
- Moves after 10 pm continued at CIC, however, we were assured that staff only effected such a move when clinical demand and patient need necessitated this; and
- All nurse practitioners were brought into the divisional management structure to provide clinical supervision, and senior nursing support was available to this cohort of staff.

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

- Nurse staffing requirement had not been formally revalidated following recent ward reconfigurations. Registered nurse staffing shortfalls and registered nurse vacancies persisted on all divisional wards. A number of registered nurse shifts remained unfilled despite escalation processes. The 'floor working' initiative within medical care should be reviewed in order to support safer nurse staffing. There was a continuing number of patient related harms around pressure ulcers and falls. Some infection prevention and control (IPC) audit outcomes highlighted a variance in compliance against cannula and catheter care key performance measures. Auditors identified some medicines related documentation that required improvement and deviation from National Early Warning Score triggers needed further consideration. Mandatory training figures were inconsistent and overall were below trust target.
- Patient outcomes in some national audits were static or worse than the national average. These were around key performance indicators in diabetes and two domains within myocardial infarction data. Completion of fluid and food charts required improvement, and the temperature of some patient meals was not optimal. Staff confirmed learning opportunities and access to professional development was variable, and appraisal rates provided by the division were inconsistent with those reported at ward level. The division had not fully embedded seven day working across all areas.
- Staff considered the endoscopy suite at CIC was not fully meeting the needs of the local population due to changes in the booking and list preparation processes. This had led to increased numbers of patients failing to attend. There remained a number

of medical outliers being cared for on non-medical wards, and care progression for those patients assessed as medically fit for discharge stalled due to multi-factorial difficulties. Some dementia initiatives to support vulnerable patient cohorts were not fully embedded.

- The divisional risk register did not correlate with top risks identified by divisional leads. Risk ratings were confusing and details of actions taken against the risks were limited. Divisional progress against the Quality Improvement Project objectives was incomplete and slow. Staff morale was variable, and junior doctors resented the perceived shift of onus onto them to take responsibility for covering gaps in the junior doctor medical rota. Staff considered the rate of change to be hurried and difficult. Senior leaders lacked visibility.

However:

- Staff confidently reported incidents, and the division had made considerable efforts to reduce harm to patients from falls and pressure ulcers. Ward environments were clean, and staff used personal protective equipment appropriately to protect themselves and the patient from infection exposure. Overall, medicines management was good and clinical documentation, in particular risk assessments and safety bundles, was completed thoroughly. Medical staffing establishment had improved, and the division considered alternative initiatives to bolster medical staffing.
- The division was actively involved in local and national audit, which provided a strong evidence base for care and treatment. Patient outcomes in a number of national audits were good and there had been some reported improvements in others. Patients reported pain management to be good and considered their nutritional needs to be met. Multidisciplinary team working across the divisional wards was integrated, inclusive, and progressive. Staff had an understanding and awareness of consent issues, Mental Capacity Act, and Deprivation of Liberty Safeguards, and capacity assessments were completed.
- Patients were positive about the care they received. Staff were committed to delivering high quality care. Staff interactions with patients were compassionate, kind, and thoughtful. Patient privacy and dignity was maintained at all times. Staff proactively involved family and considered all aspects of holistic wellbeing.
- The division supported the trust in service planning to meet the needs of the local population, acknowledging the internal and external demands upon it. The division had developed new services, extended the remit of existing services, appointed specialist practitioners, and collaborated with neighbouring trusts in service development. There were good 18 week standards reported. Access and flow was monitored, and the division worked to minimise obstacles. The division provided additional services to redirect flow and avoid unnecessary admissions. The management of medical outliers had improved. The division had made reasonable adjustments to reduce environmental conflict for vulnerable patient groups, and complaint numbers were low on divisional wards at CIC.
- The division had a strategy and vision, which was aligned to organisational aims and wider healthcare economy goals. Divisional leads had an understanding of the pressures and risks the service faced. Governance processes were clinician driven and quality measures were monitored. There were defined leadership structures across the division. Cultural improvements had been made in the last 18 months. Staff and public engagement had improved and the division was involved in a number of improvement projects.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

We rated safe as 'requires improvement' because:

- Nurse staffing requirement had not been formally revalidated following recent ward reconfigurations. Registered nurse staffing shortfalls and registered nurse vacancies persisted on all divisional wards. A number of registered nurse shifts remained unfilled despite escalation processes. The 'floor working' initiative within the medical care should be reviewed in order to support safer nurse staffing. In areas of increased patient acuity, such as non-invasive ventilation and thrombolysis, the respective areas did not meet recommended nurse staffing ratios.
- Whilst there had been improvements to address the incidence of patient harm related incidents, there was a continuing number of patient related harms around pressure ulcers and falls.
- Some IPC audit outcomes highlighted a variance in compliance against cannula and catheter care key performance measures.
- Auditors identified some medicines related documentation that required improvement, around the recording of indications for antibiotic prescribing and end dates not being specified. There was inconsistency in the recording of 'receipt' of controlled drugs. Additionally, the signing for oxygen prescribing was poor. Medicines management training compliance required improvement.
- Mandatory training figures reported by the trust varied from those recorded at ward level, and mandatory training figures overall were below trust target. Ward managers were appointing where shortfalls had been identified.
- The documenting of NEWS observations used to support clinicians in the identification of a deteriorating patient required improvement. Specifically, this focussed on the recording of any agreed deviation from NEWS triggers.

However:

- Staff confidently reported incidents and had an awareness of the Duty of Candour regulations. There were no Never Events in the division, and a reducing number of serious incidents related to patient harms.
- Staff were conversant with IPC guidelines. Staff used personal protective equipment appropriately, isolation nursing procedures were followed, and waste and sharps disposal was in accordance with trust policy. Ward cleanliness and hand hygiene audit findings were consistently good.
- Overall, ward environments were clean and equipment checks were completed in accordance with local policy. The division had recently upgraded telemetry equipment.
- Medicines were safely stored and dispensed against best practice guidelines and key performance indicators was generally good. Nursing and medical documentation standards were good. Risk assessment completion, individualised care bundles, and care pathways were evidenced very well.
- Safeguarding knowledge and procedural understanding was good and mandatory training figures were progressing to meet trust target.
- Staff responded to patient risk promptly using a combination of clinical judgment, early warning trigger tools, and treatment pathways. The stroke service had developed a 'stroke bleep' to facilitate prompt assessment and access to treatment for this cohort of patients.
- Medical staffing numbers had improved from the previous inspection, with a number of senior appointments across the division specialisms. Additionally, divisional managers considered additional workforce assurance projects to support medical cover, such as securing long-term locum contracts, developing the composite workforce model, embedding consultant of the week rotas, and partner working with neighbouring trusts.

Incidents

- The division reported incidents through the trust electronic reporting system.
- The division graded incidents according to risk rating and severity of harm in accordance with their incident management policy (including the management of serious incidents), which was published in February 2016.

- Such reported incidents were then categorised according to severity ranging from no injury to low, moderate, major, or catastrophic. Ward managers, matrons, and patient safety panel reviewed submitted incidents and grading of harm. Staff escalated serious incidents accordingly.
- Between October 2015 and September 2016 the trust reported 8,287 incidents, of which 1,766 (21%) were generated from the medical division (excluding accident and emergency). Of incidents recorded across the division, 1,069 (62%) were no harm, 527 (31%) were recorded as low harm, 88 (5%) were rated moderate, and less than 1% were classed as severe. The division reported two deaths.
- Ward managers, matrons, and divisional leads all monitored incident trends and themes. The most common incident type was the 'patient accident' category (32%). Of those incidents with moderate classification and above, most related to treatment, ongoing monitoring and review, and patient accident.
- We reviewed four incident investigation reports/root cause analysis (RCA) documents. We found that the investigation reports provided a comprehensive summary of the investigation process, the background leading to the investigation, a checklist of critical concerns, a detailed timeline of events, organisational factors, care and service delivery issues, involvement of the patient or family, and areas of good practice. The reports detailed action plans, feedback mechanisms, and processes in which lessons learnt could be embedded.
- In accordance with the Serious Incident Framework 2015, medical care services at the trust reported 45 serious incidents (SIs); 33% of the trust overall total. CIC reported 24 (53% of the total across the division) SIs which met the reporting criteria set by NHS England between October 2015 and September 2016. The most common incident classification was 'pressure ulcer (PU) meeting SI criteria', accounting for 58% of all reported.
- Staff confidently reported incidents and provided examples of incidents they would report. These primarily focussed on patient safety matters such as falls, pressure ulcers, near misses, medication errors, and manpower/resource deficiencies.
- Between October 2015 and September 2016 CIC reported no incidents which were classified as Never Events for medical care. Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers (Strategic Executive Information System, STEIS).
- Staff reported all PUs irrespective of grade or classification and moisture lesions. The tissue viability team, comprising three tissue viability nurses (TVNs) working cross-site received all reported PU incidents. The TVNs completed further assessments of the incidents and graded them according to severity. The TVNs aimed to respond to all PUs classified as category three or above within 24 hours and to review others within 72 hours.
- Staff we spoke to knew of the Duty of Candour (DoC) requirements and of the trust's 'being open' policy. Junior staff understood that this involved being open and honest with patients. Ward managers were aware of the DoC, and some staff explained to us that they had been involved in investigating and responding to patients and families under this duty.
- The division shared learning from incidents and when things went wrong at all levels. Management discussed outcomes at divisional meetings and matrons and ward managers shared learning and cascaded key information to their staff at safety huddles, ward meetings, through the patient safety newsletter, on the intranet, and with direct staff communications.
- The safety newsletter was re-launched in November 2016 and the division proposed holding safety summits on a monthly basis. The division had appointed a safety clinical director who led on programmes to improve clinical safety and learning methods.
- The division held monthly mortality and morbidity (M&M) review meetings and these were well attended, in particular by junior medical grades. The chair and attendees considered case summaries presented, reviewed outcomes, and identified key lessons. The M&M template omitted the death classification column and did not always specify how the lessons learnt from this forum were disseminated to the appropriate persons and to wider audiences for shared learning. Ward managers informed us that outcomes from the M&M group (where relevant to their area) were discussed at ward meetings.

Safety thermometer

Medical care (including older people's care)

- Safety Thermometer was used to record the prevalence of patient harms at the frontline and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline was intended to focus attention on patient harms and their elimination.
- Data from the Patient Safety Thermometer showed that the division reported 48 PUs, 53 falls with harm, and 43 catheter urinary tract infections (CUTIs) between November 2015 and November 2016. The trend line for PUs and CUTIs shows the prevalence rate to be mixed, with an upturn in reported PUs in the latter quarter and a decreasing picture for CUTIs. The trend line for falls with harm showed the prevalence rate to be steady until September 2016, when there was a sharp increase, however, the rate for October and November 2016 decreased and showed signs of improving.
- From January to November 2016, the proportion of patients who received harm free care (all harms) averaged 91%; lower than national figures for the same period (NHS Safety Thermometer).
- Senior nursing staff considered PUs and falls reduction to be a key priority.
- Between October 2015 and September 2016, the division reported 210 PUs. Thirty-six (17%) of all recorded PUs during this period were hospital acquired. Compared to figures in the previous 12 months, the trust had seen a 36% reduction in the number of hospital acquired PUs. During this period there were one category three and one category four PUs recorded across the division.
- Staff at CIC reported 22 hospital acquired PUs (61% of the divisional hospital acquired total) across all medical wards. Two of those reported were in category three or four. The highest individual ward prevalence (six) was recorded against Willow B.
- In the report to the Safety and Quality Committee In November 2016, the TVN team reported hospital acquired PUs continue to be a significant risk to patients. The trust had set a 50% reduction target for year ending 2016/17 compared to 2015/16 data, and, at the time of the report (comparing Q1 and Q2 in the respective financial years), the trust projected to meet this target. The Tissue Viability Scrutiny Group worked with the North East and North Cumbria Pressure Ulcer Collaborative to embed best practices and to maintain the target trajectory.
- The division monitored falls prevalence and classified falls according to harm. The National Audit of Inpatient Falls (NAIF) 2015 showed that the number of falls per 1,000 patient occupied bed days (OBDs) was higher than the national average (8.02 against 6.63), and within the North West region the trust reported the fifth highest prevalence out of 20 participants. The trust reported falls with moderate or severe harm to be 0.26 per 1000 OBDs, higher than the national average of 0.19 and regionally rated the highest out of 20 trusts.
- The NAIF also collected data on whether patients had been assessed for all risk factors and whether there had been appropriate interventions implemented to prevent falls. They reported compliance using a 'red/amber/green' (RAG) rating. At the trust NAIF auditors found three of the seven indicators to be compliant (mobility aid, continence care plan, and call bell access), three to be in the amber domain, and one in the red rating (blood pressure recordings).
- Between October 2015 and September 2016 the division reported 267 manager-reviewed falls. Of these, 199 (75%) were reported as no harm, 60 (22%) reported as minor harm, six (2%) as moderate harm and two (less than 1%) categorised as causing major harm.
- Reported falls from CIC accounted for 68% (182 of 267) of the overall total within the division. The prevalence according to classification of harm was almost identical to the divisional figures overall, with 73% reported as no harm, 22% as minor harm, and fewer than 5% as moderate or major. The greatest individual ward incidence of falls (41) was reported from Elm C.
- The division was actively involved in the development of the trust action plan to reduce falls, which was presented to the board in October 2016. The report highlighted falls to be a continuing problem with OBDs reported to be higher than the national average throughout 2016 at CIC. The division had appointed a trust falls champion who was supported by an older person's physician, chief matron, ward manager, and a research executive to deliver improvements in this area. It was proposed to set up various task and finish groups using a multi-disciplinary team approach, to look at multi-factorial variables contributing to falls.
- The division completed monthly VTE compliance audits. Auditors reviewed a minimum of five sets of patient records and recorded compliance against the trust benchmark of 95% against five key indicators. Between September and November 2016 the division reported

that an average 97% of patients received VTE assessment on admission, 98% of patients received appropriate prophylaxis, 92% had the VTE plan clearly documented in the notes, 77% had it documented that the patient had been informed, and 59% had a reassessment after 24 hours.
- Of the 16 sets of records reviewed we found that all except one had had VTE assessments completed in the given timeframes, providing a compliance rate of 94%.
- We found safety thermometer information displayed clearly and consistently in an accessible and readable format, on large whiteboards situated at the entrance of all wards.

Cleanliness, infection control and hygiene

- The division followed the trust infection control procedures.
- The trust healthcare associated infection (HCAI) prevention and control strategy was underpinned by national guidelines and IPC policies, to manage and monitor infection essential for patient and staff safety.
- IPC staff provided a seven day service with on-site presence and telephone advice.
- All wards we visited were visibly clean and tidy.
- The division was involved in trust-wide IPC monthly audits to monitor compliance against key IPC quality measures, such as hand hygiene, cannula care, commode and mattress cleanliness, spray and glow, catheter care, and standard precautions. Auditors rated compliance against indicators as a percentage.
- Between January and August 2016 all wards at CIC scored above 95% average for hand hygiene and spray and glow compliance across the period. Compliance with standard precautions was also good. Cannula and catheter care showed the greatest variance in compliance across the wards at CIC, ranging from 43% to 100% and 25% to 100% respectively. Mattress cleanliness data was inconsistently reported and unhelpful. Ward managers confirmed that best practice was reinforced following IPC audits, and, where findings were below standard, action plans were put in place to improve compliance in follow-up audits.
- All clinical and non-clinical areas had cleaning rotas, and all equipment that we checked was visibly clean. All clean utility areas and treatment rooms were visibly clean and tidy. We observed that clinical waste and sharps been disposed of appropriately.
- Wards we visited displayed the number of and date of last case of Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C. difficile).
- The division provided data for and was involved in the 'Quarterly Reports on Clostridium Difficile Infections in Cumbria' published by Public Health England. IPC staff investigated all C. Difficile cases by way of root cause analysis using a pro forma agreed across the local health economy and with Public Health England. Staff uploaded findings onto the regional database where themes, trends, and learning outcomes were disseminated. Staff reviewed confirmed cases at weekly HCAI meetings and the same were presented at IPC and Safety and Quality groups.
- Between August and October 2016 the trust reported eight C. Difficile cases of which six (75%) originated from the medical division. Five cases were attributed to CIC. Three of the five were from Larch A/B, and this period of increased incidence was managed by deep cleaning of the ward environment and additional IPC support.
- The division had worked with IPC colleagues to complete periodic audits of MRSA screening compliance, to develop IT support for better monitoring of cases. This project had extended to screen patients at risk of Carbapenemase-producing Enterobacteriaceae (CPE).
- The division reported no MRSA bacteraemia in the preceding 12 months. The division had two apportioned Methicillin Sensitive Staphylococcus Aureus (MSSA) bacteraemia cases, both from Willow A; one isolation was considered to be a contaminant and the other related to a urinary catheter.
- The division was involved in a number of ongoing IPC audits driven by the microbiology team. These included gonococcal and chlamydia testing, blood culture contamination audits, antimicrobial audits, and HCAI data collection for national quality indicators.
- The wards displayed clear instructions and signage to encourage staff and visitors to wash their hands on entering the ward. The signage was repeated throughout the ward environments, and there were numerous washbasins for handwashing. Wards provided wall mounted gel and soap for ease of use.
- We observed that personal protective equipment (PPE), such as disposable gloves and gowns, was available to staff. Staff used PPE appropriately.
- Staff informed us of the procedure when caring for patients who required isolation for IPC measures.

- We observed staff carrying out hand washing prior to and after patient contact. Staff adhered to the "Bare below the Elbow" protocol.
- IPC training was mandatory within the trust, staff accessed IPC staff for advice and guidance when required, and 70% of staff in the medical division had completed this training.
- The endoscopy suite had disinfection facilities on the CIC site; however, these were outside of the unit.
- The division was putting together a business case to appoint sepsis nurse specialists across both sites.
- The division contributed to the trust-wide monthly environmental audit. In September 2016 auditors reported cleaning audit scores at CIC as 92%.

Environment and equipment

- The divisional wards were situated in the main building at CIC. There had been considerable investment to improve internal facilities, and there had been a reconfiguration in ward layout. The heart centre was situated in a separate, temporary structure adjacent to the main entrance of the hospital. Reiver House, the chemotherapy day unit at CIC, was in a new building within the hospital grounds.
- All patients had designated bed space, which included a personal locker, table, call bell, and access to gender-specific toileting and bathing facilities.
- We checked the resuscitation trolleys on all the wards we visited and these contained correct stock. Staff checked the electrical equipment (defibrillator and portable suction/oxygen) daily and after use. Staff completed fuller weekly content checks of all stock, including emergency drug expiry dates. We saw that each resuscitation trolley had a log attached to it for staff to complete. We found all checks completed accordingly. Trolleys were fitted with a tamper-proof tag.
- All equipment we checked had safety-testing stickers in date, which assured staff the equipment used was safe and fit for purpose. Staff confirmed that, when equipment had not been routinely checked, they ceased to use it until they received medical engineering department approval.
- The heart unit housed the trust coronary catheter lab (cath lab) in a temporary structure adjacent to the main hospital entrance. All fixed and portable equipment was checked by staff on a daily basis, after use, and through a weekly checklist. Estates staff and company providers complemented equipment safety testing with calibration checks.
- Willow D (CCU) provided patients with bedside monitors, and the unit provided telemetry monitoring for patients on EAU and the adjacent cardiology ward. The telemetry equipment had recently been updated.
- Staff on Elm B (stroke unit) considered the lack of a designated therapy area within or near to the ward to be unhelpful.
- The division provided weekday endoscopy services at CIC. The unit had recently purchased new equipment and accessed on site disinfection facilities. The unit was not JAG accredited. (JAG is the Joint Advisory Group on GI Endoscopy. It provides formal recognition of competence to deliver services against recognised standards).
- Equipment that had been subject to ward cleaning displayed "I am clean" stickers to confirm readiness for patient use.
- Staff provided patients at risk of developing pressure sores with appropriate pressure-relieving support surfaces, such as mattresses and cushions, in accordance with their assessed risk.
- Staff provided patients who had been admitted into hospital with pressure sores, or had developed skin damage whilst in hospital, with higher specification mattresses. Staff obtained these through TVN or equipment stores.
- The division had purchased additional pressure-relieving equipment to support patient comfort and skin integrity.
- The division had contributed to the trust Patient-Led Assessments of the Care Environment (PLACE) 2016 audit. Performance had improved in all four aspects of PLACE from 2015 to 2016. The greatest performance improvement in 2016 compared to 2015 was related to facilities, which improved by 19%.

Medicines

- Nursing staff on wards at CIC wore red plastic aprons to notify others that they were doing medications rounds and so should not be disturbed.
- Divisional wards at CIC accessed a dedicated clinical pharmacy service, and pharmacists were integrated into the multi-disciplinary team, attending handovers and ward meetings.

- Divisional wards at CIC received quarterly medicines safety data at ward level to identify individual ward actions, to encourage learning and support improvement.
- These reports considered medicine safety results, reconciliation figures, allergy status compliance, medication omission rates, controlled drug audits, antibiotic audits, patient experience, and education and training, and discussed key incidents to share wider learning from other hospital areas.
- Overall, compliance figures were good, however, auditors found some areas for improvement across the wards at CIC relating to documentation, in particular, the recording of indications for antibiotics. Additionally, a number of wards were not recording receipt of controlled drugs (CDs) in the order book, which impacted on CD compliance ratings.
- Medicines on the divisional wards at CIC, including intravenous fluids, were appropriately stored and access was restricted to authorised staff. The trust's medicines safety officer identified concerns about security of medicines on EAU and several patient lockers needing replacement.
- Overall, staff managed CDs appropriately by maintaining stock, checking balances, and safely storing in accordance with trust policy.
- Nursing staff were aware of local policy and professional standards for medicine management and for the storage and administration of CDs.
- The division also took part in a specific CD audit. In September 2016 the division's overall compliance was reported to be 94%. Auditors found medicines-related documentation to be deficient in some areas, namely recording of time of administration and incorrectly amended errors in the register.
- Staff we spoke with knew how to report incidents involving medicines. There was an open culture to incident reporting, and staff received support from ward managers to learn from incidents.
- Medicines requiring refrigeration were stored securely. Staff completed daily fridge temperatures checks to ensure these medicines were safe to administer. We found some omissions in daily checks on divisional wards. Staff informed us that, when a temperature reading was outside the upper or lower limit, they would immediately contact the pharmacy department for guidance.
- We reviewed 16 medication charts and found that overall medicine related documentation was good. Medical and nursing staff completed the charts legibly, with the names of the prescribed medication clearly written along with accompanying start and end dates where appropriate. We found patient allergies and sensitivities recorded on all charts, however, we found three charts on which antibiotic end dates were not recorded and four charts on which the indication for the antibiotic prescription was omitted. This broadly correlated with trust audit findings.
- The cardiology wards at CIC carried out a safety pilot with community pharmacy colleagues to provide medicine support and assistance to those patients on high-risk medications.
- The division reported findings following the British Thoracic Society Emergency Oxygen Audit 2015. Auditors found 6% of patients at CIC had oxygen signed for on the medication charts in the preceding 24 hours (compared to 28% nationally).
- Medicines management and calculations training across divisional wards at CIC ranged from 52% to 93%, with the heart unit's compliance score being above divisional average and above target. Ward managers had actions plans in place to increase attendance on the course, to improve staff knowledge and medicines safety.

Records

- The division recorded relevant clinical patient information in paper records and a number of core documents were completed on the electronic patient record (EPR).
- Where paper records were being used, these were collated consistently and in a good state of order. Staff stored these safely in portable locked cabinets or in staffed areas.
- The division had developed a number of care bundles and specialist care pathway documentation following best practice guidelines, such as the acute stroke bundle.
- We reviewed 16 sets of nursing and medical records. Overall, the records were up-to-date with evidence of ongoing review, diagnosis and management plans, and patient involvement. Risk assessments and safety bundles were completed promptly and thoroughly. Staff documented MDT involvement; however, two sets (13%) of records that we reviewed showed no evidence of discharge considerations.

- In November 2016 the renal team completed a records review against national clinical coding standards for nephrology patients. Auditors found coding was excellent for primary and secondary diagnosis along with secondary procedures; however, they identified some primary renal admissions that only had documentation in the renal notes, so it could not be accessed on the electronic record (PAS). The team was to refer its findings to the Data Quality Group to ensure consistency in patient case notes for future review.
- The division completed annual case note audits to coincide with its requirements for the NHS Litigation Authority. Overall, the findings against the key clinical content indicators were good, however, there were some poor administrative content shortfalls concerning legibility of entries, fully completed patient details on all pages, and date/time/signatory omissions.

Safeguarding

- The trust had an executive lead and a designated team for safeguarding across the organisation.
- Senior divisional staff were involved in safeguarding board meetings.
- Staff were aware of safeguarding policy, and accessed safeguarding information such as the annual plan and key documents on the intranet. Staff were confident about identifying concerns and escalating in and out-of-hours.
- The trust had set a mandatory target of 95% for completion of mandatory safeguarding training by the end of March 2017. Compliance across the division at August 2016 showed adults and children (level 1 and level 2) training averaging 56% and level 2 training at 64% for medical staff. Nursing staff figures were better at 71% and 70% respectively. Level 3 compliance was reported as 71%. Ward managers confirmed all staff who had not attended their refresher were booked to attend before the end of year.
- We observed safeguarding policies and procedures on display in designated staff areas of wards. This information included process guidance, where to seek specialist advice, and key contact details for escalation and further advice.

Mandatory training

- Generic mandatory training modules covered core subjects such as information governance, fire safety, equality and diversity, infection control, health and safety, and basic life support.
- The division adhered to the trust mandatory training target of 95% by the end of March 2017. As of August 2016, compliance for medical staff ranged from 83% for equality and diversity and 50% for basic life support. Nursing staff compliance rates were better ranging from 97% for equality and diversity to 59% for fire safety.
- All wards displayed their own mandatory training figures and, overall these ranged from 70% to 100% at CIC.
- Ward managers also showed us mandatory training figures for their respective wards, which showed a slight variance from division figures. Generally, ward-based capture of mandatory training was higher than reported.
- Ward managers kept an internal, ward-level list of key mandatory training dates.
- Many ward staff completed e-learning mandatory training modules at home to minimise time off the ward. On Elm A the ward manager added time allotted for mandatory training into staff annual leave entitlement therefore ensuring all staff of all grades received time off for required training.
- Ward managers confirmed that, where there were identified shortfalls in mandatory training, staff were booked to attend the relevant session.

Assessing and responding to patient risk

- Staff used various tools to assess, monitor, and respond to patient risk.
- All patients admitted to divisional wards at CIC had a core safety bundle and risk assessment documents completed in a timely manner. This included an assessment of falls, PUs, nutrition, sepsis, and VTE. Staff reviewed all risk assessments on at least a weekly basis or as patient circumstances dictated, such as changes in mobility or development of infection, for example.
- Of 16 records reviewed, we found that staff completed the initial safety bundle and risk assessment in all cases (100%). We found that all patients (100%) had had a full PU risk assessment completed within six hours of admission. However there were two records (13%) where we were unable to locate a reassessment. All except one patient (therefore, 94% of patient records reviewed) had a VTE assessment completed on

admission, and, again with the exception of one patient, all had a re-assessment within 24 hours. We also observed that, for all patients who required VTE treatment, staff prescribed the relevant prophylaxis.

- Staff completed an initial falls risk assessment in 100% of patient records reviewed. The falls bundle provided for a multifactorial risk assessment process, where patient need required and risk indicated further intervention was required. Staff informed us that patient risks were discussed at board rounds with MDT input.
- The division highlighted patient safety as a key concern within the trust and had increased resources to address particular areas of priority, such as falls and PU reduction. A senior divisional nurse was co-leading on falls reduction across the trust, and the TVN team was strengthening education across the division with link nurse champions. All wards had purchased new equipment, and there was greater engagement with the wider MDT, patients, and carers to reduce potential patient harms.
- All patients had clinical observations (blood pressure, pulse, temperature, and respirations) recorded regularly. We noted that frequencies varied due to clinical need and, on occasion, due to delays in the observations being recorded.
- Staff told us they used NEWS, (within which six observational parameters are scored: respiratory rate; oxygen saturations; temperature; systolic blood pressure; pulse rate; and level of consciousness), to identify a variance from the norm and thus to support escalation of care decisions.
- Auditors completed a very detailed review of NEWS compliance on a monthly basis across the division. Between October 2015 and September 2016 auditors found on average 60% of patients had evidence of full sets of observations recorded, however, 97% of patients had the correct NEWS score applied. Auditors also reported compliance with trigger levels and care escalation. Where NEWS triggers recommended referral to a junior doctor or nurse practitioner (scores of 5-6 or 3 in any one parameter) compliance was variable and ranged from 56% to 93%. Where NEWS triggers recommended escalation for senior medical review (scores of 7 or more), compliance ranged from 44% to 100%. Ward managers confirmed that audit findings were cascaded to staff at ward meetings to reinforce the importance of adhering to NEWS triggers and to ensure any deviation from the recommendations were duly documented by an appropriate responder.
- We observed that stickers were stuck to medical and nursing notes where clinicians confirmed NEWS trigger deviation to meet individual patient need such as an elevated NEWS baseline.
- Of 16 charts reviewed, we found two charts where the NEWS triggers had been activated; however, we did not see any increased frequency in observation recording nor any corresponding entries in the medical records to confirm that a review had taken place. This would equate to 87% compliance in line with the ranges identified in the trust audit.
- In the event of a patient deteriorating, staff confirmed that senior specialist medical cover (such as from intensivists or anaesthetists) could always be obtained quickly. CIC provided level 2 or level 3 critical care (e.g. on an intensive care unit with full ventilator support).
- Where a patient was admitted due to concerns around sepsis the division followed the sepsis care bundle to screen and identify vital high risk factors within an hour. The sepsis care pathway flowchart provided guidance in treating severe sepsis, management plan documentation, critical care considerations, and observation monitoring.
- At the time of our inspection any stroke patients identified as requiring thrombolysis would have the treatment commenced in A&E before moving to Elm B, which provided two specific cubicles for this purpose, albeit not designated monitoring bays. The two cubicles were often utilised by non-thrombolysed patients (who were moved out in the event of an emergency). Out-of-hours all thrombolysis assessments would be made by way of the 'telecart' telemedicine service, a North West Network programme which provided senior consultant assessment and rapid access to clinical decision making and treatment progression. Senior staff on Elm B expressed concerns around staffing skill mix and their ability to provide safe thrombolysis provision whilst maintaining general ward oversight.
- The heart unit provided specialist coronary care interventions for patients requiring primary angioplasty, elective angiograms, percutaneous coronary intervention (PCI), and treatment for acute coronary syndromes. In the event of clinical concern or a request for a senior review out-of-hours, staff were able to send

electrocardiograms directly to the cardiologist on call for remote review and guidance. Should a patient require assessment for cardiac surgery, staff stabilised the patient on site prior to escorted transfer to specialist centres in the region.

- In respiratory medicine, staff who considered patients to be 'high-risk', such as those with pleural disease or patients known to the service would contact the respiratory lead holding the referral bleep to arrange admission or transfer. This had helped to develop and embed specific respiratory care pathways across the trust.
- Secure doors with coded entry ensured that patients being cared for on Elm C were maintained in a safe environment.
- Specialist medical and nursing staff at CIC also carried a 'stroke bleep' which was activated when a patient suspected of having suffered a stroke was being brought into CIC A&E by the local ambulance service. This allowed the team to promptly respond and treat accordingly.
- The cardiology and CCU rota was compiled to ensure that at least one member of staff on duty had an advanced life support (ALS) qualification.
- The division provided a gastrointestinal (GI) bleeding rota covered by gastroenterology, surgical endoscopists and nurse endoscopists at CIC. Out-of-hours, any urgent procedures were carried out in theatre.
- In ambulatory care, when specialist nurses had clinical concerns regarding a patient's presentation, they accessed the consultant on AMU for immediate medical review or consulted with the relevant specialism lead.
- The division completed an audit of consultant review times in 50 patients in AMU during the spring of 2016. Auditors found that 94% of patients had had a documented consultant review within 14 hours of admission. Auditors considered the small shortfall was due to some consultant entries in the records not being timed and some inefficiencies in communications regarding admission times with A&E staff.
- Staff at CIC accessed the critical care outreach team (CCOT) when required and, in particular, when patients' NEWS scores triggered escalation or clinical judgment warranted further urgent patient review. This service was provided 24/7 on site at CIC.

Nursing staffing

- Division managers confirmed that the service had used the 'Shelford Model' (a Safer Nursing Care Tool [SNCT]) to measure patient dependency and determine the number of staff required to care for those patients. The division also monitored acuity and staffing levels using the safe care system on a twice daily basis in order to respond to fluctuations in patient need and changes to anticipated staffing levels.
- The nurse staffing requirements, however, were not revalidated following significant ward reconfigurations throughout the division at CIC.
- The funded staffing establishments for all the general medical wards were based on this assessment, local knowledge, and clinical experience. At CIC registered nurse (RN) to patient ratios on wards during the day were established to be better than 1:8 (with the exception of the coronary care unit, which established ratios of 1:1.5 at all times) and between 1:6 and 1:11 overnight.
- The management team had identified nurse staffing numbers as an issue within the medical division, and this appeared on the service's risk register. All wards that we visited had registered nurse vacancies.
- The trust reported overall establishment nurse staffing figures at August 2016 to be 357.83 WTE working across the division, of which there were 302.3 in post. This equated to a shortfall of 55.53 WTE across the division.
- Trust figures reported registered nurse shortfall at CIC equating to approximately 40 WTE across all wards, with reported ranges from over 10 WTE on the heart centre to less than one reported on Elm B. All wards had appointed additional health care assistants (HCA) to support registered nurse vacancies.
- In September 2016 divisional registered nurse vacancy rates were reported at 7.7%, turnover rates at 7%, and sickness rates at 5%.
- Beech A provided oncology care. Planned registered nurse to patient ratios were 1:6.3 during the day and 1:9.5 overnight. The ward reported 80% RN fill rates during the day and 99% at night, supported by HCAs at 103% and 94% overnight.
- Beech B was a 23-bedded respiratory unit (including up to six non-invasive ventilation [NIV] beds). Reported planned ratios were 1:7 at all times. At the time of our inspection, the unit was one RN short and ratios were 1:8 during the day and 1:11.5 at night. RN vacancies collated to an average of six unfilled shifts weekly. Fill rates reported in October for the respiratory unit

showed 81% RN rates during the day and 63% overnight, reinforced by 107% and 154% HCA figures. The unit did not meet NIV staffing ratios recommended and provided by the British Thoracic Society.

- Elm A had reduced its bed capacity from a 17-bedded elderly care ward to a 12-bedded frailty unit. Planned staffing ratios for the unit were 1:4 during the day and 1:6 during the evening and overnight. Planned and actual figures correlated and met ratios during the week of our inspection. Fill rates were reported as RN 78% with 110% HCA support during the day and 90% RN with 98% HCA overnight. This corresponded with a review of historic nurse rotas showing an average of eight RN and HCA shifts deficient each week during October. The unit reported two RN vacancies.
- Elm B was divided into two clinical areas: a 23-bedded stroke unit (including two thrombolysis cubicles); and a 14-bedded neurological rehabilitation unit (with two additional escalation beds).
- In respect of stroke, planned ratios were reported as 1:5.75 during the day and 1:7.6 overnight. Actual staffing on the day of inspection showed a shortfall of one RN. This had adjusted actual ratios to 1:7.75 and 1:11.5 respectively. Fill rates in October showed RNs at 70% with HCA support at 106% during the day and 85% RN with 100% HCA support overnight. This corresponded with a review of the nursing rotas, which showed in the region of 15 unfilled RN shifts weekly. Current staffing ratios did not meet the recommended nurse staffing levels for stroke units as tabled in the National Clinical Guidance for Stroke (5th Edition) 2016.
- In respect of neurological rehabilitation, planned ratios were 1:4.6 during the day and 1:7 overnight. The unit was deficient one RN on the day of inspection providing ratios of 1:7 and 1:14 respectively. The unit reported two RN vacancies with two staff members working their notice period. The unit reported RN deficiencies equating to approximately eight shifts weekly.
- Elm C was a 12-bedded unit specialising in dementia care. Planned staffing ratios provided 1:4 during the day and 1:6 in the evening and overnight. The unit was one RN down against establishment on the day of our inspection providing 1:6 ratio across all shifts. The ward reported over three RN vacancies and an average of five RN shifts going unfilled weekly. Fill rates coincided with rota review figures and showed RN fill at 80% during the day with 132% HCA support and 98% RN overnight with 121% HCA.
- Staff on the Elm wards stated that they often 'floor worked' to provide cross cover and support to the adjacent wards (Elm A, B and C) when registered nurse figures were deficient. This process was triggered by the unit matron with a designated ward manager holding the 'bleep' (acting as the floor coordinator or 'super ward manager' and single point of contact for staffing issues). Ward managers commented that this additional role took them away from their clinical or managerial ward duties. Staff confirmed that floor working did not solve the problem, but diluted the risk. On the day of our inspection, due to RN number deficiencies, it was planned that the 'floor working' process would be implemented that evening, however, using Elm wards as an example, this would have seen five RNs and five HCAs covering the whole floor of 71 patients, providing a ratio of 1:14 (without additional RN support from additional escalation measures). This was further compounded as Elm C was essentially a locked ward and did not allow free movement of staff within the wider unit.
- Ward Larch A/B was the divisional EAU at CIC and comprised 30 beds. The unit planned staffing ratios as 1:6 and, on the day of our inspection, these were met during the day. However at night the ratio became 1:7.5. The unit reported two RN vacancies (with additional vacancies pending due to leave and long-term sickness). This was reflected by fill rates of 92% RN during the day with 180% HCA support and 97% RN overnight with 96% HCA support.
- Larch C was the nurse-led ambulatory care suite at CIC. The unit was staffed and managed by experienced nurse practitioners.
- Willow A was a 20-bedded older person's ward with four escalation beds. Planned staffing ratios for the unit were 1:6 during the day and 1:10 overnight. At the time of our inspection the additional escalation beds were open and staffing ratios were reported to be 1:8. The unit reported one RN vacancy but rota gaps compromised staff numbers further due to long-term sickness. This correlated with historic rota review and fill rates reported at 84% RN with 108% HCA during the day and 98% and 121% overnight. Staff expressed concern about the increase in bed capacity without any additional staffing resource being made available.
- Willow B was an 18 bedded renal ward. Planned staffing ratios were 1:6 during the day and 1:9 overnight. This corresponded with staffing figures at the time of our

inspection. The unit confirmed RN vacancies which corresponded with fill rates advertised at 77% RN with 135% HCA support during the day and 100% and 90% respectively overnight.

- Willow C provided cardiology care across 22 beds and worked closely with Willow D, the divisional six-bedded CCU. Planned staffing ratios on Willow C were reported as 1:6 during the day and 1:11 overnight. These ratios were met during our inspection. The ward confirmed RN vacancies which corresponded with our review of historic staffing rotas and reported fill rates of 82% RN with 129% HCA support during the day and 79% and 98% respectively overnight.
- Willow D, the divisional six-bedded CCU, had planned staffing ratios of 1:1.5 and at the time of our inspection these were 1:2. The ward manager confirmed that staffing levels on CCU were fairly good and that this allowed support to be given to the neighbouring cardiology ward by way of 'floor working' when safe and able to do so. The unit reported one RN vacancy; however, fill rates were encompassed within Willow C figures and therefore not readily accessible.
- Maple A provided care on a 17-bedded gastroenterology/general medical ward with an additional five escalation beds. The ward manager confirmed a number of RN vacancies. This was affirmed by an RN shortfall on the day of inspection and ward fill rates of 73% RN during the day with 111% HCA support. Overnight figures were reported at 97% and 100% respectively.
- The heart centre was a 12-bedded unit with six radial chairs (used Monday to Friday only), which provided specialist cardiac interventions. The unit staffed the ward area and the cath lab (Monday to Friday until 7pm). Ward staffing ratios were planned at 1:4 and RN figures met this on the day of our inspection. The ward manager confirmed that there were staffing vacancies, and fill rates identified RN fill rates during the day at 88% with HCA figures of 132%. Figures overnight showed 100% fill. Staff from the unit were often asked to support other divisional wards when cath lab procedures were completed.
- The Chemotherapy Unit at Reiver House provided 10 treatment chairs for patients requiring care for haematological and oncological conditions. The unit aimed for ratios of 1:2, however, it reported over three RN vacancies. The service was using two agency nurses on a full-time basis to support existing complement.
- Ward managers confirmed that they had difficulty in filling registered nurse shifts, which they put down to a lack of nurses generally and the geographical location of the trust. Managers relied on the goodwill of their own nurses to work additional hours and flexibility in their working patterns. Ward managers confirmed that their supervisory and management shifts were often converted into clinical shifts to support staffing levels.
- Nurse staffing was described by one senior nurse as "robbing Peter to pay Paul" in the way staff were moved from one clinical area to another. We were also told that a number of specialist nurses were used to backfill shortfalls on general wards. Staff were unhappy about this as they felt they lacked the specific skills needed for these areas.
- Where shifts could not be covered by existing staff, ward managers escalated concerns to their matrons. Escalation processes provided a number of options to help support wards where staffing remained depleted despite local ward based efforts. These included moving nursing resource from better staffed areas, sourcing bank staff, and utilising nurse specialists. Where RNs were unavailable many wards had appointed additional HCA support. Some areas had implemented the floor working concept.
- Despite nurse staffing shortfalls we obtained consistent evidence from all wards to confirm that there were processes in place for managing staffing levels and should there be a need to escalate due to a change in patient need. All staff confirmed that patients were safe and not at risk.
- The trust provided us with data on the use of bank and agency nursing staff between April 2015 and March 2016. The use of bank and agency nurses across the division at CIC was reported to be 3.38%.
- We were provided with sight of elderly care staffing guidelines used across the division. These detailed rota monitoring and escalation processes for this business unit.

Medical staffing

- Medical staffing numbers across the division had improved since our previous inspection, in 2015.
- Recent medical recruitment processes had seen the appointment of physicians in general medicine, older person's services, respiratory care, cardiology, acute

medicine, oncology, and histology in the preceding 18 months. Divisional leads acknowledged that this was an ongoing process with vacancies remaining in most specialisms across both divisional sites.

- In June 2016 the medical staffing skill mix showed the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1 and 2) staff was higher.
- Where substantive posts remained vacant the division had secured long-term locum contracts to support stability within the service. The division had also appointed a Professor of Medicine to support existing compliment.
- The division had partnered with colleagues at a neighbouring NHS trust to support haematology and cancer services. The division had also worked with primary care colleagues to utilise GP trainee clinicians and develop this workforce within the service.
- The division provided information on recruitment and medical cover at CIC.
- In cardiology the service provided an independent seven day medical rota which was covered by six substantive consultant cardiologists (66% of establishment) and further supported by a long term locum. The service was also looking to make further cardiology appointments.
- In respiratory care the division had three consultants in post (50% of establishment) and was actively recruiting to appoint to vacant positions. The stability within the respiratory service had allowed the sleep medicine service to be returned to the trust.
- In older person's medicine the division had added to the substantive consultant complement with three senior locum posts and two speciality doctors. This had allowed the business unit to provide a geriatrician of the week rota and develop frailty services at CIC.
- Oncology services had 50% substantive consultants in post with additional cover provided by partner trusts and locum staff. The service had been further bolstered with the appointment of two senior histopathologists and partnership working in haematology services.
- The division had two diabetologists at CIC and a joint appointment with a neighbouring partnership who worked cross-specialism and provided an in-reach service.
- The division was working to reinforce senior medical staffing in the gastroenterology service where it had been unable to appoint to all substantive posts due to a shortage of clinicians in this field. This was compounded by the service providing one service on the two main sites. The appointment of specialist nurses and nurse endoscopists had assisted.
- There was variation in business unit out-of-hours medical cover, however, to ensure consistency of care, divisional managers had progressed a shared general medical rota providing consultant of the week cover. The division had secured input from 15 of the divisional consultants to support this.
- The trust summarised their medical cover to be "Consultant cover from 08.00-22.00 followed by on call overnight. Middle grade cover (ST Level) is provided 24/7 [and] includes Acute Clinical Practitioners, F2, or equivalent support 24/7, F1 support on a 24/7 basis [and] H@N model embedded".
- The heart centre was supported by the consultant cardiologist of the week rota and covered by the general medical rota out-of-hours. The consultant cardiologist remained on call from home and available to attend in the event of any overnight emergencies.
- In Elm A (Frailty Unit including Willow A) there were two dedicated consultants who provided a consultant of the week rota. This was supported by two registrars, one of whom was on a rotating post, and two foundation year junior doctors. Out-of-hours the unit was covered by a registrar and two foundation year doctors.
- On Elm B (stroke) there were two dedicated stroke consultants supported by a registrar, a specialist trainee, and two foundation year junior doctors. Out-of-hours the unit was covered under the general medical rota comprising a registrar and a junior, supported by nurse practitioners and the critical care outreach service.
- EAU had designated consultants who were supported by a registrar, two middle grades, and two foundation year junior doctors. Out-of-hours cover from 9pm was provided by the registrar and a middle grade with consultant cover from home.
- Across Willow A/B wards we were advised that the units had a registrar and two foundation year junior doctors on-site, with a consultant on call from home.
- Medical rota shortfalls were managed and reinforced by acute clinical practitioners on a 24/7 basis. The division had also implemented the 'hospital at night' programme to support clinical presence on site during night hours, and CIC had a proactive critical care outreach team (CCOT) who worked 24/7.

Medical care (including older people's care)

- Junior medical grades at CIC considered their senior colleagues were supportive, available, approachable, and willing to spend time with them when required. Junior doctors told us that they were expected to cover rota gaps and work additional hours when required to support the service.
- In September 2016 the trust reported medical staffing vacancy rates to be 26% across the division. Bank and locum usage mirrored the vacancy rate at 26%. Turnover rates were reported at 13% and sickness rates at less than 1%.

Major incident awareness and training

- We saw that the trust had appropriate policies in place with regard to business continuity and major incident planning. These policies identified key persons within the service, the nature of the actions to be taken, and key contact information to assist staff in dealing with a major incident.
- Staff we spoke with knew how to access the major incident policies for guidance.
- Service managers and senior staff considered seasonal demands when planning medical beds within the trust.
- The trust Resilience Team carried out exercises to challenge emergency response procedures, and communications from the team were shared with staff.

Are medical care services effective?

Good

We rated effective as 'good' because:

- The service was actively involved in local and national audit activity and followed recognised guidance, which provided a strong evidence base for care and treatment. Staff reflected on audit outcomes and there was evidence of action plan development and changes in practice.
- The division had developed a number of evidence-based specialist care pathways.
- The division recognised the importance of good nutrition and hydration as integral to good health. Malnutrition screening was completed for all patients.
- There were good patient outcomes recorded in the national stroke audit, renal registry report, rheumatoid and early inflammatory arthritis report, and oxygen audits. The division reported improvements in lung cancer and inflammatory bowel disease standards from the previous audit window.
- Patients informed us that their pain was managed well and, overall, their nutritional and hydration needs were met. The division monitored food standards locally.
- Junior medical and nursing staff found their local supervisors to be supportive and they facilitated exposure to clinical learning opportunities.
- We found excellent examples of multi-disciplinary team working (MDT) across the division. Ward rounds, board rounds, and handovers were thorough, timely, and considered key clinical content, care progression, and risk elements. There was a real strength of working relationships between nurses, therapists, and psychiatric services.
- Staff had an awareness and understanding of the importance of considering consent, capacity, and safeguarding issues in delivering healthcare under the Mental Capacity Act (MCA). Overall, completion of capacity assessments was good, although not always timely.

However:

- The division did not take part in the heart failure audit.
- Completion of fluid and food charts required improvement. Overall, patients commented favourably about food quality and choice, however, the temperature of the food when served was not always optimal.
- Staff confirmed that learning opportunities and access to professional development were variable. A number of staff had completed division-supported higher education and specialist qualifications, however, many staff found access to some external teaching provision difficult. Appraisal rates provided by the trust were inconsistent with those reported at ward level.
- The division had not fully embedded seven day working across all areas, however, benchmarking against the NHS Services Seven Days a Week Four Priority Clinical Standards was monitored by the division.

Evidence-based care and treatment

- Staff referred to a number of National Institute for Health and Care Excellence (NICE) Guidelines/Quality Standards, and Royal College, Society, and best practice

guidelines in support of their provision of care and treatment. Local policies, which were accessible on the ward and on the trust intranet site, reflected up-to-date clinical guidelines.
- We reviewed a number of clinical guidelines on the intranet and all were current, identified author/owner, and had review dates.
- The division was actively involved in local and national audit programmes collating evidence to monitor and improve care and treatment. The division compiled an Annual Clinical Audit Report of activity that specified a range of completed, planned, and ongoing evidence-based reviews.
- In accordance with NICE Quality Standards, the division was involved in data collection activity for numerous national audits such as chronic obstructive pulmonary disease (COPD), cardiac rhythm management devices (CRM), diabetes, acute coronary syndromes, and the falls and fragility fracture audit programme (including hip fractures).
- The division at CIC had developed a number of evidence-based, condition-specific care pathways to standardise and improve patient care and service flow, for example, ambulatory care services, hot clinics, frailty pathways, and extended scope of the MPU.
- The division had reflected upon National Audit Report findings and developed action plans to support evidence-based care and treatment. Staff fed these into the respective business units and incorporated them into local quality improvement projects.
- The division had adapted guidance for sepsis screening and management.
- All endoscopic procedures were carried out in accordance with recognised best practice and professional guidelines.
- The division had a designated audit lead, and business units were active in the trust clinical audit group.

Pain relief

- We found that all patients had access to prescribed analgesia. We found analgesia prescribed on a regular basis and on an as required basis.
- Staff considered the use of analgesia alongside the patient's clinical condition and particular need.
- Staff informed us that they monitored pain and assessed effectiveness of pain relief using a number of techniques such as direct questioning, observation, anticipatory ahead of procedures, and with reference to observations and pain assessment tools such as the 0-3 pain scoring tool.
- Patients informed us that staff asked them if they had any discomfort or if they required any pain relief.
- The division accessed the trust pain team if required.
- The division took part in the trust-wide pain management audit. The audit considered four clinical indicators (pain assessment, care plan, analgesia administration, and pain reassessment) with a benchmarking compliance of 95%. Between September and November 2016 the division reported overall compliance at 96%.

Nutrition and hydration

- The division recognised the importance of good nutrition, hydration, and enjoyable meal times as an essential part of patient care.
- The division monitored nutritional documentation compliance by auditing nutritional screening, risk assessments, and care plans.
- Of 16 records reviewed during inspection, we observed all patients had had a malnutrition universal screening tool (MUST) risk assessment (equating to 100% compliance). We found variable compliance in fluid chart completion with four records being deficient, equating to 75% compliance. Staff implemented care plans for those patients who required support and assistance with eating and drinking.
- Staff told us they accessed support from dietetics and speech and language therapy service (SALT) specifically allocated to their ward to support those patients who required additional input to maintain their nutritional status.
- Poor appetite menus and pictorial menus were available for patients.
- We observed nutrition and hydration recorded on fluid and food charts, which were kept by the patient bedside and summarised periodic intake during the course of the day. Overall, the completion and accuracy of these charts was variable.
- Patients had protected meal times. Staff allowed family members to attend during meal times where patients required help or support in eating or drinking.
- We received positive comments from patients regarding food quality and menu choice. Of the 16 patients we spoke to, all confirmed that the food choice and quality

was good. There were some negative comments (25%) relating to food temperature which made the meal inedible or unenjoyable. There were various menu options for individual dietary requirement such as halal, coeliac, and vegetarian options.

- We observed nursing staff assisting and supporting patients with eating and drinking. This included feeding, supporting with drinks, and offering snack alternatives during the course of the day.
- The division contributed to the Patient-Led Assessment of the Care Environment (PLACE) 2016 survey. In the food category CIC recorded an 83% satisfaction rate, worse than the national average of 88%.
- The division was actively involved in the Nutritional Steering Group review of nutritional and hydration needs audit. This was exceptionally detailed and considered three core areas. Auditors reported on all associated staff training directly and indirectly linked to the provision of food and hydration (such as Mental Capacity Act, food and nutrition and nasogastric tube training), along with clinical indicators (comprising 11 key indicators such as MUST completion, referrals, care planning, specific dietary requirements, access to drinks, preparation for mealtimes, and monitoring of intravenous fluids) and patient satisfaction. Overall, against a target of 80%, associated staff training was reported at 88%. Clinical indicator benchmarking compliance was 95% and, between April and September 2016, this averaged 93%, with the main deficit being around the full completion and review of MUST screening, which averaged a compliance score of 87%. Patient satisfaction across the 20 domains reviewed was good overall. At CIC the overall satisfaction score averaged 73% with meal taste, food temperature, and insufficient choice for religious beliefs or dietary requirements falling below the benchmark standard of 70%.
- The division reported similar results in the 'Meeting Nutritional Needs' project completed in October 2016 and an 'Assurance Audit of Food & Nutrition' in November 2016. In the former, auditors focussed on malnutrition screening and best practice guidelines provided by NICE (CG32). There were noted improvements from the 2014 audit and auditors recommended adding MUST to ward admission bundles, converting to a real-time MUST, and reviewing the provision of snacks on the wards.

Patient outcomes

- Staff across the division were involved in large national audits and a number of local reviews to measure patient outcomes.
- CIC took part in the quarterly Sentinel Stroke National Audit Programme (SSNAP). On a scale of A-E, where A is best, the trust achieved grade C in the most recent audit, April 2016 and June 2016. Compared to the previous quarter, there were improvements in four of the domains including the key indicator level for both patient-centred and team-centred. Ratings in the remaining six domains remained the same.
- In June 2016, following SSNAP findings, the occupational therapy (OT) team completed an audit of patient and staff involvement in group work for patients receiving stroke care. The team identified that the sessions met national standards, however, it considered there to be more effective ways in which resource could be channelled to improve and develop group therapy sessions. New group therapy sessions were being considered, and we were able to see the new dance group therapy session during our inspection at CIC.
- The trust did not take part in the 2015 Heart Failure Audit.
- CIC took part in the Myocardial Ischaemia National Audit Project (MINAP) 2013/14. CIC scored better than the England average for one of the three metrics: percentage of STEMI patients referred for or had angiography. The metric 'patients admitted to a cardiac ward or unit' saw performance worsen between 2012/13 and 2013/14.
- CIC took part in the 2015 National Diabetes Inpatient Audit (NaDIA). It scored better than the England average in two metrics and worse than the England average in 15 metrics. The indicators regarding 'seen by MDFT within 24 hours', 'overall satisfaction', and 'staff awareness of diabetes' were the three lowest scoring metrics compared to the England average.
- The division recognised this historic poor performance and, to support diabetes services, had appointed three diabetologists (two of whom were based at CIC). The division had also partnered with a neighbouring trust and a joint consultant appointment to provide in-reach to inpatients and drive improvements in foot care measures and multi-disciplinary team working.
- In the National COPD Audit Programme 2014 CIC scored a total of 31 points across the five domains (less than

the national median score of 33). The respiratory service received full recognition for non-invasive ventilation services and managing respiratory failure/oxygen therapy. There were low scores against the senior review on admission and access to specialist care domains. In response to the results the division compiled a very detailed and thorough action plan to address areas for improvement.

- The division reported findings following the British Thoracic Society Emergency Oxygen Audit 2015. The summary showed 55% of patients at CIC had oxygen prescribed within target range, against the national average of 57.5%. The audit found 77% of patients were maintained within target range (compared to 63.5% nationally). Of the remainder of patients, 23% were maintained within 2% of their target range, and 93% of patients had oxygen saturations recorded in accordance with documents frequency (against the national average of 103.5%).
- The division participated in the 2015 Lung Cancer Audit, and the proportion of patients seen by a Cancer Nurse Specialist was 90%, which was the same as the audit minimum standard of 90%. The 2014 figure was 97%.The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 25%. This was significantly better than the national level. The 2014 figure was 16%.The proportion of fit patients with advanced NSCLC receiving chemotherapy was 65%, which was not significantly different from the national level. The 2014 figure was 56%.The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 64%, which was not significantly different from the national level. The 2014 figure was 56%.
- The division provided evidence for the UK Renal Registry 18th Annual Report (published in 2016) to support benchmarking against quality of care standards. There were positive findings for the division with good mortality data, good proportion of patients on home therapies or who receive transplantation early, and good practice identified with calcium, phosphate, bicarbonate, and anaemia management. The report identified high incidence of tunnel neck lines (TNL) usage and the team was working with vascular colleagues to reduce the number of patients relying on this access.
- In July 2016, the cardiology team completed a review of outcomes following intra-aortic balloon pump (IABP) implantation in cardiac catheterisation. A review of 49 patients identified a high risk cohort with cardiogenic shock post myocardial infarction. Mortality was high as a consequence of underlying disease pathology; however, use of the IABP was thought to allow time for revascularisation to occur. The audit recommended further monitoring of outcomes and alignment with percutaneous coronary intervention (PCI) outcome data.
- In June 2016 the dietetic team completed an audit against inflammatory bowel disease (IBD) standards. Eighty-eight patient records were selected over a two year period. Overall, whilst all areas were under the 100% target, there had been an improvement on 2014 measures (detailing medical history, current symptomatology, treatments, diet history, and food avoidances). The team identified areas for improvement in the recording of weight and height to inform body mass index (BMI) readings, and action plans have been implemented to improve compliance in the next reporting period.

Competent staff

- All staff employed by the trust and working in the division were required to meet their professional continual development obligations.
- The division provided a number of electronic on-line courses and specialist courses in-house for staff to attend. The division also had strong links with network colleagues, higher education establishments, medical schools, and universities.
- All newly qualified staff employed by the trust and working in the division were subject to a period of preceptorship and supervision, which varied according to the area worked in and was subject to competency sign-off.
- Ward managers discussed formal learning and training needs with individual staff members at 1:1 sessions and during appraisal. Informally, staff identified their own areas of interest and proposed study for consideration at a local level.
- Junior medical staff maintained close links with the Deanery as part of their clinical placements and post rotations. The junior medical staff stated that the division was extremely supportive of their learning, training, and developmental needs. They added that the clinical exposure they received fully underpinned the classroom and clinical skills training.

- Staff received formal engagement sessions with their ward supervisor or academic lead. These took the format of 1:1 meetings, clinical supervision sessions, attachment to specialist practitioners, mentoring and observation, reflective practice, and revalidation.
- Nursing staff told us that they had received information and support from the trust about Nursing and Midwifery Council (NMC) revalidation.
- Divisional specialist nurses provided training sessions to all grades of staff, and the link nurse programme was in force across divisional wards.
- Nurse Practitioners in ambulatory care at CIC felt that they would benefit from increased divisional support with professional development opportunities.
- A number of wards had developed clinical competencies for their specific area. For example, in the heart centre new appointees completed a multi-disciplinary competency framework, which involved robust assessment involving medical staff, radiology personnel, and nurses. In the Chemotherapy Day Unit the nurse specialist had developed banded competencies, training packages, and learning frameworks for preceptor review.
- The trust had supported staff to complete higher degree and specialist courses. However, some staff commented that access to these opportunities was difficult due to existing clinical commitments.
- A number of specialist clinicians were part of wider regional collaborative groups such as stroke and TVNs. A number of the divisional staff attended national conferences to support professional development and share learning on site.
- The Chemotherapy Nurse Specialist Lead was a member of the Northern Cancer Network. The network provided peer support, shared learning opportunities, and best practice recommendations.
- Appraisal rates reported by the division in March 2016 were reported at 55% for medical staff and 36% for nursing grades. These figures differed considerably and were significantly lower than those provided at ward level. All staff we spoke to confirmed that they had received an annual appraisal in the previous 12 months. There was an improving and upward trend in appraisal completion rates from March 2016, and ward managers confirmed all staff to be appointed prior to year-end.
- Junior nursing and medical staff were supported by their senior colleagues, who they described as approachable and willing to share. Many junior staff were involved in audit and improvement projects and were invited to attend senior staff meetings.

Multidisciplinary working

- We observed well-attended, informal, and structured multidisciplinary team (MDT) meetings throughout our visit. These meetings considered patient condition, clinical care, and discharge planning.
- The division had representation at the multi-agency steering group. The group was refreshing discharge procedures and including adult social care colleagues.
- We observed physical therapies being provided by the MDT on the divisional wards at CIC. These included ward based activities, group exercises, and educational sessions, however, staff confirmed that some clinical areas did not lend themselves to long term rehabilitation programmes.
- We also observed informal discussions between professional colleagues at safety huddles and ward meetings.
- Formal documented input from the MDT collective was recorded in the medical records. The entries highlighted involvement in care and treatment planning, discharge processes, and social considerations. Although variable in terms of timeliness of the initial MDT review, all records reviewed had formal documented MDT screening within 72 hours from admission. There was evidence of patient and family involvement in the process.
- There were clear, internal referral pathways to therapy and psychiatric services, which were especially strong on the Elm floor. Many wards had developed strong links with community colleagues when implementing discharge plans and care packages.
- We observed MDT board rounds being led by medics, nurses, and therapists.
- The EAU ward round was very well attended by the MDT. All staff had input, the summaries were concise, and decisions were progressive and relevant.
- MDT working on Elm C, specifically team relations with community psychiatric nurses (CPNs) from neighbouring trust providing psychiatric services, was well embedded and integrated across the service.
- There were excellent examples of nurse and therapy services coming together on a number of wards.

- Some areas commented that greater involvement of medical social workers (MSW) at MDT meetings would benefit service effectiveness. Staff added that this had been difficult to embed as MSWs were not attached to particular wards and had caseloads across a number of divisions and wards.
- Nurse practitioners on ambulatory care confirmed that they could access a very supportive MDT, in particular the medical staff, on EAU when required.
- The stroke team was part of the North West Network multi-disciplinary collaboration model for stroke care.

Seven-day services

- The trust monitored its current working scheme against NHS Services, Seven Days a Week Clinical Standards.
- The division provided evidence to address the four priority clinical standards, namely time to first consultant review, diagnostics, interventions, and ongoing review.
- The division engaged in the trust seven day service standards (7DS) audit published in May 2016. The review audited 259 case notes, of which 104 were from CIC. The division contributed to 58% of the reviews at CIC.
- Auditors found there to be a lack of agreement between consultant job planning information and business unit advice to meet the consultant-led ward rounds on every ward, every day. This impacted on the majority of wards across the division.
- Auditors found good compliance with patients being reviewed by a consultant within 14 hours of arrival at hospital. During weekdays at CIC this was reported as 74% and at the weekend it averaged 70%.
- Findings confirmed that 48% of patients (and where appropriate family members) at CIC were made aware of diagnosis and management plans within 48 hours of admission during weekdays. This averaged 50% at weekends.
- Auditors confirmed that 100% of patients requiring bronchoscopy services, 45% of patients at CIC requiring computerised tomography (CT), and 33% of patients requiring microbiology diagnostics were able to access consultant-directed diagnostic tests and completed reporting seven days a week within one hour for critical care needs. The trust identified gaps in accessing some diagnostics, namely pathology, magnetic resonance imaging (MRI), echocardiograms, ultrasound scanning, medical physics, and endoscopy.
- Auditors found that patients had 24 hour access to consultant-directed interventions 7DS, either on site or by formal network arrangements in cardiac pacing, primary percutaneous coronary intervention (PCI), thrombolysis, interventional endoscopy, and renal replacement.
- On AMU at CIC auditors found that 26% of patients were reviewed by a consultant twice daily during weekdays, and this averaged 17% at weekends. For the acute stroke unit at CIC (beds provided on Elm B), the figures reported were 14% during weekdays and 75% at weekends.
- The EAU provided seven day consultant presence on site until 9pm with on-call arrangements thereafter.
- The ambulatory care services based on Larch C was provided five days a week between 9am and 8pm. The division planned to extend this to seven day working.
- Endoscopy services at CIC worked on a weekend waiting list initiative and aimed to deliver seven day working with increased resource.
- The CIC critical care outreach service was available to the division at all times.
- The trust audit team referred all findings of the 7DS review to relevant business unit heads for further consideration and to identify areas where investment, model changes, and efficiency processes could be put in place to improve 7DS.

Access to information

- Staff we spoke with raised no concerns about being able to access patient information or investigation results in a timely manner.
- Staff informed us that discharge-planning considerations commenced on admission with input from the discharge team.
- Staff informed GPs of patient discharge in writing and always made themselves available in the event of any GP telephone queries.
- Staff identified which community services or ongoing care needs would be required for the patient on discharge. Staff involved the patient, his or her family, and the service providers in discharge planning.
- Staff on specialist units gave patients and their families discharge booklets which provided medical information, treatment details, contact information, and signposting for further support and guidance.
- In the CQC Inpatient Survey 2015, patients rated various criteria around information sharing. Patients found

information shared about continuity of care (6.8 out of 10), medications (8.1 out of 10), danger signals (5.3 out of 10), and details provided to family and friends (6.0 out of 10) to be in line with national average for similar trusts.

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

- We observed staff asking patients for their consent prior to care being delivered and procedures carried out.
- We saw that the trust had an appropriate policy informing staff about the consent process. This included reference to obtaining consent where patients may have capacity issues and included guidance on the Mental Capacity Act.
- All the staff we spoke with were aware of the safeguarding policies and procedures and almost all had received training. Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was delivered as part of the mandatory training programme. Staff understood that this was underpinned by legislature and understood the significance of failing to consider.
- We observed safeguarding and MCA guidance on all wards. Staff referred to the ward-based documents and intranet site to show us the steps to follow to progress an application. Staff also referred to the trust intranet pages designated for safeguarding issues.
- Staff provided us with examples of DoLS, explaining steps taken to identify and support patients who may not have the capacity to consent. We saw evidence of mental capacity assessments completed in medical records.
- We found completion of MCA/DoLS documentation to be good overall; however, staff confirmed that some capacity assessments were not completed fully or in a timely manner.
- Of the 16 records we reviewed, we found 11 had had the capacity section completed on EAU and the remaining five had had the capacity assessment completed on the receiving ward. Staff on EAU stated that they tended to complete all capacity assessments where there was a concern surrounding an individual's ability to understand and/or consent. Staff added that, on occasions, this may not be completed immediately, for example, when a patient requires urgent care, or if the patient only remained on the unit for a very short time. Staff stated that this would form part of the handover.
- Staff accessed the Safeguarding Team if they were concerned about a patient, and they confirmed that responses were prompt.
- In August 2016 the trust reported that, as at 31 August 2016, MCA training had been completed by 93% of staff across the division and DoLS training had been completed by 84% of divisional staff.
- The division had access to trust specialist nurses who had particular expertise in dealing with vulnerable groups such as those with learning disabilities and those living with dementia.

Are medical care services caring?

Good

We rated caring as 'good' because:

- Patient feedback was positive. This was reflected in good response rates in the NHS Friends and Family Test and good recommendation rates for the service. The service also reported good outcomes from the National Cancer Experience Survey 2015.
- The division collated 'real-time' patient feedback to inform service delivery and care improvements. Patient ratings were good, in particular regarding 'care involvement' and 'privacy and dignity' domains.
- Staff in the renal unit had progressed the expert patient and shared care programmes. These had empowered and involved patients to manage their care.
- Patients (and their nominated family members or carers) were involved in their care to the extent that they wanted to be. Staff were proactive in involving and informing family members and carers. Senior nursing staff on one ward completed a visiting time 'walk around' to make themselves visible and available to patients and visitors to discuss care.
- Care was delivered in a compassionate, sensitive, thoughtful, and individualised way, taking into account personal preference and physical, emotional, and social considerations. We observed clinical staff from all disciplines being involved in providing care.
- Patients described staff as "absolutely wonderful" and said that they "have a lot of patience", and that the care they received was "very good – I couldn't ask for more".

Compassionate care

Medical care (including older people's care)

- The Friends and Family Test response rate for medical care at the trust averaged 35%, which was better than the England average of 25%, between November 2015 and October 2016.
- The response rate for CIC was 33%, which was better than the England average of 25%, between November 2015 and October 2016. There were particularly exceptional response and satisfaction rates reported from CCU with 100% overall in both domains in four of the 12 months.
- The division also engaged with the 'two minutes of your time' survey which was completed on a monthly basis across divisional wards at CIC. The survey covered six core questions relating to patient experience and quality of care such as 'were you treated with dignity and respect', 'were you involved in decisions about your care and treatment, 'did you receive timely information', and 'were you treated with kindness and compassion'. Patients were asked to rate each question on a scale of 1 to 10 (with 10 being high). Additionally, patients were given the option to provide general comments about the care received as part of the survey or to underpin their scores. All wards at CIC reported positive results, which were reflected in patient ratings, which were consistently above 9 out of 10.
- The division also took part in face-to-face and real time surveys in which patients were asked to comment upon quality indicators overlapping and extending upon the 'two minutes of your time' survey, such as pain control, medicines, and noise at night. All wards involved at CIC reported consistently positive feedback, and scores overall were in excess of 9 out of 10.
- Divisional wards advertised 'you said, we did' actions on noticeboards at ward entrances to report on changes made following patient feedback on care.
- The division took part in the National Cancer Patient Experience Survey (NCPES) 2015, receiving 362 responses. The trust was in the top 20% of trusts for three of the 34 questions, in the middle 60% for 23 questions and in the bottom 20% for eight questions. The trust performed in the top 20% for 'patient did not think hospital staff deliberately misinformed them', 'patient never thought they were given conflicting information', and 'all staff asked patient what name they preferred to be called by'.
- We spent time observing care interactions between staff and patients. These were genuinely warm and compassionate, and staff took time to listen to the patient.
- Patients described being safe on the wards and said that, when they needed a member of staff, they responded promptly to the call bell.
- We noticed a number of patients wearing their own clothing and many had personal belongings in and around their personal bed area. One patient had brought in a number of food items and described how staff helped him to prepare his chosen preferences.
- Privacy and dignity was maintained and we observed staff informing patients of any care delivery and seeking their consent before proceeding.
- Staff confirmed that, when they assessed patient needs, they always took into account personal, cultural, social, and religious needs. Staff considered this to be as important as the physical assessment.
- The majority of the wards we visited had set visiting times to ensure meal times were protected. Staff authorised visiting outside of these hours to assist in individual circumstances.
- Staff enjoyed telling us of positive feedback received from patients and family members. Staff displayed and shared positive feedback on noticeboards.

Understanding and involvement of patients and those close to them

- Staff informed patients and their family members (where permission had been given to do so) of proposed treatment plans, the reasons for the treatment, the anticipated benefits and risks, and the likely time to be spent in hospital.
- We observed nurses and therapy staff actively engaging in rehabilitative activities with patients and family members. Staff ensured the intended benefit of the same was explained to them. Family members were actively encouraged to get involved in any aspect of care they felt able, willing, and had patient permission to.
- Patients stated that they were given time to speak with nurses and doctors about their care. They stated that staff were very knowledgeable and gave information in a calm and caring way.

Medical care (including older people's care)

- Senior clinical staff availed themselves to answer any questions or concerns from patients and family members. Staff informed us that relatives could book appointments to meet with medical and nursing staff at a time convenient to them.
- On Elm B staff performed a walk-around during visiting time to provide visibility and the opportunity for family members and carers to discuss updates and progress.
- In the renal service the team had embraced the 'expert patient programme' and 'shared care initiative' to promote patient empowerment and involvement in their care. This involved individual education packages, assessment of competence, support to carry out self-care procedures, and integration with other patients.
- Staff assessed patients and used clinical judgment to identify those who may require additional support in understanding care and treatment plans. Staff gave examples of interpreters, specialist practitioners, the use of supporting documents, and support by way of family presence.

Emotional support

- We observed emotional support being provided by nurses and indirect care being provided by housekeeping and domestic staff.
- All patient care plans commented on individual patient social, emotional, and spiritual needs and, where relevant, this was integrated into the care plan.
- Staff acknowledged hospitalisation was distressing and frightening to a number of patients, especially more vulnerable patients. Staff spent time understanding particular individual concerns and environmental triggers which could exacerbate emotional stability and wellbeing.
- Staff invited patients to make their bed area their own and to bring in non-valuable personal items and clothing.
- A patient described how he "couldn't cope without them", referring to the emotional support provided by the therapists during his recovery.
- Staff informed us that patients received emotional support from chaplaincy and bereavement services, support groups, charity workers, and volunteer staff.
- Staff offered patients and relatives private areas if they wanted time away from their bed area to discuss personal matters.
- A patient described staff as having "a lot of patience" to listen to concerns and worries.
- In NCPES 2015 patients rated their overall care experience to be 8.4 out of 10 (national average being 8.7), with 74% involved as much as they wanted to be (78% nationally), 79% knowing of their Clinical Nurse Specialist (90% nationally), 89% finding the nurse easy to contact (87% nationally), 85% stating that they were always treated with privacy and dignity (87% nationally), and 89% being told who to contact if they were worried (94% nationally).

Are medical care services responsive?

Good

We rated responsive as 'good' because:

- The division supported the trust in service planning to meet the needs of the local population. The division acknowledged the internal and external demands upon it and these factors were taken into account when delivering services.
- The division had reinforced service provision with the development of new services, such as the frailty unit, extending the remit of existing services, such as the medical procedures unit, the appointment of a number of specialist nurses, and collaborating with neighbouring trusts to provide specialist care.
- The division reported good results against 18-week standards across all specialisms.
- Divisional managers closely monitored access and flow through the division and were involved in a number of initiatives to identify problems within patient pathways leading to blockages in care progression, increasing unnecessary length of stay, and discharge planning.
- The division had appointed discharge navigators to support patient flow and to complement additional care pathways that were aimed at redirecting patient care away from admission, such as seven day ambulatory care services, rapid access clinics, frailty clinics, and the extension to the remit of the medical procedures unit.
- The process for the management of medical outliers was embedded at CIC. There had been improvements in medical outlier management and reducing numbers of bed moves. The division was still working on quality improvement plans to address this.

- The division had made reasonable adjustments to reduce environmental conflict for vulnerable patient groups by adapting the ward environment to minimise exposure to anxiety triggers.
- Complaint numbers were low on divisional wards at CIC, and response times to complaint resolution were in line with trust policy.

However:

- Staff considered that the endoscopy suite at CIC was not fully meeting the needs of the local population due to changes in the booking and list preparation processes. This had led to increased numbers of patients failing to attend.
- There remained a number of medical outliers being cared for on non-medical wards, however, the impact of encroachment into non-medical specialists had been diluted due to the number of receiving buddy wards. Patient moves after 10 pm were reported, however, there was a reducing trend.
- There were patients assessed as medically fit for discharge who could not be progressed due to multi-factorial obstacles, such as medical social work resource, lack of suitable community beds or facilities to provide specialist care, patient or family preferences, and local authority resource.
- Some dementia initiatives to support vulnerable patient cohorts were not fully embedded across all divisional wards at CIC.

Service planning and delivery to meet the needs of local people

- The division supported the trust in planning services to meet the needs of the people of Cumbria in conjunction with the local clinical commissioning group (CCG).
- Divisional management staff attended meetings with local CCG representatives in order to feed into the local health network and identify service improvements to meet the needs of local people.
- Divisional managers worked with partners involved in the 'Success Regime', established in the autumn of 2015, to review healthcare services across the region. These partners included Cumbria CCG, the West, North and East Cumbria Success Regime, Cumbria Partnership NHS Foundation Trust, Cumbria County Council, North West Ambulance Service, NHS England, and neighbouring NHS Foundation Trusts.
- It was acknowledged by the divisional management team that developing future services would better position it to respond to the demands upon it, namely the needs of its population, geography, local infrastructure, and recruitment issues. The evaluation of any reconfigured services would need to involve a 'whole-system' model across multi-agencies. This was further emphasised in the regional sustainability and transformation plan (STP – an integrated health strategy for the region) looking at acute and emergency care services, specifically developing new partnerships and improving service design, such as hyper-acute stroke services.
- The division had access to escalation beds at CIC (primarily for winter pressures or surges in demand) attached to various existing medical wards. When divisional managers opened the beds, these tended to be staffed by existing ward-based staff. Some wards utilised these beds during the time of our inspection.
- The division had appointed a number of specialist nurses and developed a number of specialist clinics.
- Heart failure nurse specialists were in post to support the cohort of patients requiring specialist cardiology care. These appointments had improved service access and overall patient outcomes.
- The division had appointed a specialist stroke nurse at CIC. The role had been developed to improve stroke services cross-site, and, in particular, to outreach into other clinical areas on site to capture patients requiring prompt access to specialist stroke care. Additionally, the stroke service was part of the North West Telemedicine Network, which provided consultant review of patients out-of-hours.
- In September 2015 the division opened a hybrid medical procedures unit (MPU) at CIC to support divisional services. The aim was to reduce unnecessary patient admissions and support patient ease of access to day services. The unit worked with 13 specialisms across the organisation.
- The Chemotherapy Unit at River House had specialist chemotherapy nurses and clinical leads for guidance and advice on haematological and oncological conditions.
- Staff in the endoscopy suite at CIC had escalated concerns about service changes not meeting local patient need evidenced by increasing 'did not attend' (DNA) rates and the loss of patient choice following a change in booking office procedures.

Medical care (including older people's care)

- The division was working with partners to progress the development of new hyper-acute stroke (HASU) services at CIC.
- The division had recently reconfigured elderly care services and opened a frailty assessment unit at CIC. This offered direct access and provided prompt, consultant-led geriatric assessment.
- Main oncology services were provided at CIC. The division worked with colleagues in a neighbouring trust to provide radiotherapy services. The division was preparing a business case to further develop cancer services at the CIC site.

Access and flow

- The medicine division at CIC accounted for approximately two thirds of the total admissions into the medicine service across the trust. The majority of these admissions (51%) were classified in the emergency category. The division provided care and treatment for patients in cardiology, renal, general medicine, oncology, respiratory, stroke medicine, neurological rehabilitation, and older person's services across its 234 inpatient beds and day-case units.
- Between November 2015 and October 2016 the trust's referral to treatment time (RTT) for admitted pathways for medical services had been better than the England average performance. Additionally, the division showed no specialities below the England average for admitted RTT (percentage within 18 weeks) namely general medicine, rheumatology, thoracic medicine, geriatric medicine, gastroenterology, dermatology, and cardiology.
- Between April 2015 and March 2016 patients at CIC had a lower than expected risk of readmission for non-elective admissions and a lower than expected risk for elective admissions. Elective gastroenterology had the highest relative risk of readmission and was higher than the England average.
- Between April 2015 and March 2016 the average length of stay for medical elective patients at CIC was 2.5 days, which was lower than England average of 3.9 days. For medical non-elective patients, the average length of stay was 6.4 days, which was lower than England average of 6.6 days. Non-elective Geriatric Medicine was the only specialty to have a higher average length of stay than the England average.
- Divisional managers confirmed that bed occupancy had a significant impact on flow through the service. Although trust bed occupancy figures reported an average of 85% usage (in line with the England average), the division considered its occupancy to be higher at certain times, requiring additional beds to be opened and leading to some medical patients being cared for on non-medical wards.
- The trust provided us with sight of medical outlier (medical patients being cared for on non-medical wards) bed occupancy data at CIC. Between August and November 2016 the number of patients classified as being medical outliers ranged from 1% to 9% of six wards surveyed. The majority of these patients originated from general medical wards or older person's medicine.
- Staff on the non-medical wards confirmed that medical outliers remained under the care of their admitting medical team and that these patients were reviewed regularly. Staff confirmed that these patients were discussed at bed meetings in order to facilitate return to their base ward and vacate the surgical bed. Staff stated that there had been a reduction in medical outliers and repatriation processes had improved.
- The trust held local and cross-site bed meeting teleconferences during the day to address access and flow issues. Division senior nursing staff, matrons, and business managers attended to record bed occupancy and availability, discharges, and pending admissions. Here staff identified actual and potential bottlenecks to patient flow for that day and prioritised actions to remove obstacles for patient admissions and discharges.
- The division at CIC had also implemented a daily flow meeting involving colleagues from patient transport, social care, and community services to assist in improving flow across the service. This was further underpinned by the divisional pilot project looking to improve efficiencies in discharge times and outcomes for older persons.
- All wards held daily board rounds and staff worked with pharmacy colleagues to obtain patient medications to take home in a timely manner.
- Between August 2015 and July 2016 the main reasons for delayed transfer of care (DTOC) at the trust were 'waiting for further NHS non-acute care' (35.9% compared to an England average of 18.3%) and 'awaiting care package in own home' (19.5% compared to an England average of 17.8%).

- On Elm A, for example, there were five patients (42% of ward capacity) medically fit for discharge (MFFD) whose discharge was delayed. Staff considered that the reasons for the delays were multi-factorial suggesting MSW resource, patient preferences, access to reablement services, community rehabilitation services, and ongoing bed availability in nursing and care homes. The unit had appointed a discharge navigator to support process and take unnecessary administrative duties away from nurses. Staff also added that variations in local authority practices contributed to delays, for example, the Carlisle community team came into unit to see patients whereas other teams accept directed referrals from therapy services. The ward manager worked with community colleagues for consistency and to streamline processes.
- Staff on Elm B (stroke unit) worked with teams in Carlisle and Penrith to facilitate early supported discharge when safe and appropriate to do so, therefore avoiding unnecessary admissions, streamlining discharge services, and providing care to the patient in the most suitable environment.
- Staff on Elm C confirmed that a lack of specialist community or private EMI beds impacted on discharges from their unit. Staff added that this was compounded by the local authority not resourcing 24 hour 'care at home' services. This had led to patients deemed to be MFFD remaining in hospital for considerably longer periods.
- EAU fully utilised the 'home first' service to ensure patients admitted to the unit were rapidly assessed and, where appropriate, the team (comprising therapists and community partnership staff) provided support to divert care into a suitable community setting.
- Divisional managers worked with partners to look at projects to improve patient flow standards, facilitate an improved transition to discharge, and reduce DTOC. The division had implemented the SAFER model (acronym for senior medical review, all patients having a discharge date, flow, early discharge, and review). We identified this framework being referred to at the bed meeting.
- Business units and the discharge steering group monitored the improvement plan. In the SAFER care bundle compliance audit data, reported in September 2016, divisional wards at CIC were not meeting all targets.
- The FAU set up at CIC in August 2016 to provide specialist care to those patients who would benefit from the frailty pathway, had brought patient flow improvements and reduced length of stay. The service was set up to provide early specialist geriatric assessment of frail, elderly patients to reduce admissions, reduce length of stay, and ensure that the most appropriate care pathway or referral was put in place. The service had evolved in a short time, accepting direct A&E/GP admissions, in-reaching to other clinical areas to identify patients who would be best cared for on the frailty pathway, redesigning 'hot' clinic provision, and implementing the geriatrician of the week rota. The unit had received a small number of inappropriate referrals, which led to difficulties in flow later in the care pathway. The team looked to further improve services by eradicating wrongful admissions and considering proposals to extend the pathway to seven day working.
- The division had developed a nurse-led ambulatory care model at CIC. The service provided treatment to patients from a variety of specialisms and had standard operating procedures detailing referral criteria. These included patients requiring assessment and treatment for atrial fibrillation, cellulitis, low risk chest pain, and pulmonary embolism. These pathways provided criteria to help staff identify patients who could be safely cared for in ambulatory care settings without hospitalisation. The unit tended to see in the region of 250 patients a month (the range from May to October 2016 was 217 to 285).
- The division had also developed a number of acute medicine clinics or rapid access clinics (hot clinics), for example, to deal with suspected transient ischaemic attacks (TIAs). The hot clinic initiative avoided admission for many patients and ensured same day consultant review. Between May and October 2016 there were 404 new referrals into the clinics at CIC. Additionally, the 'hot' frailty clinical started receiving patients from August 2016. Between August and October 2016 attendances had more than doubled.
- The six bedded divisional MPU facility at CIC had carried out over 2,700 procedures since September 2015. The unit supported divisional services across 13 specialisms recovering patients following liver and lung biopsies and dealing with pacing recovery and loop recorders, endocrinology testing, and various specialist infusions. The unit provided care to approximately 230 patients each month.

- Between September 2015 and August 2016 48% of patients did not move wards and 12% moved twice or more at CIC.
- From March to August 2016 there were a number of patients moving wards after 10pm at CIC. The total numbers were low on the non-acute wards. In EAU and CCU, however, numbers averaged over 100, but monthly figures showed a reducing trend. Ward managers confirmed that moves at night were potentially distressing to patients. They stressed that such moves were only made when service demand and clinical need necessitated.
- There had been no mixed sex breaches in the division in the previous 12 months.
- In the trust-wide Quality Improvement Plan (QIP) dated October 2015, the service detailed plans to improve patient flow throughout the hospital, minimising outliers, reducing bed moves, and minimising night moves. This outcome remained 'open' and 'in progress' at the time of our inspection, however; whilst improvements had been made, actions were ongoing.

Meeting people's individual needs

- The divisional managers confirmed that, when planning services, the needs of all patients, irrespective of age, disability, gender, race, religion, or belief were taken into account.
- Staff confirmed that, when patients required additional support, for example, due to complex needs or vulnerability, the division took all reasonable steps to ensure the care that they received was uncompromised.
- The division had senior lead nurses for vulnerable patient groups, such as those living with dementia. The trust had a dementia strategy with a vision to 'establish a programme of improvement to deliver best practice in dementia care consistently across the trust'. The strategic goals were to ensure the division met the dementia dozen standards, to ensure ward environments were dementia friendly, and to ensure 100% compliance with trust dementia e-learning.
- During the course of our inspection at CIC we observed various dementia initiatives in place to improve the care for the cohort of patients. These included dementia care bundles, John's campaign (a programme to reinforce corroboration and partnerships in care), Forget-me-not (an awareness project to reinforce the needs of people living with dementia), and the butterfly scheme (a recognisable visual identifier which alerts staff to individuals with particular needs as a result of a dementia-related memory impairment).
- On ward visits we observed the butterfly symbol to be in use, however, there were a number of patients who were identified as living with dementia who did not have the symbol displayed in or around their bed area.
- A number of wards had made environmental changes to reduce conflict and anxiety, such as pictorial signage, furnishings, decorations, and reminiscence triggers. This was especially evident on Elm C. Here the unit had revamped the environment to accommodate this cohort of patients. The unit provided an activities room, communal seating areas, reminiscence boxes, games, computer access, music, and dance therapy.
- The dementia working group had a detailed list of actions which had been in place since 2014. The same showed progression against key objectives and further activities under consideration. Current projects were looking to embed care partnerships with patients and their families, to improve dementia care bundles, and to enhance staff knowledge and awareness.
- The division used 'This is me' passports to support patients who had particular needs as a result of a learning disability. This booklet, owned by the patient, detailed personal preferences, likes/dislikes, anxiety triggers, and interventions which were helpful in supporting them during difficult periods.
- Staff informed us that they had ease of access/referral into psychiatric services for those patients requiring this care, in particular when needing MCA/DoLS guidance.
- All wards displayed information for patients and carers on a variety of topics such as trust information, quality standards, disease/condition specific information, ward/staff contact details, a who's who of staff on the ward, and general useful signposting on where to get further information such as Patient Advice and Liaison Services (PALS), complaints, and support groups.
- Staff explained that translation services were available and found the process easy to use.
- The trust had chaplains who provided access to major faiths within their communities. Staff accommodated faith preferences in accordance with patient wishes, and this was facilitated by the chaplaincy service or at the bedside.

Medical care (including older people's care)

- Staff we spoke with explained that they could access bariatric equipment via equipment storage when this was required. This included access to special beds, wheelchairs, and chairs.

Learning from complaints and concerns

- The trust reported 291 complaints between September 2015 and August 2016. During this period 21 (7%) complaints were attributed to the medical division (excluding accident and emergency). Twenty of these complaints were received at CIC. The majority of these (67%) related to treatment and care provided by a clinician or nurse and admission, discharge and transfer arrangements (14%).
- The division responded to complaints following the trust policy timetable and, at CIC, averaged 33.9 working days to conclude.
- The wards we visited displayed leaflets and posters outlining the complaints procedure, escalation processes, and how to access further support from PALS. We saw that the trust had a complaint policy and staff were aware of it.
- Staff discussed feedback from complaints and lessons learnt at ward meetings.

Are medical care services well-led?

Requires improvement

Surgery

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

Information about the service

The Cumberland Infirmary (CIC) provided surgical services for general surgery, head and neck, ENT, orthopaedics, gynaecology, and ophthalmology. There were six wards, an operating suite, a day-case unit, an assessment unit and a ward which had a mix of medical and surgical patients, due to medical outliers. In total, the surgical division had 35 daycase and 151 inpatient beds.

Across the surgical division the trust had 24,171 admissions between April 2015 and March 2016. Emergency admissions accounted for 6,469 (26.8%), 13,210 (54.7%) were day operations, and the remaining 4,492 (18.6%) were elective.

During this inspection we visited all surgical wards, the surgical assessment unit, and the day surgery unit. We observed care being given and surgical procedures being undertaken in theatres and recovery areas.

We spoke with 14 patients and relatives and 36 members of staff. We observed care and treatment and looked at 13 care records.

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

The overall surgery rating from the 2015 inspection was 'good'. Actions the trust were told it must take were:

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

During the December 2016 inspection we rated surgical services as 'requires improvement' because:

- There had been seven Never Events for Surgery between June 2015 and February 2016. These were a wrong site block, a wrong site injection, a wrong implant, three retained foreign objects, and one wrong site surgery.
- The majority of surgical wards were below the nursing establishment levels. The data for CIC at the time of inspection showed that Beech B required 14.4 WTE but had 11.72 WTE nursing staffing in post. Similarly, Beech D was 2.24 WTE short and Maple D was 6.49 WTE short. At WCH ward 1 required 20.86 WTE but had 17.68 WTE nursing staffing in post. Similarly, the day case unit had 7 WTE but required 8.93 WTE.

Surgery

- As of September 2016 the trust reported a vacancy rate of 8.9% in surgical staff at CIC, with a turnover rate of 23.6% between April 2015 and March 2016.
- We saw that 26% (November 2016) of patients were re-assessed for venous thromboembolism (VTE) within 24 hours of admission. This was a decrease from October 2016, when 72% of patients were re-assessed with 24 hours of admission. September 2016 figures were 37%. The target was 95%.
- Surgical debrief as part of 'five steps to safer surgery' was undertaken 14% of the time. A trust audit recommended further work on encouraging the team debrief through business unit governance meetings and dissemination of learning by governance leads.
- We found that training rates for matters such as fire safety (58%), hygiene for clinical staff (67%), trust doctors patient safety programme (31%), and duty of candour (45%) were below the trust target.
- The proportion of patients having hip fracture surgery on the day or day after admission was 68.3%, which does not meet the national standard of 85%. The 2015 figure was 75.1%.
- Between March 2015 and April 2016, patients at the trust had a higher than expected risk of readmission for both elective and non-elective admissions. Relative risk of readmission for general surgery and trauma and orthopaedics both had similar performance to the trust level.
- A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital, or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice. For the period Q2 2014/15 to Q1 2016/17 the trust cancelled 1,410 elective operations on the day of surgery. Of these, 12% were not rescheduled and treated within 28 days. The overall trend was that the trust had a much higher percentage of these than the England average. Performance improved from Q1 2015/16 to Q3 2015/16; however, performance deteriorated again from Q4 2015/16 and was showing signs of deteriorating further.
- Cancelled operations as a percentage of elective admissions includes all cancellations rather than just short-notice cancellations. Cancelled operations as a percentage of elective admissions for the period Q2 2014/15 to Q1 2016/17 at the trust was consistently greater than the England average. The trust trend had followed a similar pattern to the England average, although the peaks and troughs were far more pronounced, particularly the increase in Q3 2015/16, although it should be noted that junior doctor strikes were planned during this period, and this may have contributed to the sharp rise.
- For the period November 2015 to November 2016 CIC cancelled 573 elective surgeries for non-clinical reasons.
- Four surgical specialties were below the England average for admitted RTT (percentage within 18 weeks).
- An action in the quality improvement plan stated that the division aimed to achieve compliance with 18 week RTT for the incomplete pathway standard by September 2016. The status of this action remained 'in progress' as of December 2016.
- At trust level, general surgery had a longer average length of stay than the England average for both elective and non-elective admissions.
- At the time of inspection the perioperative improvement plan was in the early stages of implementation, impacting upon some areas but not yet fully embedded within the division.
- Staff morale was variable on the wards, in theatres and in recovery areas. Morale was affected by working in difficult circumstances during the preceding 18 months to cover staff and skill shortages.
- We were advised of ongoing bullying allegations within the theatre departments.

However:

- The division held regular emergency surgery and elective care business unit meetings where serious incidents were discussed, investigations analysed, and changes to practice identified.
- Senior nursing staff had daily responsibility for safe and effective nurse staffing levels. Staffing guidelines with clear escalation procedures were in place. Site

cover was provided out-of-hours 24 hours per day, seven days per week, by a team of senior nurses with access to an on-call manager. Numbers of staff on duty were displayed clearly at ward entrances.

- A 'red flag' and safer staffing system had been introduced to identify when lower than optimal staff numbers may impact upon patient care, and thus to initiate mitigation. Escalation processes were in place through the matron, service manager, and chief matron. Capacity bed meetings were held twice daily to monitor bed availability, review planned discharges, and assess bed availability throughout the trust.
- All wards participated in the NHS safety thermometer approach to display consistent data to assure people using the service that the ward was improving practice, based on experience and information. This tool was used to measure, monitor, and analyse patient 'harm free' care.
- We looked at medical records across wards and saw that they were appropriately completed, legible, and organised consistently. All documentation that we checked was signed and dated, clearly stating details of the named nurse and clinician.
- Patients were treated in accordance with national guidance and enhanced recovery (fast track) pathways were used. Local policies were written in line with national guidelines. A range of standardised, documented pathways and agreed care plans were in place across surgery.
- During 2015/16, the surgical business unit participated in 12/14 national clinical audits, covering a range of specialties, and completed 122 local audits. Outcomes from each audit were reported to the Business Unit Governance Board (BUG Board).
- The perioperative surgical assessment rate was 92.4%, which does not meet the national standard of 100%. However, the 2015 figure was 62.4%, showing considerable improvement.
- CIC was one of only 18 Hospitals in England and Wales referred to in the first National Emergency Laparotomy Audit (NELA) audit for contributing examples of best practice in care of patients undergoing emergency laparotomy.
- Patients admitted with a fractured neck of femur had their pain assessed immediately upon presentation at hospital and within 30 minutes of administering initial analgesia, then hourly until settled on the ward and regularly as part of routine nursing observations throughout admission.
- A dedicated pain team was accessible to support with analgesia as required. The pain team visited patients when baseline pain relief was ineffective. Anaesthetists provided support with pain relief out-of-hours.
- The Friends and Family Test (FFT) response rate for surgery at the trust was 38%, which was better than the England average of 29%, between November 2015 and October 2016. Ward level recommendation rates were variable, although recommendation rates were generally high, being between 70 and 100% for the overall period across all participating wards.
- We observed the treatment of patients to be compassionate, dignified, and respectful throughout our inspection. Ward managers and matrons were available on the wards so that relatives and patients could speak with them as necessary.
- The trust was actively working with commissioners to provide an appropriate level of service, based on demand, complexity, and commissioning requirements.
- The division had an escalation policy and procedure to deal with busy times, and matrons and ward managers held capacity bed meetings to monitor bed availability.
- Complaints were handled in line with the trust policy and discussed at all monthly staff meetings. Patients or relatives making an informal complaint were able to speak to individual members of staff or the ward manager. Wherever possible the Patient Advice & Liaison Service (PALS) would look to resolve complaints at a local level.
- We met with senior trust and divisional managers who had a clear vision and strategy for the division and identified actions for addressing issues within the division. The divisional leadership team detailed its understanding of the challenges associated with providing good quality care, and it identified actions needed.

Surgery

- The trust had developed a quality improvement plan (QIP) and had identified specific objectives to improve the management of the deteriorating patient, the recognition and initiation of treatment for patients with sepsis, and ongoing development of the Mortality and Morbidity (M&M) Framework.
- The division had also developed a perioperative improvement plan in response to recent issues identified within surgery. This aimed to enhance governance through learning from events and incidents, develop the workforce through a positive learning environment, and initiate external assessment and compliance.
- There was a systematic programme of clinical and internal audit, which was used to monitor quality and systems to identify where action should be taken. Monthly audits were undertaken and audit outcomes were published quarterly.
- The division's risk register was updated following safety and quality meetings with risks discussed and controls identified, with progress against mitigation, risk grading, and assurance sources, and with gaps in control documented.

Are surgery services safe?

Requires improvement

We rated safe as 'requires improvement' because:

- There had been seven Never Events for Surgery between June 2015 and February 2016. These were a wrong site block, a wrong site injection, a wrong implant, three retained foreign objects, and one wrong site surgery.
- The majority of surgical wards were below the nursing establishment levels. The data for CIC at the time of inspection showed that Beech B required 14.4 WTE but had 11.72 WTE nursing staf in post. Similarly, Beech D was 2.24 WTE short and Maple D was 6.49 WTE short.
- As of September 2016 the trust reported a vacancy rate of 8.9% in surgical staff at CIC, with a turnover rate of 23.6% between April 2015 and March 2016.
- We saw that 26% (November 2016) of patients were re-assessed for VTE within 24 hours of admission. This was a decrease from October 2016, when 72% of patients were re-assessed within 24 hours of admission. September 2016 figures were 37%. The target was 95%.
- Surgical debrief as part of 'five steps to safer surgery' was undertaken 14% of the time. A trust audit had recommended further work on encouraging the team debrief through business unit governance meetings and dissemination of learning by governance leads. A presentation provided by the trust highlighted that improvement work was underway.
- We found that rates of training in subjects such as fire safety (58%), hygiene for clinical staff (67%), trust doctors patient safety programme (31%), and duty of candour (45%) were below the trust target.

However:

- The division held regular emergency surgery and elective care business unit meetings where serious incidents were discussed, investigations analysed, and changes to practice identified.
- Senior nursing staff had daily responsibility for safe and effective nurse staffing levels. Staffing guidelines with clear escalation procedures were in place. Site cover was provided out-of-hours 24 hours per day, seven days per week, by a team of senior nurses with access to an on-call manager. Numbers of staff on duty were displayed clearly at ward entrances.

- A 'red flag' and safer staffing system had been introduced to identify when lower than optimal staff numbers may impact upon patient care, and so to initiate mitigation. Escalation processes were in place through the matron, service manager, and chief matron. Capacity bed meetings were held twice daily to monitor bed availability, review planned discharges, and assess bed availability throughout the trust.
- All wards participated in the NHS safety thermometer approach, displaying consistent data to assure people using the service that the ward was improving practice based on experience and information. This tool was used to measure, monitor, and analyse patient 'harm free' care.
- The trust carried out monthly audits of hand hygiene compliance, commode, cannulas, urinary catheters, personal protective equipment and ventilated patients, and we saw that the standard of environmental cleanliness was good across all wards inspected.
- We looked at medical records across wards and saw that they were appropriately completed, legible and organised consistently. All documentation checked was signed and dated, clearly stating details of the named nurse and clinician.

Incidents

- Never events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Between July 2015 and November 2016, CIC reported seven incidents which were classified as a Never Event for surgery. There had been six Never Events between June 2015 and February 2016. These were a wrong site block, wrong site injection, wrong implant, two retained foreign objects, a wrong site surgery, and a wrong route medication.
- The Never Events had been subject to an early management report and had been fully investigated, root cause analyses undertaken, and changes to practice made where appropriate.
- The trust had commissioned an external review of Never Events by the Royal College of Surgeons (RCS) and been visited by the Clinical Commissioning Group (CCG). Actions were incorporated into the perioperative improvement plan and monitored by senior management.
- In accordance with the Serious Incident Framework 2015 the surgical division reported 19 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England between October 2015 and September 2016. Of these, the most common type of incident reported was pressure ulcer (46.2%) followed by surgical/invasive procedure (30.8%). Seven SIs were reported from CIC.
- The division held regular emergency surgery and elective care business unit meetings, at which serious incidents were discussed, investigations analysed, and changes to practice identified.
- Staff told us how they reported incidents through the electronic system, and most said that learning was shared through meetings, communication books, and team briefings. However, staff said that they received no feedback on reported incidents.
- Matrons had an overview of every incident, complaint, and concern and operated a system of response and feedback to patients and staff.
- The trust held regular mortality and morbidity case review meetings within all specialities to discuss case descriptions and summaries, classification, outcome, and key lessons. These were attended by multi-disciplinary teams and lessons learnt were identified and used to inform service development through audit (e.g. for implant compliance, Warfarin reversal protocol, and wrong site surgery), safety huddles, ward meetings, newsletters, and on a one to one basis as necessary.
- There were no active mortality outlier alerts as at October 2016.

Safety thermometer

- Safety Thermometer is used to record the prevalence of patient harms at the frontline, and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.
- Data from the Patient Safety Thermometer for surgery showed that the surgical division reported 32 pressure ulcers, seven falls with harm, and seven catheter urinary

tract infections between November 2015 and November 2016. This information was displayed in ward entrances and was easy to understand, and staff had knowledge of the displayed information and ward performance.
- Audits showed that 100% (September, October and November 2016) of patients received an assessment of venous thromboembolism (VTE) in and bleeding risk using the clinical risk assessment criteria described in the national tool.
- We saw 26% (November 2016) of patients were re-assessed within 24 hours of admission. This was a decrease from October 2016 when 72% of patients were re-assessed with 24 hours of admission. September 2016 figures were 37%. The target was 95%.
- Patient safety was monitored through the completion of moving and handling assessments, falls risk assessments, the national early warning score (NEWS), and malnutrition (MUST) assessments and by following infection, prevention, and control measures.

Cleanliness, infection control and hygiene

- The trust had an infection surveillance programme and an infection control matron in place. An annual infection prevention and control report was presented to the board and monthly reports to the safety and quality committee.
- The trust had policies in place to cover aseptic techniques, patient transfers, hand hygiene, outbreaks, norovirus, and Methicillin Resistant Staphylococcus Aureus (MRSA). These were available as paper copies and on the trust intranet.
- The trust carried out monthly audits of hand hygiene compliance, commode, cannulas, urinary catheters, personal protective equipment, ventilated patients, ultra violet spray, and glow cleanliness.
- Each ward had daily, weekly, and monthly cleaning schedules for domestic staff, housekeepers, and nursing staff. Cleaning and environmental audits were completed on a monthly basis and these showed that all wards met the hygiene target between February 2016 and August 2016.
- Incidence of infection and cleaning audits were displayed clearly to visitors at the entrance to all wards and surgical areas. These showed compliance with clean commodes, hand hygiene, and cannula and catheter audits.
- Trust environmental cleanliness audits (January to August 2016) showed divisional compliance with hand hygiene techniques at 100%. However, theatre recovery failed to submit seven out of eight months' audits.
- We saw that the standard of environmental cleanliness was good across all wards that we inspected. Infection control and hand hygiene signage was consistent, and we observed clear signage for isolation of patients in single rooms.
- There were no cases of MRSA reported between September 2015 and August 2016.
- Quality of care boards were displayed on the ward and showed three episodes of Clostridium Difficile (C. Diff) between July 2016 and December 2016.
- All Trust C diff cases underwent a root cause analysis (RCA) using pro formas agreed across the local health economy and with Public Health England, which were uploaded onto a database, which then reported generated themes. Each RCA was reviewed and a synopsis of each apportioned case was presented to the Infection Prevention Control Committee (IPCC) and the safety and quality committee.
- A Healthcare Associated Infection (HCAI) Delivery Plan had been developed to ensure compliance with, for example, urinary catheter insertion techniques, hand hygiene, surgical scrub uniform policy, SSI national standards, cleaning standards, and learning from SSI root cause analyses.
- We observed staff washing their hands and all patients we spoke with told us that this was done. Hand gel was available throughout the hospitals at the point of care and staff used personal protective equipment (PPE) compliant with policy.
- We observed clean equipment throughout surgical areas, and staff completed cleaning records and domestic cleaning schedules.
- Clinical and domestic waste disposal and signage was good. Staff were observed disposing of clinical waste appropriately. Linen storage, segregation of soiled linen in sluice rooms, and the disposal of sharps followed trust policy.
- Surgical Site Infection (SSI) group meetings were held to reduce the incidence of infections through for example, temperature monitoring, patient education, inter-operative practices, treatment rooms, pre-admission screening, SSI rates, and day zero practice.

- The trust report for April to June 2016 showed SSI rates of 1.73% for total hip replacements, 2.32% total knee replacements, 1.72% for repair of neck of femur, and 2.85% revision of total knee replacements. No SSIs were recorded for revision of total hip replacements.

Environment and equipment

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

Medicines

- In all wards and surgical areas, medicines were stored, prescribed, and administered in line with trust policy and procedures. We saw that the trust had introduced an electronic dispensing system which staff had been trained to use.
- Medicine prescription records for individual patients were clearly written, and medicines were prescribed and administered in line with trust policy and procedures.
- Although pharmacists liaised with and supported ward teams regularly, we were told by staff that pharmacist input to theatres at CIC was less regular.
- Staff were required to attend mandatory updates on storage and recording of controlled drugs, and newly qualified staff were required to attend training and complete the e-learning safe medications training.
- Temperature checks were recorded for the safe storage of medication in refrigerated units on a daily basis.
- Discharge medication was planned in advance as the pharmacy department did not provide discharge medication after 3:30 pm. If a patient required discharge medication after this time, the ward sister provided a prescription for the patient to take to the local chemist. This prevented delayed discharges.

Records

- We looked at 13 sets of medical records across wards at CIC and saw that they were appropriately completed, legible, and organised consistently. All documentation that we checked was signed and dated, clearly stating the details of the named nurse and clinician.
- Daily entries of care and treatment plans were clearly documented and care plans and charts were reviewed regularly. Completed patient assessment, observation charts, food and fluid balance sheets, consent forms with mental capacity assessments, and diabetes and wound care charts were inserted as applicable.
- Records included a pain score, and allergies were documented.
- We reviewed handover sheets used by ward staff, and found that escalation documentation was effective in communication and decision-making for those patients at risk of deterioration.
- We saw good examples of complete preoperative checklists and consent documentation in the patient notes we checked.

Safeguarding

- The trust had a clear safeguarding strategy and held safeguarding board meetings. Minutes and action plans were clear, and these meetings were well attended by senior staff from across the trust. Learning from serious case reviews was monitored, and there was good attendance at and compliance with safeguarding training.
- Safeguarding training plans and schedules were displayed in ward offices and held centrally by the training department.
- Divisional data (November 2016) showed 67% of medical and nursing staff had attended safeguarding adults level two and 62% had attended safeguarding children level two. The percentage of staff who had attended that had completed level 3 was 63%. The trust had set a target of 95% for completion of safeguarding training by the end of March 2017.

- On the wards staff understood their responsibilities and discussed safeguarding policies and procedures confidently and competently. Staff felt that safeguarding processes were embedded throughout the trust.
- Information was available at ward level with guides, advice, and details of contact leads to support staff in safeguarding decision-making.

Mandatory training

- The trust set a target of 95% for completion of mandatory training modules by the end of March 2017. Divisional audits showed 100% of staff had attended the trust induction. Medical, nursing and healthcare assistants within surgery met the training targets for equality and diversity (89%), risk management (85%), VTE training (88%), moving and handling (83%), and advance life support (100%). All staff had met the training target for the 12 'essence of care' core modules set by the trust.
- We found that training levels in areas such as medicines management level 2/3 (75%), dementia (77%), NEWS (76%), information governance compliance (61%), fire safety (58%), hygiene for clinical staff (67%), and the trust doctors patient safety programme (31%) were below the trust target.
- Duty of Candour requirements were explicitly stated within trust policies, on the trust intranet, and in training, and staff described to us how these procedures had been used following specific incidents. However, training levels were not meeting the trust target of 95% and were only 45% in November 2016.
- The surgical division had an action plan in place to achieve compliance with mandatory training targets by March 2017 (95%) and attendance at mandatory training programmes for all staff was monitored locally, and also by the education department.
- Staff told us that they accessed mandatory training in a number of ways, such as online modules and e-Learning, workbooks, and key trainer-delivered sessions. Staff said that they were supported with professional development through education.
- Staff said that they had had a good induction and preceptorship programme when joining the trust, and they attended local sessions and those provided at a trust level.
- A clinical educator was in post and supported staff with training, their continued professional development, and professional revalidation.

Assessing and responding to patient risk

- The trust used an early warning score risk assessment system. The strategy and processes for recognition and treatment of the deteriorating patient in surgery were embedded. Staff recorded observations, with trigger levels to generate alerts, which identified acutely unwell patients.
- We saw full completion of early warning score risk assessments and sepsis screening tools and staff were aware of escalation procedures.
- Comprehensive risk assessments were in place in surgical records and included the completion of cognitive assessment tools, falls risks, pressure ulcer risks, and bed rails assessments.
- Care planning based on patients' assessed risks was good. We saw evidence of risk assessment for nutrition with the Malnutrition Universal Screening Tool (MUST), and this helped staff to identify patient nutritional needs. Pain scores and diaries for patients were available.
- Staff knew how to highlight and escalate key risks that could affect patient safety, such as staffing and patient assessment and screening.
- A trust audit (May 2016) measured compliance with the 'Five Steps to Patient safety' procedure. This showed 98% compliance with undertaking the team brief before surgery (previously 50%). The audit also showed 98% sign-in by the surgeon prior to anaesthesia at CIC.
- Time out was taken for all patients at the hospital with all members of the team listening and stopping, and 100% responding as required.
- Debrief was undertaken 14% of the time. However, when debrief was undertaken all staff were present. The audit had recommended further work on encouraging the team debrief through business unit governance meetings and dissemination of learning by governance leads. A presentation provided by the trust highlighted that improvement work was underway.
- We observed the checklist being used appropriately in theatre and saw completed preoperative checklists and consent documentation in all patient notes, where applicable.

Nursing staffing

- The National Institute for Health and Care Excellence (NICE) states that assessing the nursing needs of individual patients is paramount when making decisions about safe nursing staff requirements for adult inpatient wards in acute hospitals.
- A 'red flag' and safer staffing system had been introduced to identify when lower than optimal staff numbers may impact upon patient care and so to initiate mitigation. Escalation processes were in place through the matron, service manager, and chief matron. Monitoring of patient acuity, dependency, and actual against planned staffing levels took place on a shift-by-shift basis.
- Senior nursing staff had daily responsibility for safe and effective nurse staffing levels. Staffing guidelines with clear escalation procedures were in place. Site cover was provided out-of-hours 24 hours per day, seven days per week, by a team of senior nurses with access to an on-call manager. Matrons told us that shortfalls in nursing cover were managed day to day through regular senior nurse team meetings and cross-site conference calls, as a business unit working together to meet demands in ward activity.
- Numbers of staff on duty were displayed clearly at ward entrances. During the inspection all wards were staffed to the required levels.
- The data for CIC at the time of inspection showed that Beech B required 14.4 WTE but had 11.72 WTE nursing staff in post. Similarly, Beech D was 2.24 WTE short and Maple D was 6.49 WTE short. At WCH ward 1 required 20.86 WTE but had 17.68 WTE nursing staffing in post. Similarly the day case unit had 7 WTE but required 8.93 WTE.
- As of September 2016 the trust reported a vacancy rate of 1.4% at CIC (although it should be noted that this was an average of the vacancy rates, and the trust reported a vacancy whole number of 6.55 for this site).
- Between April 2015 and March 2016, the trust reported a nursing turnover rate of 3.3% and a bank and agency usage rate of 3.5 % in surgical care.
- To address this, the division had developed recruitment plans, sickness monitoring was reported quarterly to the Safety and Quality Board, and it used bank staff and overtime. Additionally, daily board rounds were undertaken to prioritise care, monitor rotas, and inform patients and families of actions taken.
- All wards within surgery cared for a number of 'outlier' medical patients. Staff told us these patients had different needs to surgical patients and increased their workload. Many staff expressed concern about the difference in skill required to care for medical patients. We saw no evidence to support an increase in incidents.

Surgical staffing

- Medical staffing skill mix across the hospital varied across grades compared to the England average, with 39% consultant (national average 43%), 16% middle career (national average 10%), 26% registrar group (national average 35%), and 20% junior doctors (national average 11%). As of June 2016 the ratio of consultant staff to junior (foundation year 1-2) staff reported to be working at the trust was about the same as the England average.
- As at 30 September 2016 the trust reported a vacancy rate of 8.9% in surgical care at CIC, with a turnover rate of 23.6% between April 2015 and March 2016. CIC had the higher turnover rate of the two sites, with ENT having the largest turnover rate of the specialities listed (56.5% or 3 whole number).
- Between April 2015 and March 2016 the trust reported a sickness rate of 1.4% in surgical care at CIC. CIC reported the higher sickness rate of the two sites, with oral surgery showing the greatest rate of the departments listed (7.2%).
- Between April 2015 and March 2016, the trust reported a bank and locum usage rate of -18% in surgical care. The trust stated that the negative rates could occur due to the method finance used to calculate the rate, as occasionally they can over-estimate and this can result in negative spend in a future month when actual costs become known.
- The emergency surgical and elective care business unit risk register (September 2016) identified issues with staffing across the trust. The division had developed recruitment and retention policies to address these issues.
- Further risks were identified around clinical capacity and the reliance on locum cover in ophthalmology. Concerns had been raised about the quality of cover, changes to appointments, and lack of continuity.
- We saw that surgical handovers took place daily, were primarily consultant-led and took place in private areas to maintain confidentiality.
- The trust had gained in-house Royal College of Surgeons accredited START surgery course for foundation doctors in surgery.

Surgery

Major incident awareness and training

- The trust major incident response plan was in place and available to staff on the trust intranet. This policy aimed to adopt a unified and cohesive approach to resilience, through business continuity planning and emergency response.
- There were business continuity plans for surgery. These included the risks specific to the clinical areas and the actions and resources required to support recovery.
- A trust assurance process was in place to ensure compliance with NHS England core standards for emergency preparedness, resilience, and response.
- The trust's major incident plan provided guidance on actions to be undertaken by departments and staff who may be called upon to provide an emergency response, additional service, or special assistance to meet the demands of a major incident or emergency.
- Training was provided by the resilience team which involved a "live" exercise every three years, a table-top exercise every year and a communications cascade test every 6 months, Executives and senior managers were required to complete media training every three years.

Are surgery services effective?

Good

We rated effective as 'good' because:

- Patients were treated in accordance with national guidance and enhanced recovery (fast track) pathways were used. Local policies were written in line with national guidelines. A range of standardised, documented pathways and agreed care plans were in place across surgery.
- During 2015/16, the surgical business unit participated in 12/14 national clinical audits, covering a range of specialties, and completed 122 local audits. Outcomes from each audit were reported to the Business Unit Governance Board (BUG Board). In addition, the audit activity and outcomes of different services were scrutinised via the trust's quality panels and safety and quality committee.
- The perioperative surgical assessment rate was 92.4%, which does not meet the national standard of 100%. However, the 2015 figure had been 62.4%, so this showed considerable improvement.
- CIC was one of only 18 Hospitals in England and Wales referred to in the first NELA audit for contributing examples of best practice in care of patients undergoing emergency laparotomy.
- In the Patient Reporting Outcomes Measures (PROMS) from April 2015 to March 2016, the Hip Replacement (EQ VAS) and Knee Replacement (Oxford Knee Score) indicators showed more patients' health improving and fewer patients' health worsening than the England averages. Groin Hernia (EQ-5D Index) showed fewer patients' health improving than the England average, although slightly fewer patients' health worsened than the England average. The remainder of indicators were in line with the England averages.
- Patients admitted with a fractured neck of femur had their pain assessed immediately upon presentation at hospital and within 30 minutes of administering initial analgesia, then hourly until settled on the ward and regularly as part of routine nursing observations throughout admission.
- A dedicated pain team was accessible to support with analgesia as required. The pain team visited patients when baseline pain relief was ineffective. Anaesthetists provided support with pain relief out-of-hours.
- The trust reported that, as at 31 August 2016, Mental Capacity Act (MCA) training had been completed by 89% of staff in within surgery for Level 1 and 72% for Level 2. Deprivation of Liberty training had been completed by 76% of staff within surgery.

However:

- In the 2016 Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 6.7%, which falls within expectations. The 2015 figure was 6.2%. The proportion of patients having surgery on the day or day after admission was 68.3%, which does not meet the national standard of 85%. The 2015 figure was 75.1%.
- Between March 2015 and April 2016 patients at the trust had a higher than expected risk of readmission for both elective and non-elective admissions. Relative risk of readmission for general surgery and trauma and orthopaedics both had similar performance to the trust level.

Evidence-based care and treatment

- Patient treatment was in accordance with national guidance from the National Institute of Health and Care Excellence (NICE), the Association of Anaesthetists, and The Royal College of Surgeons.
- New systems and processes for the registration and monitoring of clinical audits were introduced corporately in the Clinical Audit Policy and continued to be developed, along with new processes for providing assurance around compliance with NICE guidance and quality standards. These required full implementation within the business unit during 2016/17.
- We saw that patients had their needs assessed and their care planned and delivered in line with evidence-based guidance, standards, and best practice.
- During 2015/16, the surgical business unit participated in 12/14 national clinical audits covering a range of specialties, and completed 122 local audits. Outcomes from each audit were reported to the Business Unit Governance Board (BUG Board). In addition, the audit activity and outcomes of different services were scrutinised via the trust's quality panels and safety and quality committee.

Pain relief

- Patients were regularly asked about their pain levels, particularly immediately after surgery, and this was recorded on a pain scoring tool that was used to assess patients' pain levels. All patients reported that their pain management needs had been met.
- There was a pain assessment scale within the NEWS chart used throughout the hospital. NEWS audits were in place and supported through feedback from the Friends and Family Test (FFT) and directly from patients.
- A dedicated pain team was accessible to support with analgesia as required. The pain team visited patients when baseline pain relief was ineffective.
- Anaesthetists provided support with pain relief out-of-hours.
- Patients admitted with a fractured neck of femur had their pain assessed immediately upon presentation at hospital and within 30 minutes of administering initial analgesia, then hourly until settled on the ward and regularly as part of routine nursing observations throughout admission.

Nutrition and hydration

- Priority was given to appropriate nutritional and hydration support for surgical patients on each ward. Staff identified patients at risk of malnutrition by working with patients and their families to complete a MUST score.
- Ward audits included checking whether patients received a nutritional risk assessment on admission and whether this risk assessment was reviewed within the required timescales.
- We observed appropriately completed fluid balance charts and dietary intake charts.
- The nutritional risk assessment identified the levels at which dietitian referral was recommended.
- Arrangements were in place for when enteral feeding was required out-of-hours as part of a protocol to ensure that patients did not have to wait for a dietitian to be on duty.
- We saw a range of food choice, meals, and snacks. Patients who required nutritional support were identified.
- Surgical pre-operative assessments performed by nursing staff, offered tailored nutrition and hydration guidance to patients, and provided all elective patients with fasting instructions to follow on the day of their surgery.
- Records showed patients were advised as to what time they would need to fast from. Fasting times varied depending on whether the surgery was in the morning or afternoon and were recorded on the nursing notes.
- We reviewed 13 records and saw that nurses completed food charts for patients who were vulnerable or required nutritional supplements, and support was provided by the dietetic department.
- Meal charts were completed comprehensively and reviewed.

Patient outcomes

- Between March 2015 and April 2016 patients at the trust had a higher than expected risk of readmission for both elective and non-elective admissions. Relative risk of readmission for general surgery and trauma and orthopaedics both had similar performance to the trust level.
- In the 2016 Hip Fracture Audit the risk-adjusted 30-day mortality rate was 6.7%, which falls within expectations.

The 2015 figure was 6.2%. The proportion of patients having surgery on the day or day after admission was 68.3%, which does not meet the national standard of 85%. The 2015 figure was 75.1%.

- The perioperative surgical assessment rate was 92.4%, which does not meet the national standard of 100%. The 2015 figure had been 62.4%, however, so this showed considerable improvement.
- The proportion of patients who did not develop pressure ulcers was 94.7%, which falls in the middle 50% of trusts. The 2015 figure was 97.7%.
- The length of stay was 16.7 days, which falls in the middle 50% of trusts. The 2015 figure was 15.1 days.
- The trust showed marked improvement from 2015 for the perioperative medical assessment rate, although all other measures had deteriorated from the 2015 audit results. Case ascertainment also dropped from 98.1% in 2015 to 92% in 2016, although the trust was higher than the England and Wales aggregate of 90.7%.
- In the 2015 Bowel Cancer Audit 55% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was better than than the national aggregate. The 2014 figure was 52%.
- The risk-adjusted 90-day post-operative mortality rate was not submitted by the trust in the 2015 audit. The 2014 figure was 8.3%.
- The risk-adjusted 2-year post-operative mortality rate was 19.4%, which falls within the expected range. The 2014 figure was 22.8%.
- The risk-adjusted 90-day unplanned readmission rate was not submitted by the trust in the 2015 audit. The 2014 figure was 24.2%.
- The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 34%, which was lower than expected. The 2014 figure was 37%.
- Case ascertainment was 87% in the 2015 audit, a slight improvement on the 2014 figure of 86%, and was good compared to other participating hospitals, although was below the England and Wales aggregate of 94%.
- In the 2015 National Vascular Registry (NVR) audit the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 1.6% for Abdominal Aortic Aneurysms, indicating that the trust performed within expectations. The 2013 figure was 3%.
- Within Carotid Endarterectomy the median time from symptom to surgery was 19 days, which was worse than than the national standard of 14 days. The 30-day risk-adjusted mortality and stroke rate was 1.9% and within the expected range. The 2013 figure was 0%.
- Case ascertainment for both Abdominal Aortic Aneurysms and Carotid Endarterectomy had markedly dropped from the 2013 figures (42% from 87% and 37% from 88% respectively) and was worse than the audit aspirational standard of 90%.
- In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), the age- and sex-adjusted proportion of patients diagnosed after an emergency admission was 9.9%. This placed the trust within the middle 50% of all trusts for this measure. The 90-day post-operative mortality rate was not reported for this trust in the audit.
- The proportion of patients treated with curative intent in the Strategic Clinical Network was 34.2%, which was significantly lower than the national aggregate.
- In the 2015 National Emergency Laparotomy Audit (NELA) at CIC the trust achieved a green rating (>70%) for five measures, an amber rating (50-69%) for two measures, and a red rating (<49%) for three measures. The final case ascertainment rate was rated as green. The rating represents a score of between 80-100%. In the 2014 National Emergency Laparotomy Audit 11 of 28 services were found to be available and two were available on request.
- CIC was one of only 18 Hospitals in England and Wales referred to in the first NELA audit for contributing examples of best practice in care of patients undergoing emergency laparotomy.
- In the Patient Reporting Outcomes Measures (PROMS) from April 2015 to March 2016, the Hip Replacement (EQ VAS) and Knee Replacement (Oxford Knee Score) indicators showed more patients' health improving and fewer patients' health worsening than the England averages. Groin Hernia (EQ-5D Index) showed fewer patients' health improving than the England average, although slightly fewer patients' health worsened than the England average. The remainder of indicators were in line with the England averages.
- Theatre utilisation at CIC ranged from 50.1% to 76.5% during the period June 2016 to August 2016. Theatre 5 had the lowest average utilisation over the period at

55.4% while Theatre 7 had the highest (74.3%). Overall average utilisation rates trust-wide had decreased over the 3 month period from 64.1% in June to 56.6% in August 2016.

Competent staff

- The percentage and numbers for medical appraisals within the surgical division were 95% (106 out of 115) completion rate at consultant levels and 91% (49 out of 51) for trust doctors across both locations up to December 2016.
- In the same period 91.7% (99 out of 108) of nursing staff at the CIC had received their appraisal. This was an increase from 2014/15 of 22% for consultants and 12% for nursing staff.
- Staff we spoke with felt able to discuss their training needs with their line manager. However, many felt continued professional development was limited due to staff shortage and an inability to attend development training.
- Support was provided for nursing revalidation by identifying expectations and continued education required.

Multidisciplinary working

- Protocols had been developed for the effective multidisciplinary handover of patients when needed. These involved the identification of bed availability, NEWS assessment, and verbal, electronic, and written transfer of information.
- Therapists worked closely with the nursing teams on the ward where appropriate. Ward staff told us that they had good access to physiotherapists and occupational therapists.
- Staff explained to us that the wards worked with local authority services as part of discharge planning, and weekend discharges requiring support were identified at pre-assessment so that appropriate equipment and support could be arranged.
- We observed staff, including those in different teams and services, becomes involved in assessing, planning, and delivering people's care and treatment.
- There were established multi-disciplinary team (MDT) meetings for care pathways and these included nurses, nurse specialists, surgeons, anaesthetists, and radiologists.
- Ward staff worked closely with patients, their families, allied health professionals, and the local authority when planning discharge of complex patients, to ensure the relevant care was in place and that discharge timings were appropriate.
- There was pharmacy input on the wards during weekdays. We observed pharmacist involvement with patient care.

Seven-day services

- The trauma and orthopaedic wards delivered a seven day service.
- Out-of-hours ward and on-call cover for general surgery and the trauma & orthopaedic service had a specialist registrar. Junior doctors were also available but were shared with ENT and general surgery.
- Patients received daily consultant ward rounds, including on weekends.
- Theatres had 24 hour shift cover plus an on-call.
- There were a dedicated physiotherapist and occupational therapists for each ward, available Monday to Friday.
- There was limited access to physiotherapists and occupational therapists at the weekend, and patients were prioritised by level of need and orthopaedic plan of care and treatment.
- There was no speech and language support service at the weekends.
- There were pharmacists on site Monday to Friday, 9am to 5pm. Out-of-hours medication prescribing was nurse-led by trained ward sisters.

Access to information

- Risk assessments, care plans, and test results were completed at appropriate times during the patient's care and treatment. Records were available to staff enabling effective care and treatment.
- There were appropriate and effective systems in place to ensure patient information was co-ordinated between systems and accessible to staff.
- Staff had access to policies, procedures, and guidelines on the trust intranet system. All staff felt confident in accessing the information they required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Surgery

- The trust reported that, as at 31 August 2016, Mental Capacity Act (MCA) training had been completed by 89% of staff within surgery for Level 1 and 72% for Level 2.
- Deprivation of Liberty training had been completed by 76% of staff within surgery.
- We looked at clinical records and observed that patients had consented to surgery in line with the trust policy and Department of Health guidelines.
- Mental capacity assessments were undertaken by the nurse or consultant responsible for the patient's care, and Deprivation of Liberty Safeguards (DoLS) were referred to the trust's safeguarding team.
- MCA and DoLS assessments were included in risk assessments.
- We found that policy and procedures in place ensured that capacity assessments and consent were obtained by middle grade level medical staff or above. Elective patients were informed about consent as part of their pre-assessment process and were given information regarding risks and potential complications. However, some patients consented on the day of procedure.
- There was access to an independent mental capacity advocate (IMCA) when best interest decision meetings were required.
- Mental health liaison support was available at CIC.

Are surgery services caring?

Good

We rated caring as 'good' because:

- The Friends and Family Test response rate for surgery at the trust was 38%, which was better than the England average of 29%, between November 2015 and October 2016. Cumberland Infirmary had a better response rate than the England average. Ward level recommendation rates were variable across the two sites, although recommendation rates were generally high, being between 70 and 100% for the overall period across all participating wards.
- The 'Two minutes of your time' survey was used to elicit patient feedback on how likely patients were to recommend the hospital to family and friends, respect and dignity, involvement in care and treatment, cleanliness, and kindness and compassion received. These indicators, from April 2015 to September 2016 gave overall scores (maximum 10) of between 9.44 and 10.
- The trust took part in the Patient-Led Assessment of the Care Environment (PLACE, 2015). The results showed the surgical division scored 90.4% for providing privacy and dignity for patients and 70% for dementia care.
- We observed the treatment of patients to be compassionate, dignified, and respectful throughout our inspection. Ward managers and matrons were available on the wards so that relatives and patients could speak with them as necessary.
- Patients felt that their privacy and dignity had been respected, and they were happy with the quality of care they had received.
- Patients we spoke to said, "The nurses are great", "I have been looked after well", "the surgeon explained everything to me and talked about my future needs", and "the staff are very caring and friendly".

Compassionate care

- The Friends and Family Test response rate for surgery at the trust was 38%, which was better than the England average of 29%, between November 2015 and October 2016. Cumberland Infirmary had a better response rate than the England average. Ward level recommendation rates were variable across the two sites although recommendation rates were generally high, being between 70 and 100% for the overall period across all participating wards.
- In the Cancer Patient Experience Survey 2015 the trust was in the top 20% of trusts for three of the 34 questions, in the middle 60% for 23 questions, and in the bottom 20% for eight questions. The trust performed in the top 20% for: patient did not think hospital staff deliberately misinformed them; patient never thought they were given conflicting information; and all staff asked patient what name they preferred to be called by.
- The 'Two minutes of your time' survey was used to elicit patient feedback on how likely patients were to recommend the hospital to family and friends, respect and dignity, involvement in care and treatment, cleanliness, kindness, and compassion received. These indicators, from April 2015 to September 2016 gave overall scores (maximum 10) of between 9.44 and 10.

- The trust took part in the Patient-Led Assessment of the Care Environment (PLACE, 2015). The results showed the surgical division scored 90.38% for providing privacy and dignity for patients and 70% for dementia care.
- 'You said we did' was used to identify patient views. We saw many examples of patient's opinions and comments being acted upon.
- Patients we spoke to said, "The nurses are great", "I have been looked after well", "the surgeon explained everything to me and talked about my future needs", and "the staff are very caring and friendly".
- Patients felt that their privacy and dignity had been respected, and they were happy with the quality of care they had received.
- During inspection we observed patients being spoken to in an appropriate manner, information being shared in a method that they understood, and staff taking time to reassure and comfort patients.

Understanding and involvement of patients and those close to them

- All patients said they were made fully aware of their surgical procedure and that it had been explained to them thoroughly and clearly.
- Patients said they felt involved in their care and had been given the opportunity to speak with the consultant looking after them.
- Patients told us that staff kept them well informed, explained why tests and scans were being carried out, and did their best to keep patients reassured.
- We saw that ward managers and matrons were visible on the wards so that relatives and patients could speak with them.
- As part of the elective surgery pre-operative assessment process, patients had the opportunity to bring relatives or friends along to the consultation should they so wish.
- Patients felt they were well educated, supported, and prepared for their surgical procedures.
- The trust offered a 'forget-me-not' passport of care for every inpatient admission. This was completed by the families and carers, telling the staff how to care for the person in their unique way, and offering individual detail to give a personalised approach.
- There was a dementia lead nurse on each ward who undertook assessment and provided guidance, and support. There was access to a psychiatric liaison team who supported with dementia, delirium, depression, and anxiety.

Emotional support

- Patients reported that staff spent time with them and staff recognised the importance of time to care and support patients emotional needs. Care plans highlighted the assessment of patients emotional, spiritual, and mental health needs.
- We were given information about support groups for patients. These included the local head and neck cancer support groups. Counselling clinics for the National Bowel Cancer Screening Programme took place on both main hospital sites.
- A chaplaincy service was available within the hospital to help patients, visitors, and staff to respond to their spiritual and emotional needs. This included pastoral and spiritual care, regardless of religion. The Infirmary chapel and quiet room were available day and night as places for quiet reflection and private prayer.
- Clinical psychology support services commissioned by the trust supported patients as necessary. For example, support was routinely provided for amputee patients and those requiring stomas.
- Staff were aware of the impact that a person's care, treatment, or condition may have on their wellbeing, both emotionally and socially.

Are surgery services responsive?

Requires improvement

We rated responsive as 'requires improvement' because:

- A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice. For the period Q2 2014/15 to Q1 2016/17 the trust cancelled 1,410 elective operations on the day of surgery. Of these, 12% were not rescheduled and treated within 28 days. The overall trend was that the trust had a much higher percentage of operations not treated within 28 days than the England average. Performance improved from Q1 2015/16 to Q3 2015/16; however, performance deteriorated again from Q4 2015/16 and was showing signs of deteriorating further.

- Cancelled operations as a percentage of elective admissions included all cancellations rather than just short notice cancellations. Cancelled operations as a percentage of elective admissions for the period Q2 2014/15 to Q1 2016/17 at the trust was consistently greater than the England average. The trust trend had followed a similar pattern to the England average, although the peaks and troughs were far more pronounced, particularly the increase in Q3 2015/16, although it should be noted that junior doctor strikes were planned during this period and may have contributed to the sharp rise.
- For the period November 2015 to November 2016 Cumberland Infirmary cancelled 573 elective surgeries for non-clinical reasons.
- Four surgical specialties were below the England average for admitted RTT (percentage within 18 weeks). Ophthalmology showed the poorest performance compared to the England average, with a marked deterioration in June and July 2016 when the percentage within 18 weeks was 24.4%. This speciality improved in August, to 29.6%, but remained notably below the England average of 77.5%.
- An action on the quality improvement plan stated that the division aimed to achieve compliance with 18 week referral to treatment for the incomplete pathway standard by September 2016. The status of this action remained 'in progress' as of December 2016.
- At trust level general surgery had a longer average length of stay than the England average for both elective and non-elective admissions. Average length of stay for trauma & orthopaedics had contrasting performance, with elective admissions being shorter than the England average (2.9 days compared to 3.5) and non-elective being longer than the England average (9.3 compared to 8.8 days). Compared to the trust level, average length of stay at Cumberland Infirmary was longer for both elective and non-elective admissions (at 2.5 and 5 days respectively).

However:

- The trust was actively working with commissioners to provide an appropriate level of service, based on demand, complexity, and commissioning requirements.
- The hospital had an escalation policy and procedure to deal with busy times, and matrons and ward managers held capacity bed meetings to monitor bed availability.
- Complaints were handled in line with the trust policy and discussed at all monthly staff meetings. This highlighted that training needs and learning was identified as appropriate.
- Patients or relatives making an informal complaint were able to speak to individual members of staff or the ward manager. Contact details for the Patient Advice Liaison Service (PALS) and Complaints were clearly listed. Wherever possible PALS would look to resolve complaints at a local level.

Service planning and delivery to meet the needs of local people

- The trust was actively working with Cumbria Clinical Commissioning group (CCG) to provide an appropriate level of service, based on demand, complexity, and commissioning requirements.
- The Patient Panel (an independent voluntary group) assisted the trust in providing improved communication and information between patients, relatives, carers, staff, and the trust board to help improve service provision. Members reviewed and made suggestions for ways and means of improving the quality and accessibility of services.
- North Cumbria University Hospitals maintain links with the Overview and Scrutiny Committee, which provides the checks and balances that ensure that decisions are made which reflect the needs of the people of Cumbria, and is part of the county council's governance arrangements.
- The trust maintain links with Healthwatch Cumbria, which is an independent organisation set up to champion the views of patients and social care users in Cumbria, with the goal of making services better and improving health and wellbeing.

Access and flow

- Between April 2015 and March 2016 the average length of stay for surgical elective patients at the trust was 2.3 days, compared to 3.3 days for the England average. For surgical, non-elective patients the average length of stay was 4.8 days, compared to 5.1 for the England average.
- At trust level general surgery had a longer average length of stay than the England average for both elective and non-elective admissions. Average length of stay for trauma & orthopaedics had contrasting performance, with elective admissions being shorter than the England average (2.9 days compared to 3.5) and non-elective

being longer than the England average (9.3 compared to 8.8 days). Compared to the trust level average length of stay at Cumberland Infirmary was longer for both elective non-elective admissions (at 2.5 and 5 days respectively).

- Three surgical specialties were above the England average for admitted RTT (percentage within 18 weeks). These were general surgery at 86.7% (England average 76.4%), ENT 85.8% (England average 70.3%), and urology at 81.4% (England average 80.2%).
- An action on the quality improvement plan stated that the division aimed to achieve compliance with 18 week referral to treatment for the incomplete pathway standard by September 2016. The status of this action remained 'in progress' as of December 2016.
- Four surgical specialties were below the England average for admitted RTT (percentage within 18 weeks). Ophthalmology showed the poorest performance compared to the England average, with a marked deterioration in June and July 2016, when the percentage within 18 weeks was 24.4% and 8.9%. This speciality had improved in August, to 29.6%, but remained notably below the England average of 77.5%.
- A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital, or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice. For the period Q2 2014/15 to Q1 2016/17 the trust cancelled 1,410 elective operations on the day of surgery. Of these, 12% were not rescheduled and treated within 28 days. The overall trend was that the trust had a much higher percentage of operations not treated within 28 days than to the England average. Performance improved from Q1 2015/16 to Q3 2015/16; however, performance deteriorated again from Q4 2015/16 and was showing signs of deteriorating further.
- Cancelled operations as a percentage of elective admissions includes all cancellations rather than just short notice cancellations. Cancelled operations as a percentage of elective admissions for the period Q2 2014/15 to Q1 2016/17 at the trust were consistently greater than the England average. The trust trend had followed a similar pattern to the England average, although the peaks and troughs were far more pronounced, particularly the increase in Q3 2015/16, although it should be noted that junior doctor strikes were planned during this period and may have contributed to the sharp rise.
- For the period November 2015 to November 2016 Cumberland Infirmary cancelled 573 elective surgeries for non-clinical reasons.
- Capacity bed meetings were held twice daily to monitor bed availability, review planned discharges, and assess bed availability throughout the trust.

Meeting people's individual needs

- Surgical teams personalised patient care in line with patient preferences and individual and cultural needs.
- Ward information boards identified who was in charge of wards for any given shift and whom to contact if there were any problems.
- Leaflets were available for patients regarding their surgical procedure, pain relief, and anaesthetic. Alternative languages and formats were available on request.
- There was good access to the wards. There were lifts available in each area and ample space for wheelchairs or walking aids.
- The surgical division applied the 'This is me' personal patient passport/health record to support patients with learning needs and dementia. Symbols on files identified special requirements such as dementia.
- The psychiatric liaison team was available for patients displaying confusion, delirium, and undiagnosed dementia as part of the National Commissioning for Quality and Innovation(CQUIN), which also identified diagnosis of dementia using specific admission documentation. If confusion or forgetfulness was evident but there was no confirmed diagnosis of dementia a cognitive assessment was carried out by nurses on the surgical ward and appropriate referral made for diagnosis.
- Support needs were identified through the Butterfly Scheme, encouraging family and carers to be involved in providing important information about the patient.
- There were no mixed sex accommodation breaches over the preceding 12 months on any surgical ward at Cumberland Infirmary.
- Specific equipment had been designed for the use of bariatric patients to ensure safety for both staff and patients. Requests were made when further equipment was required.

- An equality and diversity surgery nurse raised awareness of the needs of transgender patients.
- The Patient Advice and Liaison Serviceassisted with the provision of interpreters. Sign language interpreters could also be provided for patients with hearing or speech-impairment who require a qualified communicator, 24 hours per day.
- One-stop general surgery clinics were established (i.e. pre-assessment and booking date for surgery at same visit).
- Joint/parallel clinics were set up with community surgeons in community hospitals.
- Telephone advice clinics were in place for patients.

Learning from complaints and concerns

- Between September 2015 and August 2016 there were 69 complaints related to surgical care across both the Cumberland Infirmary and West Cumberland Hospital. There was an average of six complaints per month and trend analysis showed that the number of monthly complaints remained consistent. The highest number of complaints was in respect of the trauma & orthopaedic department (32 complaints).
- The trust had a 30 working day response timeframe with a 95% compliance requirement. The trust had seen a systematic increase, from April 2016, in response rates, achieving full 95% compliance in the first two months of Q2 2016/17.
- Ward meetings discussed complaints received as a standing agenda item.
- We reviewed complaints, and compliments were discussed. We saw evidence of audit activity and learning from complaints and clinical risk management issues.
- All wards and departments had posters situated at the entrance clearly explaining what to do if unhappy with the care, services, or facilities provided. Contact details for the PALS were clearly listed. Wherever possible PALS would look to resolve complaints at a local level.
- Patients or relatives making an informal complaint were able to speak to individual members of staff or the ward manager. Themes of complaints were discussed with staff, who were encouraged to share learning to prevent recurrence.
- Ward staff were able to describe complaint escalation procedures, the role of PALS, and the mechanisms for making a formal complaint.

Are surgery services well-led?

Good

We rated well-led as 'good' because:

- We met with senior trust and divisional managers, who had a clear vision and strategy for the division and identified actions for addressing issues within the division. The divisional leadership team detailed its understanding of the challenges associated with providing good quality care and identified actions needed.
- The trust had developed a Quality Improvement Plan (QIP) to ensure implementation of its Clinical Strategy, Nursing, Midwifery, and Allied Health Professionals (AHP) Strategy. Within the QIP the trust had identified specific objectives to improve the management of the deteriorating patient, the recognition and initiation of treatment for patients with sepsis, and ongoing development of the Mortality and Morbidity Framework.
- The division had also developed a Perioperative Quality Improvement Plan in response to recent issues identified within surgery. This aimed to enhance governance through learning from events and incidents, to develop the workforce through a positive learning environment, and to initiate external assessment and compliance.
- Regular divisional, emergency surgery and elective care business unit, safety and quality group, and clinical leads for National safety Standards for Invasive Procedures (NatSSIPS) meetings were held.
- There was a systematic programme of clinical and internal audit, which was used to monitor quality and systems to identify where action should be taken. Monthly audits were undertaken and audit outcomes were published quarterly.
- The division's risk register was updated following the safety and quality meetings with risks discussed and controls identified, with progress against mitigation, risk grading, assurance sources, and gaps in control documented.
- An integrated performance report which gave progress updates on the emergency surgery and elective care improvement plan was presented to the trust board at

each meeting. An example of actions identified highlighted the implementation of additional clinical sessions to improve compliance against national standards for referral to treatment.

However:

- At the time of inspection the Perioperative Improvement Plan was in the early stages of implementation, impacting upon some areas but not yet fully embedded within the division. Although most staff were aware of the plan, they could not articulate specific outcomes.
- Staff morale was variable on the wards, in theatres and in recovery areas. Morale was affected by working in difficult circumstances during the preceding eighteen months to cover staff and skill shortages.
- We were advised of ongoing bullying allegations within the theatre departments.

Vision and strategy for this service

- We met with senior trust and divisional managers, who had a clear vision and strategy for the division and identified actions for addressing issues within the division.
- The trust vision and strategy was displayed in wards and staff were able to articulate to us the trust's values and objectives across the surgical division.
- Staff demonstrated the values of the trust during the inspection, were clear about the trust vision, and understood their role in contributing to achieving the trust-wide and directorate goals.
- The trust had developed a Quality Improvement Plan (QIP) to ensure implementation of its Clinical, Nursing, Midwifery, and Allied Health Professionals (AHP) Strategies. Within the QIP the trust had identified specific objectives to improve the management of the deteriorating patient, the recognition and initiation of treatment for patients with sepsis, and ongoing development of the Mortality and Morbidity Framework.
- The division had also developed a Perioperative Quality Improvement Plan in response to recent issues identified within surgery. This aimed to enhance governance through learning from events and incidents, develop the workforce through a positive learning environment, and initiate external assessment and compliance.
- Patients were treated in accordance with national guidance and enhanced recovery (fast track) pathways were used. Local policies were written in line with national guidelines. A range of standardised, documented pathways and agreed care plans was in place across surgery.
- The plan also identified initiatives for improvements in booking and scheduling, performance, information and reporting, reductions in sickness absence, patient and public involvement, and the implementation and monitoring of National safety Standards for Invasive Procedures (NatSSIPS).

Governance, risk management and quality measurement

- An integrated performance report which gave progress updates on the emergency surgery and elective care improvement plan was presented to the trust board at each meeting. An example of actions identified highlighted the implementation of additional clinical sessions to improve compliance against national standards for referral to treatment.
- Regular divisional, emergency surgery and elective care business unit, safety and quality group, and Clinical Leads for National safety Standards for Invasive Procedures (NatSSIPS) meetings were held.
- We reviewed agendas and minutes and these showed serious and clinical incidents, guidelines, and standard operating procedures. We saw some evidence of audit activity and lessons learned.
- There was a systematic programme of clinical and internal audit, which was used to monitor quality and systems to identify where action should be taken. Monthly audits were undertaken and audit outcomes were published quarterly.
- The division's risk register was updated following the safety and quality meetings with risks discussed and controls identified, with progress against mitigation, risk grading, assurance sources, and gaps in control documented.
- Risks identified included, for example, theatre overruns, staffing, compliance with national targets and guidelines, cost improvement plans, and ward capacity. Action plans were monitored across the division and sub-groups were tasked with implementation.
- Additionally, the division had commissioned a programme of 'Human Factors' awareness training designed to increase awareness of the individual's role in and impact on procedures. The programme was part completed at the time of inspection.

Surgery

Leadership of service

- We held meetings with the divisional leadership team who detailed their understanding of the challenges associated with providing good quality care and identified actions needed.
- The team had identified specific strategies and initiatives to meet the challenges within the division and had developed the perioperative quality improvement plan to facilitate improvements.
- At the time of inspection the plan was in the early stages of implementation, impacting upon some areas but not yet fully embedded within the division. Although most staff were aware of the plan, they could not articulate specific outcomes from it. We saw improvement since the inspection in September 2016.
- Senior staff were motivated and enthusiastic about their roles and had clear direction with plans in relation to improving patient care. Senior managers and clinical leads showed knowledge, skills, and experience.
- Staff said that service leads and managers were available, visible within the division, and approachable. Staff we spoke with told us that leadership of the service was better but required further improvement. Clinical management meetings were held and involved service leads and speciality managers.
- Monthly speciality meetings were held and discussed financial and clinical performance, patient safety, and operational issues.
- The senior leadership team was fully aware that there were particular difficulties within the division and these were 'being tackled'. Specific issues identified that were on the risk register were:
  - the referral to treatment rate within 18 weeks for admitted patients;
  - the percentage of patients whose operations were cancelled and were not then treated within 28 days;
  - Inability to recruit permanent anaesthetic staff to maintain a sustainable anaesthetic care model for clinical strategy;
  - Theatre overruns, with multiple theatres finishing late resulting in no theatre staff available for emergency theatres CIC.

Culture within the service

- We interviewed staff on an individual and group basis throughout wards, units, and theatres. They told us that the division had improved leadership and most senior managers were visible and 'hands on'. This reflected the vision and values of the division and the trust.
- Staff spoke positively about the service they provided for patients, and high quality compassionate care was a priority.
- Nursing staff stated that they were supported by their managers and they could access one-to-one meetings, which were mostly informal, as well as more structured meetings and forums.
- Medical staff stated that they were supported by colleagues and confirmed they received feedback from governance and action planning meetings.
- There was an acknowledgement that the trust had plans in place to increase staffing levels and develop effective recruitment and retention plans. However, some staff told us they had been working in difficult circumstances during the preceding eighteen months to cover staff and skills shortages.
- The numbers of shifts not staffed to establishment across most surgical wards and areas, caring for medical 'outliers', and the high acuity and needs of patients supported the view expressed by staff that they were working under pressure within the division.
- Although staff were enthusiastic about their work the service they provided, and, generally, the organisation they worked for, staff morale was variable and not always high on wards, in theatres, and in recovery areas. Staff explained that morale had been difficult to maintain despite recognised leadership support and effective team working. Ongoing pressures had left some staff feeling exhausted, consequently undervalued, and not always listened to by senior staff.
- Most staff described good teamwork within the division and we saw that staff worked well together. We saw examples of good team working on the wards between staff of different disciplines.
- We were advised of ongoing bullying allegations within the theatre department. We were assured that appropriate action plans were in place and being monitored.

Public engagement

- People using the service were encouraged to give their opinion on the quality of service they received. Leaflets about the Friends and Family Test, PALS, and 'Two

Minutes of Your Time, Tell us what you think' questionnaires were available on all ward and reception areas. Internet feedback was gathered along with complaint trends and outcomes.
- Ward managers were visible on the ward, which provided patients with opportunities to express their views and opinions.
- Discussions with patients and families regarding decision-making was recorded in patient notes.
- All staff spoken to were clear about their roles and responsibilities, were patient-focused, and worked well together.
- The Friends and Family Test response rate for surgery at the trust was 37%, which was better than the England average of 29%, between September 2015 and August 2016. The recommendation rate was between 70% and 100%.
- The 'Two minutes of your time' survey was used to elicit patient feedback on how likely patients were to recommend the hospital to family and friends, respect and dignity, involvement in care and treatment, cleanliness, and kindness and compassion received.
- These results were supported through discussions with patients during our inspection. Patients were complimentary about the care and treatment they had received at the hospital and were very supportive of the services provided.

Staff engagement

- All staff were invited to attend regular forums with the chief executive, where they were able to voice their opinions, listen to updates, and discuss any concerns. Several staff members stated that these forums were difficult to attend due to staff shortage on the wards.
- We saw that senior managers communicated to staff through the trust intranet, e-bulletins, team briefs, and internal campaigns. Each ward held monthly staff meetings, at which key issues for continuous service development were discussed.

Innovation, improvement and sustainability

- The trust had been a National Patient Safety Awards finalist for better outcomes in orthopaedics.
- Trauma reorganisation within the service had commenced.
- The trust had the only surgeon between Leeds and Glasgow doing a meniscal augment in the knee.
- An Honorary Professorship University of Cumbria had been received by a consultant for work on applying digital technologies in health care for an elderly population in rural setting; a part of CACHET.
- The trust was conducting a multinational, multicentre prospective study in the use of intramedullary nail in varus malalignment of the knee. The trust had the largest international experience of this technology for this application.
- CIC was one of only 18 Hospitals in England and Wales referred to in the first NELA audit for contributing examples of best practice in care of patients undergoing emergency laparotomy.
- A one-stop general surgery clinic had been established (pre-assessment and booking date for surgery at same visit).
- Joint/parallel clinics were set up with community surgeons in community hospitals.
- Telephone advice clinics were in place for patients.
- The trust had gained In-house Royal College of Surgeons accredited START surgery course for foundation doctors in surgery.
- There had been development of emergency ambulatory care in surgery.
- An equality and diversity surgery nurse was raising awareness of the needs of transgender patients.

Critical care

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

Information about the service

The North Cumbria NHS Foundation Trust (NCFT) provides critical care services in the Cumberland Infirmary in Carlisle (CIC) and the West Cumberland Hospital (WCH) in Whitehaven. For the purposes of governance the unit sits in the surgical and critical care division. The unit is part of, and works closely with, the North of England and Cumbria Critical Care Network (NoECCCN).

The trust has a total of 15 adult critical care beds and the Intensive Care National Audit and Research Centre (ICNARC) data indicates that there are around 1150 admissions a year, with 850 at the CIC site. Across two sites there are eleven 'intensive care' (ITU) beds for complex level 3 patients who require advanced respiratory support or at least support for two organ systems, and four 'high dependency' (HDU) beds for level 2 patients who require very close observation, pre-operative optimisation, extended post-operative care, or single organ support, and this includes care for those 'stepping down' from level 3 care. Beds are used flexibly with the resources to increase and decrease the numbers of either ITU or HDU admissions.

The focus of this report is the critical care unit at CIC, which can flexibly admit seven level 3 and two level 2 patients into nine beds. One bed space of the nine in total is a single room. The service provides intensive and high dependency care for patients who have had complex surgery. It also provides care for emergency admissions. The unit admits small numbers of paediatric admissions, who have short stay for stabilisation prior to transfer to specialist hospitals outside of the trust.

During inspection our team spoke with 20 members of staff. We spoke with four patients and one relative. We observed care, reviewed policy and documentation, and checked equipment. We were able to review a range of performance data during the inspection.

Critical care

Summary of findings

We rated safe as 'good' because :

- There was ongoing progress towards a harm free culture. Incident reporting was understood by the staff we spoke with and improvement in reporting culture had been noted by the critical care team. There were low numbers of incidents in critical care and evidence of good reporting culture.
- There was a proactive approach to the assessment and management of patient-centred risks, and staff had a good understanding of the trust position related to learning from serious incidents and Never Events. Staff we spoke with took responsibility for driving improvement to reduce risk of patient harm or acute deterioration. We observed examples of good practice around patient nasogastric tube insertion and feeding as a result of learning from incidents.
- At the time of inspection there were good numbers of skilled nursing staff, including a supernumerary coordinator. There were low vacancies and sickness levels in critical care at CIC and staffing levels and acuity of patients were closely monitored. We did not see any evidence that the Intensive Care Society standards were compromised for nurse to patient ratio for level 3 and level 2 critical care, as found on previous inspections across both units.
- A CCOR team was well established and covered 24/7. We observed good practice for recognition and treatment of the deteriorating patient. One hundred percent of patients received follow up once discharged from the unit. Practice was in line with GPICS (2015), NICE CG50 and against the seven core elements of Comprehensive Critical Care Outreach, (C3O 2011) 'PREPARE'; 1. Patients track and trigger, 2. Rapid response, 3. Education and Training, 4. Patient safety and governance, 5. Audit and evaluation (monitoring patient outcome), 6. Rehabilitation after critical illness and 7. Enhancing service delivery.
- The approach to transfer of the critically ill patient was good and monitored closely with training provided for staff. The arrangements for stabilisation and transfer of 17 paediatric patients in the unit in 2015/16 were very good and consistent across both units.
- Consultants were all experienced in critical care and there was a consultant clinical lead. Medical staffing rotas offered continuity for patient care and we observed good multidisciplinary (MDT) handovers and consultant-led ward rounds. Consultant to patient ratios were in line with GPICS (2015). Staff we spoke with recognised, however, that there was an increased use of locum staff (35%) due to vacancy (10.36%) and sickness (6.82%) rates at the CIC unit. There were good processes in place for multidisciplinary mortality and morbidity review and cardiac arrest audit as part of the surgical and anaesthetic directorate and trust governance structure.
- The unit was visibly clean and equipment and stores were well organised. We observed staff adhering to infection prevention and control policy without exception. There were good processes in place for decontamination of equipment and equipment training and provision of domestic services.
- During inspection we observed that medicines management was good and controlled drugs and medicines were stored securely in the unit. All clinical fridges had the correct recording of temperatures as per policy and national standards for pharmacy. Medicines audits and monitoring of incidents were performed by the pharmacy team and senior nursing staff.
- Critical care had developed an electronic patient record. We reviewed six care records in the electronic patient record system. The team was familiar with the system and staff we spoke with were positive about the system. Good processes were in place to be able to transfer patient information to paper for discharges and transfers. Entries in the records were complete and in line with GPICS (2015) and professional General Medical Council (GMC) and Nursing and Midwifery Council (NMC) standards. The six patients received a daily review and treatment plans.
- Mandatory training provision was organised and staff attendance was good overall at 88% and with a plan

Critical care

to achieve the trust targets of 80% attendance in most areas across 2016/17. This included a target of 95% for safeguarding training to protect vulnerable adults and children and staff had good understanding of safeguarding for both adults and children. There was an increased priority given to level two and three child safeguarding training and paediatric resuscitation training in view of the paediatric admissions to the unit.

However:

- Although nurse staffing and establishment was good in critical care with low vacancies and sickness rates, staff would be moved frequently (including the CCOR team) to support shortfalls in staffing in other wards and departments. We spoke with staff who felt that this affected morale of nursing staff in the unit, although patient safety was felt to not be compromised. We also noted in rotas we reviewed that it was frequently not possible to protect the provision of a supernumerary coordinator role when staff were moved. Staff we spoke with also confirmed this to be a regular occurrence.
- The number of pressure sores recorded in the incident reporting system had not showed improvement since our last inspection and staff reporting of pressure ulcer grading and level of harm appeared to be inconsistent. The staff we spoke with attributed the static figures to improved reporting across all grades of pressure ulcers rather than worsened performance.
- In 2015 we reported that the unit had limits in storage and patient bed space and during this inspection we noted again that although the unit was modern in design it would not meet current national standards for new buildings and environment. (HBN 04-02). During the inspection we noted that the senior team had submitted proposals which outlined the plans for unit upgrade and expansion.

Are critical care services safe?

Good

We rated safe as 'good' because:

- There was ongoing progress towards a harm free culture. Incident reporting was understood by the staff we spoke with and improvement in reporting culture had been noted by the critical care team. There were low numbers of incidents in critical care and evidence of a good reporting culture.
- There was a proactive approach to the assessment and management of patient-centred risks and staff had a good understanding of the trust position related to learning from serious incidents and Never Events. Staff we spoke with took responsibility for driving improvement to reduce risk of patient harm or acute deterioration. We observed examples of good practice around patient nasogastric tube insertion and feeding as a result of learning from incidents.
- At the time of inspection there were good numbers of skilled nursing staff, including a supernumerary coordinator. There were low vacancies and sickness levels in critical care at CIC and staffing levels and acuity of patients were closely monitored. We did not see any evidence that the Intensive Care Society standards were compromised for nurse to patient ratio for level 3 and level 2 critical care, as found on previous inspections across both units.
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Critical care

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- Mandatory training provision was organised and staff attendance was good overall at 88%, with a plan to achieve the trust targets of 95% attendance in most areas across 2016/17. This included a target of 95% for safeguarding training to protect vulnerable adults and children, and staff had good understanding of safeguarding for both adults and children. There was an increased priority given to level two and three child safeguarding training and paediatric resuscitation training in view of the paediatric admissions to the unit.

However:

- Although nurse staffing and establishment was good in critical care with low vacancies and sickness rates, staff would be moved frequently (including the CCOR team) to support shortfalls in staffing in other wards and departments. We spoke with staff who felt that this affected morale of nursing staff in the unit, although patient safety was felt to not be compromised. We also noted in rotas we reviewed, that it was frequently not possible to protect the provision of a supernumerary coordinator role when staff were moved. Staff we spoke with also confirmed this to be a regular occurrence.
- The number of pressure sores recorded in the incident reporting system had not showed improvement since our last inspection, and staff reporting of pressure ulcer grading and level of harm appeared to be inconsistent. The staff we spoke with attributed the static figures to improved reporting across all grades of pressure ulcers rather than worsened performance.
- In 2015 we reported that the unit had limits in storage and patient bed space, and during this inspection we noted again that although the unit was modern in design it would not meet current national standards for new buildings and environment. (HBN 04-02). During the inspection we noted that the senior team had submitted proposals which outlined the plans for unit upgrade and expansion.

Incidents

- Staff we spoke with had a good understanding of the incident reporting system and trust policy. Learning from incidents was shared across the team in meetings and daily safety communications. There was good understanding of duty of candour amongst all staff we spoke with, however zero incidents that had triggered the duty in 2015/16 in CIC. The duty of candour is a legal duty on healthcare providers that sets out specific requirements on the principle of being open with patients when things go wrong.
- Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and

should have been implemented by all healthcare providers. Between October 2015 and September 2016, the trust reported no incidents which were classified as Never Events for critical care services.

- In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SI) in critical care services (WCH) which met the reporting criteria set by NHS England between October 2015 and September 2016.
- We reviewed the National Reporting and Learning System (NRLS) incidents between May 2016 and August 2016. There were 86 incidents attributed to critical care across both hospital sites, with 59 at the CIC unit. All incidents were reported in the following categories; negligible (n10), minor (n33), moderate (n14), major (n1) or catastrophic (n1). There were some inconsistencies in grading and categorisation of pressure ulcer incidents in this timescale. The main trends in reported incidents were moisture lesions (n9) and pressure ulcers (n11) with some being reported under the heading 'accidents' (n7). We reviewed that grade 2-4 pressure ulcers were reported under each of the moderate, negligible and minor categories. Staff we spoke with reported that every incident of pressure damage would be reported and that consequently there had been a rise in numbers over 2015/16, however improvement work was ongoing to reduce the rate of all grades.
- There was a good level of detail in the reporting system and it was clear that staff were able to report safety concerns and near misses. We saw good evidence of learning from incidents related to suturing central venous catheter lines into position where action had been taken to improve practice amongst consultant and junior staff.
- We observed that incidents were discussed in multi-professional meetings to share learning as needed and actions were documented. This demonstrated a commitment to developing an open and transparent safety culture in critical care and across the trust.
- Mortality and morbidity review took place as part of the surgical and anaesthetic directorate governance meeting agenda. Staff we spoke with told us that meetings took place regularly for review of all deaths and alternate monthly themes were discussed in the directorate audit meeting. We saw evidence of Cardiac Arrest audit findings being reviewed as part of the meeting. Grading of cases adhered to National Confidential Enquiry into Patient Outcome and Death (NCEPOD) guidance. The meeting was open to the MDT.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harm-free care. This focuses on four avoidable harms: pressure ulcers, falls, catheter associated urinary tract infections (CAUTI) and blood clots or venous thromboembolism (VTE).
- Avoidable patient harm incidents were reported as follows in 2015/16; one fall, 12 CAUTI, zero VTE and 12 pressure ulcers in CIC critical care across all four reportable areas.
- The unit displayed performance information on the 'Quality Board' at the entrance to the unit. The display included a range of information and all the measures of harm, including associated audit activity.
- We observed good practice in critical care for completion of VTE risk assessments on admission and prescription of prophylaxis. There were zero reported incidents for 2015/16 in critical care.

Cleanliness, infection control and hygiene

- According to the data published by the Intensive Care National Audit and Research Centre (ICNARC) the unit performance (1.3) was better than similar units (1.7) for unit acquired infections in the blood. Unit acquired methicillin-resistant staphylococcus aureus (MRSA) and clostridium difficile infection rates were zero. There was ongoing monitoring of sepsis admission activity to the unit which was also submitted to ICNARC.
- The clinical environment was visibly clean and although the unit had limited space at the bedside, equipment and stock was stored appropriately. There was one isolation room in the unit with appropriate design and air exchange for infection prevention and control.
- Staff had access to trust infection prevention and control policies. We observed good compliance with hand hygiene by all nursing staff, with good access to sinks in the unit. We observed staff using alcohol hand gels. Uniform and 'bare below the elbows' policy was observed to be good and staff use of personal protective equipment (PPE), whilst caring for patients was also

good. Disposable curtains were in use at the bedside and were in date, these were changed as required or every 3 months. This was consistent with previous inspection observations.

- Standards of infection prevention and control practice were monitored by senior staff. Hand hygiene, environmental cleanliness, mattress audit, cannula commode cleaning and infection data showed consistently good standards in critical care, with 100% compliance in most areas, this information was displayed on 'Quality Boards' and discussed with staff in team meetings.
- The consultant microbiologist attended the unit daily and reviewed patients as part of the consultant led ward round. Microbiology also performed relevant audit.

Environment and equipment

- The unit had nine bed spaces including one single room. A central nurse's station allowed staff good visibility to most patients in the unit, as the unit had two separated areas; it was difficult to observe patients in the bed spaces furthest from the nurses' station. The design and space available fell short of HBN-04-02 specifications, although the unit was modern and well lit.
- The unit was accessed securely from a small corridor with good display of information for patients and staff. There was access to a spacious visitors' room.
- Consultant staff we spoke with told us that there were proposals outlining plans for unit upgrade at CIC as part of an overall future strategy and vision for critical care services across both sites.
- We checked 26 pieces of equipment and found all to be clean with appropriate labelling and safety checks. We checked blood gas monitoring and point of care equipment and found all to be clean, with good maintenance systems in place.
- Patient bed spaces were noted to be around half the recommended 25.5 m2 (Department of Health, Health Building Note - HBN 04-02, 2013) for a new build intensive care unit. The bed space size we observed, did not give sufficient clear floor space to allow room for visitors, staff and equipment brought to the bedside. We observed difficulties manoeuvring the larger purpose design patient chairs.
- The emergency resuscitation equipment and patient transfer bags and trolleys were checked daily with a good system in place as per trust policy. The equipment was central and easy to access. There was also good provision of emergency paediatric equipment which was also checked regularly to ensure it was ready for use.
- There was good provision of equipment required for level 3 and level 2 critical care for both adults and children. We observed a thorough record and a robust reporting system of medical device training for all staff. Staff we spoke with told us that the links with the medical engineering team were good. The risks associated to loss of service if equipment is broken and replacing capital equipment were part of a service review in September 2016.

Medicines

- We observed good storage and security associated with the management of medicines in the unit. We observed good practice and checking systems for use and storage of controlled drugs by nursing and pharmacy staff. There were two 'negligible' incidents in 2015/16 around controlled drug storage and action plans were managed by senior nursing staff to prevent reoccurrence.
- Staff we spoke with told us that the pharmacist accompanied the morning consultant led ward round as often as possible but was not able to attend for the duration. They attended the unit every day and this included daily review of prescribing Monday to Friday. There was no available dedicated pharmacist at weekends.
- There was a low number (five) of drug related incidents in the unit in 2015/16 and the process for reporting and investigation was good. We noted that an open and transparent approach was taken to sharing lessons learnt with the team and patients and this was supported by the senior nursing and consultant staff in the absence of a pharmacist.
- We observed six prescription charts and allergies were clearly documented in all cases. The microbiologist took responsibility for antimicrobial stewardship.
- The unit was not included in the trust medicines safety audit, however the EPR system provided assurance as prompted staff to check antimicrobial prescribing and missed doses were not reported as an issue in the unit.

Records

- The team in the unit had invested in and implemented an electronic patient record (EPR) and prescription system specific to intensive care which we observed to be comprehensive and well understood by staff.
- We reviewed six EPR and six ITU care charts. Entries in the EPR were complete and in line GPICS (2015) and professional General Medical Council (GMC) and Nursing and Midwifery Council (NMC) standards. Patients received a daily review and treatment plans.
- Notes were stored securely and electronic versions were accessed on computers on trolleys with appropriate password protection as per trust policy. There had been no incidence of confidentiality breach in the unit. Staff did not report any issues with the electronic record.
- Nursing staff reported that using a critical care specific EPR did create some difficulty when they were moved to work in ward areas, as they were no longer familiar with the paper notes system in use across the hospital.

Safeguarding

- The trust safeguarding policy and resources were available to staff and the unit had an organised approach to provision and staff attendance of safeguarding training to protect vulnerable adults and children, with good planning by senior staff to ensure staff were up to date. ITU at CIC had staff attendance compliance of 100% for level one safeguarding training for adults and children and 100% for level two. Sisters and senior nurses attended level 3 for children to ensure each shift had a nurse on duty with training.
- Staff we spoke with told us that they understood the safeguarding processes and could identify staff to contact to escalate any concerns for vulnerable adults and children.

Mandatory training

- The trust had a mandatory training compliance target of 80% for staff attendance and senior nursing staff we spoke with had an organised approach to achieving the targets for unit staff across the year.
- Senior clinical leads we spoke with reported overall 88% achievement at the time of inspection against all areas. Fire safety and Basic Life Support had the worst attendance at 68% and 62%; staff we spoke with were aware of the shortfall and had a plan in place for these sessions.
- The trust provided core elements in mandatory training to include, fire, equality and diversity, basic life support, infection prevention and control, information governance, health and safety, safeguarding adults and children, and manual handling.
- Training provision for infection prevention and control was good with 88% of staff having attended hand hygiene and infection prevention and control mandatory training.
- Staff attendance of information governance training as part of mandatory training, was below 80% target at 68%. Senior staff we spoke with had a plan to achieve target. Staff could access mandatory training in a number of ways, online eLearning modules and face to face sessions delivered by key trainers.

Assessing and responding to patient risk

- There was a designated Critical Care Outreach Team (CCOR) at the trust who covered the service 24/7. This included 100% patient follow-up after discharge to wards within 36 hours. The team also had oversight for the compliance and training for staff using National Early Warning Score (NEWS) observations across the trust. There was good evidence of escalation policy being implemented on wards and critical care. There was an eLearning package for NEWS training.
- The EPR included a range of risk assessments completed on patients' admission to critical care. We observed good compliance with completion for Malnutrition Universal Screening Tool (MUST) assessment, moving and handling, tissue viability, VTE, delirium, infection control and falls risk. If a patient was identified as having an elevated risk the action required to reduce it was evident in the care plan and practice.
- We observed good use of 'quality check lists' which prompted staff to check equipment, processes, referrals, incidents, stock levels, documentation, infection issues and reviews.
- NEWS and patient escalation audit was performed across the trust with mixed performance. Critical care compliance with NEWS was comparably good across both sites with 85% to 100% compliance.
- CCOR staff were responsible to deliver training across the trust for the ALERT course, which was being replaced by the AIMS course in 2016.

- Patients with tracheostomy were cared for on designated ward areas to manage the increased risks associated with their care. Training was provided to staff by CCOR and the team took the lead on a tracheostomy group across the trust to support best practice.
- Staff we spoke with told us that transfer of adult and paediatric patients was well managed. A trust and network policy was in place. There were zero incidents to report as part of critical care transfers.
- Follow up clinics were being planned for critical care patients and a dedicated team was in the progress of being recruited to support the rehabilitation of patients after critical illness. At the time of inspection clinics were not in place.

Nursing staffing

- Nurse establishment and staffing in the unit at the time of inspection was good, although the senior nurse did not have a full protected supernumerary coordinator shift. We observed seven actual registered nurses against a plan of eight on duty, with the sister working as the eighth nurse when patients were admitted from theatre.
- We reviewed rotas and spoke to nursing staff of all grades and did not see any evidence of reducing qualified nurse to patient ratios below critical care staffing guidance (GPICS, 2015) of 1:1 for Level 3 patient care and 1:2 Level 2 patient care during day or night shift. However, nursing staff and CCOR staff were moved frequently to cover shortfalls in ward areas however staff did report that ratios were not compromised and staff would return to the unit if demand changed.
- We reviewed nursing rotas as part of our inspection and calculated that over 300 hours had been provided by critical care nurses to ward areas from September to November 2016. This was reported to senior nursing staff who agreed that this was a fair assessment of the reallocated nursing hours and that staffing budgets were being monitored across the wards and critical care.
- Staff we spoke with gave mixed feedback about visibility and support from trust site managers who would call the unit or visit when they needed to request staffing support from critical care to ward areas. The critical care senior team and clinical leaders were reported as supportive to the needs of critical care however staff expressed concerns around decisions made by some trust-wide managers about acuity and staffing movement and the risk posed to patient safety.
- The unit had funding to support a supernumerary unit coordinator across a seven day week and 12 hour day shift pattern in line with GPICS (2015) standards for nine bedded units. A supernumerary clinical educator was in post at this site.
- A 'red flag' and safer staffing system had been introduced to identify when lower than optimal staff numbers may impact upon patient care and to initiate mitigation. Escalation processes were in place through the matron, service manager and chief matron. Monitoring of patient acuity, dependency and actual against planned staffing levels took place on a shift-by-shift basis.
- Nursing staff sickness was better than the trust target of 3.5% at 3.16% in the 2015/16 reporting period. The use of agency staff was minimal, despite the overall registered nurse turnover being reported as 14% for CIC. The unit relied on established unit bank staff to cover any shortfalls in critical care as could not draw on staff across the trust due to the competency requirements. There were no vacant nursing posts at the time of inspection.
- A comprehensive six week local induction was in place for any staff new to the department with support from the clinical educator and senior staff.
- Nurse handovers were well organised and effective and the multidisciplinary team worked well together with daily performance of safety huddles and meetings. CCOR staff attended the team and medical handover.
- There had been the development of advanced critical care nursing posts in CCOR and across both sites and the roles were well established.
- There was a mixed and concerned response amongst staff we spoke with about management of team rotas and although clinical leads and senior nursing staff were knowledgeable about the challenges and shortfalls when they occurred, concerns existed around the frequency of critical care staff movement to cover staffing shortfalls in ward areas and the inability to achieve a supernumerary coordinators on shift. Staff addressed risks on a daily basis and proactively as part of an efficient approach to managing the unit. Clinical leads attended trust bed management meetings.

- Nursing staff we spoke with were positive and professional and morale appeared to be improving. All staff reported that they felt supported within the unit and enjoyed their work.

Medical staffing

- Care was led by a consultant in intensive care medicine and rotas had been developed across a five day block system to support competent medical cover and patient continuity. Consultant staff to patient ratios were in line with GPICS (2015).
- Monday to Friday cover at CIC included two consultants during the day time. A 'consultant of the week' system provided continuity for patient care and an on-call consultant is resident on duty from 0800 until 1800 and then on-call 1800 to 0800 the following morning. At weekends there is a single consultant covering the unit on each day, who is on-call for the 24 hours. Consultants also attend the unit in person for handover and ward round at the weekends.
- Resident cover is also provided by anaesthetic trainees (CT1 - ST7), ACCS trainees, MTI trainees, Staff grade or locum staff. Shifts run from 0800 - 2030 and nights from 2000 - 0830 Monday to Sunday. The doctors on this rota only have on-call commitment for ITU and are supported by a second on-call who is always competent in advanced airway skills. Trainees performing blocks of training in ITU will also work daytime shifts from 0800-1800.
- There were significant staff vacancies (10%) and sickness (6.8%) in anaesthetic cover across critical care and recruitment was discussed as challenging. Staff we spoke with recognised that there was an increased use of locum staff (35%) due to vacancy and sickness rates at the CIC unit and the cover out-of-hours at WCH was not always sufficient to provide a service to maternity services as well as critical care. These issues were included on the risk register and staff we spoke with told us that they were 'managing' to cover the service.
- There were consultant led unit ward rounds and patient review twice daily. These were attended by the Multidisciplinary Team (MDT) which was encouraged by the consultant team.
- The team had developed and established advanced critical care practitioner (ACCP) roles in response to some of the recruitment and cover challenges. The roles were embedded and working well across site providing cover for daytime sessions in addition to the trainees both during the week and at weekends across both sites.
- We spoke with all grades of doctors who gave us positive feedback about working and support in critical care from consultant and senior colleagues. We were told of examples of consultants being in overnight when "patients were very unstable". Junior doctors told us that there was good opportunity to participate in ward rounds and attend protected teaching programmes, were they are 'bleep free'. Staff reported that "consultants are active and very supportive on the ICU; they like teaching and are approachable." And "the morale of the staff is good and there is a strong culture of team support in the unit."

Major incident awareness and training

- Major incident and business continuity plans were in place and policy was clear and available to staff on the intranet and in paper copy.
- Staff had attended training to test the plans and escalation processes in critical care as part of the surgical and anaesthetic directorate.
- Staff we spoke with told us that there had been no test of the policy in practice.

Are critical care services effective?

Good

We rated effective as 'good' because:

- During this inspection and in our 2015 inspection we found patient care was planned and delivered by staff who were knowledgeable and aware of implementing current evidence based guidance and standards. There was a programme of clinical audit in place.
- There was consistent data collection and submission of ICNARC data, with a dedicated member of staff in post to support. Patient outcomes were comparable or better than national and local critical care unit performance for April 2016 to September 2016. Unit mortality had improved since our last inspection and was better in comparison to other units as reported to

ICNARC. The patient unplanned readmission rate within 48 hours of discharge from the unit was also monitored and compared with the national average for the same time period.

- The critical care service continued to be part of the North of England Critical Care Network (NoECCN), working with other stakeholders (acute trusts and clinical commissioning groups) to commit to sharing and promoting best practice.
- Commitment to education and training was good since 2015, with six week supernumerary induction for new nursing staff, and a sustained performance in ensuring 50% or more nursing staff had a post registration award in critical care or were working towards achievement at local universities. Across both sites 84% of nursing staff had achieved the course. Continued commitment to nurse appraisal was evident with 92% staff performance and a part time (0.8WTE) supernumerary practice educator was in post at CIC. Staff were knowledgeable and committed to critical care education.
- There was good evidence of transfers for adults and children being managed safely and effectively, with monitored activity, training priorities and assurances around competence and equipment management.
- We observed good multidisciplinary handovers, led by consultants with critical care team involvement in ward rounds and safety huddles.
- Patient's pain was well managed; we noted good evidence of delirium scoring in the EPR. Individual patient nutrition and hydration needs were met, and we observed a person centred approach to assessment and planning of individualised care.
- There was a good culture of discussion, documentation of decisions around Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards DoLS. The EPR had a prompt system for staff. Consultants were knowledgeable and engaged with the process. The matron for critical care had been the MCA/DoLs lead and had extended knowledge of best interest assessment, which supported the team education and practice in critical care.

However:

- The role of the supernumerary clinical educator was embedded and valued however, this role was provided in a 0.8 WTE post and the post holder had commitments to deliver nasogastric (NG) education across the trust, in response to trust-wide serious incidents. Although this training was valuable it meant that the clinical educator was only able to provide a part time service in the CIC unit and not across both units and did not meet GPICS (2015) standards for a unit of this size.
- The critical care pharmacist cover was well below GPICS (2015) standards as provided 0.2 WTE post to critical care. We spoke with staff in the unit who did not report any issues with management of medicines and pharmacy support, however pharmacists were not able to fulfil the critical care role, join ward rounds or deliver improvements and audit in practice with 0.2 WTE dedicated hours.

Evidence-based care and treatment

- We reviewed policies and guidelines in the unit, on the intranet and in paper copies and found all to have review dates. The unit used a combination of national guidelines and policy to determine the care and treatment they provided. These included guidance from National Institute for Health and Care Excellence (NICE), Intensive Care Society, the Faculty of Intensive Care Medicine and the NOECCN. There was a continued commitment to clinical audit and evaluation amongst all levels of staff.
- We found that ICNARC data showed that patient outcomes were comparable or better than expected when compared with other units nationally, this included unit mortality. ICNARC data had been collected and submitted consistently at CIC for around three years since the appointment of a dedicated member of the team. The data was available to the team and during inspection we were able to review consistent annual data; however we reported to the critical care team that it was not published on the ICNARC website for the Carlisle site. Staff we spoke with were not aware of this and could not explain why it was not published, or if it had any impact on the data to time of reporting.
- During this inspection we saw evidence of progress towards meeting the NICE CG83 pathway for rehabilitation after critical care which was supported fully and had a lead for rehabilitation. Collection of data to measure if assessment and rehabilitation prescriptions were documented within the first 24 hours of admission and pre-discharge showed good performance for patient admission. The matron and senior physiotherapist had taken the lead for achieving this standard.

- Patients at risk of VTE were risk assessed and prescribed prophylaxis in accordance with NICE QS3 quality statement and pathway. Staff we spoke with told us that audit and monitoring was carried out to ensure compliance targets were maintained in critical care and across the directorate.
- Recognised care bundles to reduce the risk of ventilator – acquired pneumonia (VAP), sepsis, falls and nutrition were embedded in practice and audit work was ongoing to monitor compliance. The unit had adopted a delirium scoring system since our 2015 inspection.

Pain relief

- We reviewed six care records and observed that pain was assessed and pain and delirium scores recorded in the unit. All patients we spoke with told us that staff paid attention to their pain and comfort needs.
- The trust had an acute pain management team and staff would access the specialist advice as required, with some post-operative patients receiving follow up routinely. We observed pain scores and patient assessments being discussed in the ward round by the MDT and conversations were led by the consultant. The EPR prompted assessment.
- We observed nursing staff explain the use of the patient controlled analgesia (PCA) machine in a way the patient could understand, explaining "don't worry about pressing the button too often".

Nutrition and hydration

- Patients admitted to critical care had a malnutrition universal screening tool (MUST) assessment. Patients who are malnourished, at risk of malnutrition or obese were identified using this tool. In all six EPR's scores were documented.
- A dietitian was allocated to support patients in the unit and had expertise in critical care. Patients were commenced on feeding regimes as soon as possible. We observed patients receiving total parenteral nutrition (TPN) and nasogastric (NG) feeding. Training was being embedded by the clinical educator and dieticians around safe insertion and care of NG tubes.
- We saw excellent fluid management and hourly documentation of fluid balance. There was good training provision for fluid balance management for staff in the unit.
- We observed nursing staff taking time to assist patients with oral nutrition and when they required support at mealtimes. Patients whose condition had improved were offered drinks by staff and assisted as needed. Nutritional intake was documented. There was good choice of suitable foods for patients.

Patient outcomes

- The unit could demonstrate continuous patient data contributions to the Intensive Care National Audit and Research Centre (ICNARC). Dedicated staff were in post to support ICNARC data collection and reporting.
- ICNARC supports critically ill patients by providing information and feedback data on specific quality indicators as part of its case mix programme (CMP). Critical care units can benchmark their practice and services against 90% of other units. This was in line with the recommendations of the Faculty of Intensive Care Medicine Core Standards (FICM).
- Low levels of harm around infections and sepsis was noted, with a comparable or better than national mortality rate, indicating a good approach to patient care.
- There was good evidence of transfers for adults and children being managed safely and effectively, with monitored activity, training priorities and assurances around competence and equipment management. Both adult and paediatric patients were transferred to tertiary centres for specialist care and treatment from CIC. There were five cases of adult patients being repatriated to WCH.
- Since our 2015 inspection risk adjusted hospital mortality ratio had improved and was comparable with national reporting at 1.0 across both units. Risk adjusted mortality ratio for patients with a predicted risk of death of less than 20% was 1.0 at CIC. Mortality was reported as a percentage of all discharges, deaths and transfers out of the unit. It was reported that mortality was comparable or lower than expected range within the ICNARC CMP.
- Unplanned patient readmission to ITU within 48 hours after discharge was better than other units in the reporting period April to September 2016 at 1.2%, and comparable to units in ICNARC 2015-2016 at 1.6%.
- We also noted that against regional units the 'post unit in hospital survivorship' was better than the network and national average.

Competent staff

- Staff we spoke with told us that they received trust induction and we noted that 100% had attended. Appraisals had been carried out for 100% of nursing staff at the time of inspection.
- GPICS (2015) outlines that critical care units should have a supernumerary educational coordinator. The post holder was 0.8 WTE working across both sites and delivering key objectives across the trust for training staff in care of NG tubes as a response to serious incidents and Never Events. It was not possible for the post holder to fulfil the requirements of the GPICS (2015) standard for the unit.
- New nursing staff to the unit were given a local induction and six weeks supernumerary period whilst they achieved critical care competencies essential for safe practice. Junior staff were supported by the clinical educator and by working alongside senior skilled nurse mentors in the unit.
- Fifty percent of staff should hold a post registration award in critical care nursing, in line with GPICS. At the time of reporting this standard had been exceeded for nursing staff on ITU across both sites (71 of 85 staff) had achieved this target. There was good access locally to the course and staff were supported to attend.
- There was also a commitment to the Critical Care Steps programme for staff with good levels of achievement.
- We observed examples of the nursing and medical staff teaching junior members of the team at the bedside and during handovers and ward rounds.
- Nurses we spoke with told us the trust had a supportive strategy in place for revalidation. We saw nursing staff sharing the processes for revalidation in the unit.

Multidisciplinary (MDT) working

- We observed good working relationships and commitment to critical care between members of the MDT. Members of the team attended ward rounds and safety huddles in the unit.
- Physiotherapy staff were supporting critical care patients in essential care, respiratory assessment, review and rehabilitation from critical care and provided treatment for patients requiring passive movements to prevent muscle contracture during periods of restricted mobility. GPICS (2015) supported a minimum rehabilitation standard of 45 minute sessions, admission and discharge prescriptions and staff were able to consistently deliver this during weekdays.
- We spoke with the dietitian and speech and language therapy (SaLT) staff during the inspection. The dietitian had a daily visit to the unit and took referrals on unit attendance or by telephone. They did not attend ward rounds. SaLT had a referral system and attended to patients as required.
- The units had dedicated administrative ICNARC support to ensure consistent data collection and reporting.
- The critical care pharmacist provision was well below GPICS (2015) standards. We spoke with staff in the unit who did not report any issues with management of medicines and pharmacy support, however pharmacists were not able to fulfil the critical care role, join ward rounds or deliver improvements in practice with only 0.2 WTE dedicated hours.

Seven-day services

- Consultant anaesthetists were available 24/7 through an on call system to support the junior team. Daily consultant ward rounds were embedded with documented daily reviews. The critical care unit provided services 24/7.
- Seven day working had been extended with the addition of advanced critical care nurse practitioners (ACCP's) working at middle tier grade and consultant working across the service.
- There was an on call physiotherapy and pharmacy service out-of-hours and at weekends.
- Admissions to critical care of emergency and unplanned patients can be at any time of day or night, in the case of critical emergencies consultants directed diagnostic tests and reporting of results.

Access to information

- Information could be accessed in electronic and paper systems. We did not see any problems with the transfer of information from the critical care EPR to paper handover.
- Staff involved in the critically ill patients care pathway at every stage could access the information that they needed in a timely manner. We saw good evidence of access to transfer and discharge summaries in paper and electronic versions
- We observed safe transfer and handover processes and had assurances for staff we spoke with that practice was consistent.

Critical care

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

- We spoke with consultants in critical care and staff told us they would seek independent mental capacity advocate (IMCA) advice when required. There was a good culture of discussion, documentation of decisions and challenge from medical and nursing staff around MCA and DoLS. Consultants were engaged with the process and policy. The matron for critical care had been the MCA and DoLs lead and had extended knowledge of best interest assessment, which supported the team education and practice in critical care.
- Staff had attended training with an 80% attendance rate against the trust target. Junior staff could explain experiences of application in practice in the critical care environment. Senior staff were more knowledgeable, however all staff we spoke with knew how to seek advice and could access guidance in paper and intranet resources.
- We observed good assessment of consciousness, delirium and confusion with use of Glasgow Coma Scale (GCS) and the Confusion Assessment Method, CAM-ICU, all recorded on the daily observation chart and care plan. These validated measures supported assessment of patient confusion, delirium and subsequent level of mental capacity in the unit.

Are critical care services caring?

Good

We rated caring as 'good' because:

- As in our previous inspections we observed care, evaluated data and had conversations with families, patients and staff and judged the critical care unit at the CIC to be delivered by caring and compassionate staff. We observed a visible person centred culture. Staff were positive and motivated and delivered care that was kind and promoted peoples dignity.
- Nursing staff managed support groups and held them in the local community as part of the ITU national support programme. Ten patients had attended the first group.
- The bereavement support in the unit was very good. The team ran a memorial service which had been well attended by people in the community whose relatives had received care and treatment in the critical care unit. Memory boxes were provided to patients relatives and this work was a sustained approach since our previous inspection.
- The model for rehabilitation after critical illness was making good progress and support for patients was evident after discharge from critical care.
- We observed the use of a 'Sound Ear' technology in the unit which flashed red to indicate to staff the noise levels. This had been audited as being effective in reducing noise for patients, especially at night.
- There was continued commitment to organ donation and a dedicated specialist nurse for organ donation (SNOD) was appointed to manage the sensitive issues relating to approaching families to discuss the possibility of organ donation.
- We saw sustained and good use of individual patient diaries to support care planning, rehabilitation and recovery in critical care.
- Survey responses from service users were consistently positive in the Family and Friends Test (FFT) and two minutes of your time responses. During previous inspections we found that the unit were not gathering patient experience information consistently and the team have worked to achieve significant improvement. They had introduced a 'talk to us' email box through social media.

Compassionate care

- We observed staff to be caring and compassionate with patients and their relatives without exception during the inspection. We observed episodes of care that promoted patient dignity and respect.
- We observed letters and cards of thanks from patients and relatives on display and filed in the staff room. Senior staff shared positive messages from patients in team meetings, on noticeboards in staff and public areas and during one to one opportunities with staff.
- The NHS Family and Friends Test (FFT) data was collected in critical care and there was a commitment to continuous improvement to response rates with 75% - 100% responses (for around 6- 7 patients). Display was

consistent with the trust approach in a format that is easy to understand by staff and visitors. We saw positive results and comments, with 100% of patients highly recommending the unit to family and friends.

- The following quotes represented the themes in many of the comments and compliments we observed; "we do feel that everything has been explained to us very well and in a gentle way. It can't be nice for the staff at times having to deal with stressed relatives but the kindness and compassion shines through." "I was told that I would be wakening up in HDU and I thought that I would be frightened but it is an amazing place, dedicated staff and I would say that I really enjoyed the one to one care, it felt reassuring." In response to work that had been ongoing to reduce noise in the unit and the use of the 'sound ear' a patient responded with, **"**The only noise I hear at night is staff working and machines. This is a lovely ward and nothing is too much trouble."

Understanding and involvement of patients and those close to them

- We observed staff communicate with patients and their families and friends in approaches that supported their understanding of care and treatment in critical care. We observed good examples of documented discussions in the EPR between medical staff and patients and families in care records. The EPR prompted medical staff to discuss care and treatment with patients daily.
- We saw evidence of consistent use of patient diaries in critical care. This supported the patient in better understanding of their experience, which supported recovery and rehabilitation.
- Staff we spoke with told us that they could access specialist advice for a range of support services in the trust or externally. This included specialist nurses and teams for organ donation and language interpretation services at the trust.

Emotional support

- The spiritual needs of patient's takes priority in critical care and the trust had good access and provision of spiritual, religious and pastoral support. We saw evidence of information about services in the visitors' room. We observed individual needs of patients recorded as part of assessments and reviews in the EPR.
- The bereavement support in the unit was very good. The team ran a Memorial Service which had been attended by over 80 people in the community whose relative had received care and treatment in the critical care unit. Memory boxes were provided to patients relatives and this work was a sustained approach since our previous inspection
- Additional psychological support was assessed on an individual basis. In-patient and General Practitioner (G.P) referrals to a psychologist would be made by Consultants staff. There was work ongoing to introduce follow up clinics, this had not been implemented at the time of inspection, but plans were positive.
- The unit operated a flexible approach to visiting times for family and friends to promote the emotional support of patients. We observed nursing, medical, and support workers, and members of the MDT talking to relatives and patients and it was evident that they had established positive, supportive relationships.

Are critical care services responsive?

Good

We rated responsive as 'good' because:

- The unit had sustained its performance since the previous inspection in 2015, supporting patients discharge within four hours of the decision being made by a consultant. There were minimal occasions were the patient discharge was delayed and this was managed closely by the senior team against a CQUIN target for delays of greater than 24 hours. We also noted zero mixed sex breaches in 2015/16 in line with Department of Health guidance (November 2010) When we reviewed ICNARC data we found that the unit was much better (1.1%) than other national units (5.0%) for eight hour discharge targets. Length of stay in the unit was 1.6 days which was also better than national averages of 2.2 days.
- Discharges out-of-hours, between 22.00hrs and 06.59hrs have been proven to have a negative effect on patient outcome and recovery. Critical care discharges out-of-hours were reported as 0.8% in April to September 2015/16, against a national average of 2.0% as reported by ICNARC for 2015/16.
- There was also a commitment to providing patients rehabilitation needs after critical illness and this was being led by the matron and senior physiotherapist.

Patients were assessed within 24 hours of admission to the unit. There was a plan to introduce and develop MDT follow up clinics, in line with GPICS (2015) and at the time of inspection they were not in place at the CIC. Staff we spoke with recognised that this would give the opportunity for patients to gain further explanation of events, access screening for critical care complications, including psychological, physiotherapy or pharmacological support as required.

- There were zero formal complaints in critical care at CIC and when people did complain at a unit level staff knew how to respond. The policy and processes for managing complaints was good and understood by all staff we spoke with.
- Patients received timely access to critical care treatment, when decision to admit had been made. Patients were not transferred out of the unit for the non-clinical reasons and readmission rates were low (1.2%) against similar units (1.6%).
- Bed occupancy in critical care fluctuated from 40% to 80% in CIC (60% overall) with the total number of admissions being stable with no increase in activity since 2014. There had been 332 admissions in the CIC unit in the six month period from April to September 2016, which indicated no significant increase as had been predicted by the team and reported in 2015. The team reported there was the need to refurbish and extend critical care services at the CIC and this was included in proposals for future service planning, the detail of decisions around capacity planning was not available at the time of inspection.
- We have previously reported concerns with the admission of critical care patients (also known as outliers) to theatre recovery in critical care units. We spoke with theatre and critical care staff and reviewed the data and found minimal 'rare' occasions when critical care patients were reported as outliers. This was corroborated when speaking with the CCOR team.
- The number of surgical cancellations continued to be monitored across the surgical and anaesthetic directorate and although the numbers were reported in line with national average it was noted that cancellations were inconsistent with peaks and troughs in performance.

Service planning and delivery to meet the needs of local people

- Critical care service planning and delivery was managed as part of the Surgical and Anaesthetic Directorate in the trust. There was evidence of consistent and collaborative working during our inspection and in the review of minutes of senior meetings. Senior staff were committed to the cross site working model and recognised the challenges of delivering critical care services across two units separated geographically in rural and separate sites.
- We reviewed local proposals and spoke with senior staff about the longer term strategy for provision of critical care across the trust. The service was still under review by the trust since our last inspection and future proposals for strategy and vision for the service was documented in reports we reviewed in an open and transparent approach, although decisions were pending.
- Structured bed management meetings took place throughout the day with representation from all specialities.
- There was involvement in the critical care network and good practice and learning was shared across the region.
- There was evidence of support groups in the local community which were well attended by patients and relatives who had experienced critical care illness and admission to the unit.

Meeting people's individual needs

- The critical care team were skilled in managing patients with complex needs and we saw evidence of individual care planning and treatment. We saw good examples of individual care and management of patients requiring one to one support.
- We observed staff to be supportive of families who needed an overnight stay and a kitchen facility was available in the visitors' room.
- A range of information leaflets and specific guides were on display in the unit for visitors. The team were able to meet the cultural needs of patients in terms of religious beliefs and specialist support or dietary requirements. There was an easy to access number displayed for staff to arrange bariatric equipment for patients.
- We observed excellent leaflet information to support paediatric patients and their relatives. In view of the low number of admissions to the unit (17 in 2015/16) it was very positive to see how the needs of children had been prioritised.

- The information available to patients about physical and psychological aspects after critical illness was specific to the needs of patients and relatives in the unit.
- Specialist rehabilitation chairs had been purchased to enhance patient recovery in critical care.
- The trust had a good system for access to translation services through switchboard as either an on-call or pre-booked service.

Access and flow

- The unit had written operational policy for admission and discharge.
- GPICS (2015) states admission to critical care should be timely and within four hours from the decision to admit for emergency patients, to improve their outcomes. The decision to admit was made by the critical care consultant together with the consultant caring for the patient. Reviews were performed within 12 hours of admission in line with GPCS (2015)
- Information provided to ICNARC presented a picture of bed occupancy at CIC was lower than the national average and fluctuated between 40% and 80%. Length of stay in the unit was 1.6 days which was also better than national averages of 2.2 days.
- The unit had sustained its performance since the previous inspection in 2015, supporting patients discharge within four hours of the decision being made by a consultant. There were minimal occasions were the patient discharge was delayed and this was managed closely by the senior nursing team. We also noted zero mixed sex breaches in 2015/16 in line with Department of Health guidance (November 2010). As expected when we reviewed ICNARC data we found that the unit was much better (1.1%) than other national units (5.0%) for eight hour discharge targets.
- Discharges out-of-hours, between 22.00hrs and 06.59hrs have been proven to have a negative effect on patient outcome and recovery. Critical care discharges out-of-hours were reported as 0.8% in 2015/16, against a national average of 2.0% as reported by ICNARC for 2015/16.
- There were four transfers to other units for non-clinical reasons recorded by the team in 2015/16.
- We have reported concerns with the admission of critical care patients (also known as outliers) to theatre recovery in critical care units. We spoke with theatre and critical care staff and reviewed the data and found minimal 'rare' occasions when critical care patients were reported as outliers. This was corroborated when speaking with the CCOR team.
- The proportion of elective surgical critical care bed bookings cancelled due to lack of availability of a post-operative critical care bed were low, with close monitoring at a directorate level.

Learning from complaints and concerns

- We reviewed zero number of complaints in critical care at CIC with one reported at WCH, across the trust for 2015/16. We spoke with senior managers who told us that concerns were resolved promptly at trust level with issues having included aspects of clinical treatment and provision of timely information.
- The trust had a Patient Advice and Liaison Service (PALS) and we observed patient information leaflets in the relative room areas, including poster display.
- The surgical and anaesthetic directorate had good processes for the management of complaints. Staff we spoke with were aware of the complaints policy and process and complaints were discussed in unit meetings

Are critical care services well-led?

Good

We rated well-led as 'good' because:

- Staff we spoke with at all levels had a good understanding of the governance framework in critical care. The management structure had changed since the inspection in 2015 and critical care sat in the surgical and anaesthetic directorate. Staff spoke positively about this change and felt that support was improved. We noted good leadership in the unit. The clinical leads represented the unit at an executive level and communicated vision and strategy across the team.
- Staff felt valued by the clinical leads in critical care, specifically the clinical sisters, matron, senior matron and Consultant leads. It was evident from conversations we had with staff that patient centred; quality of care was the priority.
- During inspection of critical care we found a positive, open culture with knowledgeable staff at all levels. Staff

were encouraged by the leads in critical care to share concerns or comments they had about patient care, colleagues or the service. We did not hear of any complaints or conflict amongst staff in the critical care unit. The team communicated very well with one another and with partners across the network.

- The team in critical care services spoke highly of their local leadership and felt supported by matrons, consultants and senior matrons. A culture of listening, learning and improvement was evident amongst all staff we spoke with. Staff we spoke with across the team were positive about their role. Trust governance arrangements were clear to the staff we spoke with, despite staff reporting frequent changes in the senior team over the past five years. Staff expressed that they wanted a period of stability in the senior and executive team.
- There was strategy and vision for the trust that had been updated and cascaded to staff. The team had been given opportunity to attend listening sessions with the chief executive and had found them to be positive. Proposals for longer term vision or expansion of the unit at CIC had been made but decisions had not been made since our last inspection around the future planning of services.

However:

- Morale was low amongst nursing staff with the impact of being moved frequently. Staff we spoke with recognised the need to cover ward areas that had staffing shortfalls, and across the trust the nurse recruitment and staffing issues could mean that this was a daily occurrence. Staff wanted to provide safe care for patients in the unit and ward areas but felt compromised and spoke of how the differences in working in critical care and working in ward areas were overlooked.
- Staff reported concerns about past behaviours of senior staff across the trust when staffing moves were being managed and expressed that they had felt unsupported by some members of the senior team. This issue had been reported in 2015 but it was clear that recent changes to senior team management structure had improved the support in the unit and it was reported that the executive team had a better understanding of the nature of critical care and acuity of patients.

Vision and strategy for this service

- All senior staff we spoke with in critical care were knowledgeable about the trust vision, values and strategy and junior staff told us that patient safety and quality of care was a priority. They had a good understanding of the challenges facing staff across the units.
- Critical care priorities were given proportionate and appropriate attention as part of the surgical and anaesthetic directorate. There had not been an update to the critical care capacity review in 2014 that we noted during our last inspection as being a key driver for planning and coordinating services across the trust.
- The advanced nurse practitioner roles were embedded across both sites and working well since inspection in 2015.
-

Governance, risk management and quality measurement

- Governance arrangements were clear. Critical care was represented at board and trust level and information was shared across the service. We reviewed minutes of staff meetings and reviewed performance and dashboard reports that presented that staff monitored and reviewed quality, incidents and risk across critical care.
- Although trust governance arrangements were clear to the staff we spoke with, they also reported that frequent changes in the senior team over the past five years had a negative effect on the team. Staff expressed that they wanted a period of stability in the senior and executive team.
- Guidelines and policy were consistent across both sites and units.
- Dedicated data administrators produced a detailed critical care ICNARC submission, by working closely with the consultants and clinical team. There was consistent submission of information to the ICNARC CMP.
- The risk register for critical care was detailed with progress and ownership being documented as part of the surgical and anaesthetic directorates overall risk register. We saw reviews and action plans associated to specific critical care risk and felt that the items on the register reflected what we observed and discussed with staff during inspection as their concerns.
- Matrons and senior staff shared information in a variety of ways to reinforce the quality agenda with good effect. Staff discussed key issues in daily safety huddles.

Critical care

Leadership of service

- The senior team structure in critical care was established and understood by staff we spoke with on both sites. Changes at an executive level and as part of a restructure were seen as positive by the staff we spoke with, however the need for stability was requested by all staff we spoke with. There was a commitment by senior staff to be visible on both units. There was good leadership support and clear line management, with an emphasis on 'cross site working' and support.
- There was a designated consultant clinical lead, experienced senior matron and matron across site.
- We interviewed the senior individuals responsible for critical care units at both sites and they consistently reported that they felt supported by the executive team. There was a clinical director in intensive care, and experienced senior nurses. The clinical educator also provided additional leadership support in the unit.
- Staff felt valued by the clinical leads in critical care, specifically the clinical sisters, matron, senior matron and consultant leads. It was evident from conversations we had with staff that patient centred; quality of care was the priority. Staff we spoke with told us that a culture of listening, learning and improvement was developing across the trust. Staff we spoke with across the critical care team were positive about local leadership.
- The unit could not provide the consistent support of a supernumerary clinical coordinator due to staffing pressures across the trust and critical care staffing movement to support staffing shortfalls in wards.

Culture within the service

- During inspection of critical care we found a positive, open culture with knowledgeable staff at all levels. Staff were encouraged by the leads in critical care to share concerns or comments they had about patient care, colleagues or the service. We did not hear of any complaints or conflict amongst staff in the critical care unit. The team communicated very well with one another and with partners across the network.
- Morale was generally good amongst the staff we spoke with, who we found to be very positive and professional. Staff we spoke with told us that it was difficult sometimes to work in a trust in special measures and that they had to defend that position with patients and relatives on occasion. Staff expressed concern around 'bad press' in the media and the impact on patients using the service.
- Morale was low amongst nursing staff with the impact of being moved frequently to cover ward areas that had staffing shortfalls. Staff we spoke with told us that experienced staff had left as a consequence. Across the trust the nurse recruitment and staffing issues would mean that this could be a daily occurrence. Staff wanted to provide safe care for patients in the unit and ward areas but felt compromised and spoke of how the differences in working in critical care and working in ward areas had been overlooked by some senior trust management staff.
- Doctors reported that "consultants are active and very supportive on the ICU; they like teaching and are approachable." And "the morale of the staff is good and there is a strong culture of team support in the unit."
- Without exception, staff we spoke with spoke positively about the culture in the unit, the support and training given by senior staff. It was considered a good place to work in the trust amongst junior and senior staff and in contrast to many ward areas experienced by junior staff.
- There was an open and transparent culture. Staff were encouraged to share concerns or comments they had about patient care, colleagues, or the service. We did not hear of any complaints or conflict amongst staff in critical care.
- Collaboration was good within the surgical and anaesthetic directorate, the wider trust team and across the region in the critical care network.

Public engagement

- We observed how experiences of patients influenced staff to improve care and develop new services, for example development of the local organ donation team. We observed the proposals for development of follow up clinics and the ongoing commitment to supporting rehabilitation of people in the community who had experienced critical care. Staff were engaged with seeking patient feedback and acting on results. The unit was engaged with the wider critical care network.
- We observed good examples of critical care staff engaging with the public to share lessons around care, treatment and prevention. The CCOR team had spent time talking to visitors in the atrium of the hospital about key messages around sepsis.

Critical care

Staff engagement

- Critical care senior staff recognised that ongoing work was required to continue improvement in employee engagement. The results from the NHS staff survey 2015 showed that improvements had been made overall, but responses (3.60) were less than the national average (3.79). Further independent staff survey responses showed an improvement in key issues around prioritising the care of patients, incident reporting and acting on concerns. These responses aligned to the positive discussions we had with staff during inspection.
- Senior staff communicated key information through the trust internet, team briefings, encouraging daily safety huddles and on one to one or meetings as required. There was a good structure for team meetings with regular agenda items and detailed minutes with staff responsibility made clear against actions.
- There was investment in training and education of staff in critical care. We spoke with members of the team who felt valued and had opportunity to develop professionally.
- The team had been given opportunity to attend listening sessions with the chief executive and had found them to be positive.

Innovation, improvement and sustainability

- Critical care had introduced patient diaries to allow patients to process the impact of critical illness, improve memory recall and support staff to respond more holistically to patient's needs. Staff had also developed support groups for patients in the community who had experienced critical care admission.
- Specialist rehabilitation chairs had been purchased to enhance patient recovery in critical care.
- The unit was an active member of the North of England Critical Care Network. Membership of the network enabled the unit to work collaboratively with commissioners, providers and users of critical care to focus on making improvements.
- The arrangements for the small numbers (17 in 2015/16) paediatric admission for stabilisation for hours prior to transfer were also very good, to include levels of staff training and competence and storage and checking of essential equipment. The unit were part of the 'North East Children's Transport and Retrieval' (NECTAR) new transport service.
- The development of the electronic patient record in the unit had been embedded and was working well. EPR was not yet established across the trust and the system we reviewed in the unit was easy to use and understand and had been tested across other units in the United Kingdom. The team had driven this improvement at a local level with trust support.

Maternity and gynaecology

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

Information about the service

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

There were 10 maternity beds. The gynaecology ward had 16 inpatient beds (shared with surgery).

Between April 2015 and March 2016, there were 1,759 births at CIC. Across the trust, the percentage of births to mothers aged 20-34 and percentage of births to mothers aged 20 and under was slightly higher than the England average.

During our inspection, we visited the antenatal clinic, antenatal and postnatal ward, labour ward and gynaecology ward. We spoke with six women and their partners and 31 staff, which included: midwives ward sisters, matrons, doctors, consultants, senior managers and support staff. We observed care and treatment and looked at 17 care records. We also reviewed the trust's performance data.

Summary of findings

During the last inspection in April 2015 the service was rated as requires improvement for being safe, effective and well-led. This was because of a lack of dedicated medical staff cover, no epidural service, mandatory training levels not being met, ineffective medicines management, insufficient governance and audit processes, staff not following guidelines and lack of cohesive working across hospital sites.

At this inspection although some improvements had been made the service remained as requires improvement for being safe and well-led because:

- Some of the risks identified were still in place and sufficient actions to mitigate the risks had not yet been implemented, particularly the lack of senior paediatric medical cover out-of-hours to manage advanced neonatal resuscitation. Although there was no evidence of adverse outcomes this still presented a risk to patients.
- There remained no clear vision or formal strategy for the future of maternity services due to the review of the Cumbria wide provision and managers were awaiting the outcome of the consultation.
- Although there was some improvement in cross site working the cohesiveness of the two hospital sites for maternity services was not fully embedded.
- There was some improvement in strengthening of governance processes but there were no indicators to ensure performance and understanding of risk or

Maternity and gynaecology

governance roles. There continued to be gaps in how outcomes and actions from audit of clinical practice were used to monitor quality and systems to identify where action should be taken.
- The checking of equipment and medicines was not consistent across all areas. The quality of record-keeping was variable particularly ante-natal information.

However:

- Staff understood their responsibilities to raise concerns, to record safety incidents and near misses.
- Medical and midwifery staffing levels were similar to the national recommendations for the number of babies delivered on the unit each year.
- Care outcomes were meeting expectations in most areas, and where improvements were required the service had identified action.
- Women were positive about their treatment by clinical staff and the standard of care they had received. They were treated with dignity and respect.
- Services were planned, delivered and co-ordinated to take account of women with complex needs, there was access to specialist support and expertise. An epidural service was available.
- Midwifery and medical staff worked together ensuring women received care which met their needs.

Are maternity and gynaecology services safe?

Requires improvement

We rated safe as 'requires improvement' because:

- There remained concerns about the lack of senior paediatric provision for advanced neonatal resuscitation out-of-hours; the current situation was that the lead midwife on shift on delivery suite was the first line for basic neonatal resuscitation. There were no midwives trained in advanced life support. There was discussion that additional funding was being sourced to train midwives in advanced neonatal resuscitation however this was not yet implemented.
- There was no supernumerary delivery suite co-ordinator within the staffing establishment; this was not in line with national guidelines.
- Although staff awareness of which incidents to report had improved further work was required to ensure that staff received sufficient information about themes and trends. Perinatal mortality and morbidity meetings were not held jointly across hospital sites which meant that sharing of lessons and feedback was only carried out locally.
- Safeguarding champions were in place but due to the high demands of the service safeguarding supervision was not well established and fell short of national recommendations.
- Medical midwifery and nursing staff in maternity services were not meeting trust targets for mandatory training or training in safeguarding adults and children; this was particularly low for some medical staff.
- Checks on equipment and medicines were not being carried out consistently. The quality of record-keeping was variable particularly ante-natal information. Patient information was visible on a whiteboard in the gynaecology ward which meant that patient confidentiality was not being maintained.

However:

- Staff awareness of what incidents to report had improved. There were systems to share learning from incidents across maternity and gynaecology services.

- Medical and midwifery staffing levels were similar to the national recommendations for the number of babies delivered on the unit each year.
- Clinical risks to patients were identified and actions to reduce them were put in place. The maternity and gynaecology units were clean and staff adhered to infection control policies.

Incidents

- Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Between October 2015 and September 2016, the trust reported one incident, which was classified as a Never Event for Maternity and Gynaecology. The Never Event occurred in theatre at CIC but was not directly related to maternity services. The incident was under the category Surgical / invasive procedure incident meeting SI criteria. To reduce risk the maternity service had a standard operating procedure (SOP) in relation to swab and instrument counts. Accountability for this was reflected in maternity documentation including mandatory fields in the electronic reporting system.
- In accordance with the Serious Incident Framework 2015, the trust reported 12 serious incidents (SIs) in Maternity and Gynaecology, which met the reporting criteria, set by NHS England between October 2015 and September 2016. Of these, the most common type of incident reported was maternity / obstetrics incident meeting SI criteria: mother only. Nine of the 12 incidents were reported for CIC.
- There were 790 incidents reported for maternity and gynaecology across all hospital sites between October 2015 and September 2016. The majority of incidents were reported as low or no harm, 51 (6.5%) were moderate, three severe (0.4%) and one death (0.1%).
- The main category of incident was treatment /procedure (41.5%), infrastructure including staffing (23.3%) and access, admission, transfer discharge (13.5%).
- Staff completed incident reports using an electronic system. The initial incident review was by the risk team to agree severity of harm. The risk midwife said this could take up to a week to complete. The trust risk team notified the maternity team of any serious harm incidents. Risk midwives and clinicians did not review incidents they had been involved in, which ensured independence during the investigation. The consultant labour ward lead undertook incident reviews.
- The risk midwives produced a monthly incident report, which was presented at the maternity directorate meetings. The quality of the report needed improvement to include more information about themes and trends.
- There were monthly perinatal mortality and morbidity meetings. All serious cases, including stillbirths and neonatal deaths, were reviewed by a multi-disciplinary peer group which included obstetricians, paediatricians, junior doctors and medical students. There was limited attendance by midwives. The meetings were not held jointly across hospital sites.
- We looked at four root cause analysis investigation reports following incidents, which showed that duty of candour regulations, were followed. There was evidence to show women and families were involved in the investigation process, and informed of the outcomes. Staff were able to describe duty of candour.

Safety thermometer

- The maternity services used the national maternity safety thermometer. This allowed the maternity team to check on harm and record the care.
- Some of the data for the maternity safety thermometer was incomplete so the data could not be interpreted accurately however the median average for the last 18 months showed 87% of women did not express concern over their perception of safety and 73% of women or babies did not experience any of the combined harms at this trust.
- The maternity dashboard and external measures showed that outcomes for obstetrics and gynaecology were either similar to or were meeting national and local targets.

Cleanliness, infection control and hygiene

- There were no cases of hospital-acquired Methicillin-Resistant Staphylococcus Aureus (MRSA) or Clostridium difficile (C. difficile) in 2016/17.
- Observations during the inspection confirmed that all staff wore appropriate, personal protective equipment when required, and they adhered to 'bare below the elbow' guidance in line with national good hygiene practice. All clinical areas were clean.

- Hand hygiene audits showed 100% compliance for the maternity ward and 100% with exception of May 92% for labour ward.
- Training records showed that 58% of medical and 79% of nursing and midwifery staff in maternity and gynaecology had completed Infection Prevention and Control training against a trust target of 95% completion by the end of March 2017.
- The CQC Survey of Women's Experience of Maternity Services (2015) showed that the service scored 'about the same' as other trusts for cleanliness, infection control and hygiene.

Environment and equipment

- There was adequate equipment on the wards to ensure safe care, specifically cardiotocograph (CTG) and resuscitation equipment. Staff confirmed they had sufficient equipment to meet women's needs.
- Checks on resuscitation equipment should be carried out daily. Records we looked at showed there were no checks recorded for the neonatal resuscitation trolley on 11 occasions between 15 and 26 November 2016. There were also six gaps in records for checking the neonatal resuscitaire. Daily checks on the obstetric emergency trolley, suturing trolley and adult resuscitation trolley were completed.
- There was a laryngeal handle in a sterile pack which had expired in September 2016; this was stored in a draw ready for use.
- There were four large delivery rooms with en-suite facilities and four smaller delivery rooms with a shared bathroom plus one birthing pool/midwifery led care room.
- The service had made appropriate adjustments to ensure women with a disability had access to suitable facilities. Specialist equipment for women with a high body mass index (BMI) was available when required.
- All community midwives had emergency equipment bags. These were standardised across areas with checklists so that staff could access the correct equipment for home births.
- The neonatal unit was close to the delivery suite. Staff said that paediatric staff could attend emergencies quickly.
- There was a birthing pool. There was appropriate evacuation equipment, which was tested. All equipment was serviced and maintained to the relevant safety standards.

Medicines

- Neonatal drugs stored in the resuscitation trolley did not contain a record of the drug expiry date on the checklist. Staff said they would review expiry dates when checking the trolley.
- There was no expiry date on a pack containing Oxytocin which should be replaced every three months if not refrigerated therefore it was not clear when the medicines should be used by. Not all medicines were stored in a tamper proof container.
- We found out of date baby milk which was removed during the inspection and a notice sent to staff to check stock dates.
- Fridge temperatures were checked weekly not daily but were in range**.**
- The controlled drug register showed that stock levels were recorded correctly and daily checks completed.

Records

- The service used the standardised maternity notes developed by the Perinatal Institute. We reviewed seven birth /post-natal records, which were completed to a good standard. Each record contained a pathway of care that described what women should expect at each stage of labour. There was evidence of senior review. Staff signatures were legible and staff designation recorded in most cases. However, we reviewed 10 sets of antenatal records and these were of variable quality. Four had been fully completed. Other records were lacking in detail, for example, allergies, age, body mass index, flu, growth or parity were not recorded. An audit of record-keeping (November 2016) showed 77% of ante-natal summaries were completed. The target for minimum overall % compliance for was 75%. However, where compliance fell below 100%, actions had been included in the action plan to ensure increased compliance at the next audit.
- On the gynaecology ward patient details on the whiteboard were visible to the public. This did not ensure patient confidentiality.
- We looked at three CTG recordings which were annotated with patient name, DOB and hospital numbers, all were dated and timed, stored in separate brown paper wallet. The service had introduced the use of hourly systematic CTG review using a sticker. We found stickers were available in the notes but were not being consistently used. Staff informed us that the new

guideline was only introduced in December 2016 and was not yet fully embedded. At CIC a record-keeping audit showed 85% compliance for foetal monitoring documentation.
- Trust data showed 75% of medical staff and 60% of midwifery and nursing staff in maternity and gynaecology had completed information governance training against a trust target of 95% completion rate by the end of March 2017.

Safeguarding

- There was a named midwife for professional safeguarding issues who worked two days a week and was due to retire. A full-time post was being recommended at a Grade 8(as recommended by the Inter Collegiate Document 2014). Maternity safeguarding was managed clinically by the Associate Head of Midwifery.
- Safeguarding champions were in place but due to the high demands of the service safeguarding supervision was not well established and fell short of national recommendations. The named Midwife did provide group supervision when there were specific cases to discuss. Twelve episodes of supervision were held between April 2015 and March 2016
- There was good liaison with other specialist midwives such as teenage pregnancy, mental health and substance misuse.
- The lead midwife for safeguarding was the lead for female genital mutilation (FGM). There was FGM guidance for staff. Staff had received training on child sexual exploitation.
- Midwifery manager and safeguarding lead meetings were held monthly. Any risks were reported as an incident and discussed at weekly ward meetings on both sites alternating on all three maternity sites and at governance monthly meetings.
- All teenage pregnancies were risk assessed for safeguarding issues at booking and early help assessment was started. The teenage pregnancy pathway was embedded in midwifery practice.
- Staff had access to an independent domestic and sexual violence advisor. There was a lead midwife for domestic abuse.
- The trust set a target of 95% for completion of safeguarding training by the end of March 2017. The trust had not yet achieved its target for any safeguarding training course. Training figures for medical staff showed 58% had received training at level 1 for safeguarding vulnerable adults 50% had completed training for safeguarding children level 2; and 60% level 3. For midwifery and nursing staff 66% level 1; 85% level 2 and 75% level 3. The plan was to offer training every month to all staff and to achieve 95% target within 18 months.
- Infant security was in place using a baby tagging system and CCTV including secure access to the ward**.** Staff we spoke with said they had received an abduction practice drill.
- Women were asked about abuse at booking and when they were alone. Midwives tried to see women alone at least three times in their pregnancy.

Mandatory training

- Mandatory training was provided using e-learning or study days and included health and safety, infection control, equality and diversity, information governance, first safety and basic life support. The trust's target compliance rate was 95%.
- Trust data for 31 August 2016 for maternity and gynaecology services showed that no targets had been met by medical staff, equality and diversity training was 92%. All other training compliance was between 42-75%. For the same period for nursing and health care assistants, training compliance was at 55-79% with the exception of equality and diversity training which was 100%. There were plans to ensure that staff achieved the trust target of 95% by the end of March 2017.

Assessing and responding to patient risk

- The service used an early warning assessment tool known as the 'Maternity Early Obstetric Warning System' (MEOWS) to assess the health and wellbeing of women who were identified as being at risk. This assessment tool enabled staff to identify and respond with additional medical support. We looked at seven records, which showed observations were recorded on admission to the unit and an early warning score was calculated in line with trust guidelines, recording of observations were increased when MEOWS increased.
- A MEOWS audit of 123 entries showed 100% were completed correctly between January and September 2016.
- There was a lack of senior paediatric provision for advanced neonatal resuscitation out-of-hours due to a lack of paediatric middle grade and resident paediatric consultant cover. Current gaps were weekdays 7pm - 9

am and weekends 12 noon – 9am. The lead midwife on shift on delivery suite was the first line for neonatal resuscitation (NLS trained) There were no midwives trained in advanced NLS. Paediatricians stayed outside of their contracted hours if a difficult delivery was predicted. This risk was identified on the maternity risk register. Some incidents were reported with no adverse outcomes (this included occasions when paediatrics had been asked to attend an anticipated problem and then asked to stand down as not required). This was not in line with Safer Childbirth (2007) paragraph 4.4 (Paediatric staffing levels).

- Staff undertook training that enabled them to identify and act in the instance of a critically ill woman. Trust data showed attendance figures at PROMPT (Practical Obstetric Multi-Professional Training) for maternity staff; August 2016 was 76% midwives on delivery suite, 100% antenatal staff, 85% community midwives and 75% medical staff had completed this training against a trust target of 80%.
- The 'five steps to safer surgery' procedures (World Health Organisation safety checklist (WHO)) were completed consistently. A retrospective audit of the checklist between June and December 2016 showed 100% compliance with the exception of surgeon 'sign in' which was 95%.
- There were clear processes in the event of maternal transfer by ambulance, transfer from homebirth to hospital and transfers postnatally to another unit.
- There were guidelines for the risk assessment of venous thromboembolism and staff were aware of their responsibilities to assess and reduce this risk.
- The unit used the 'fresh eyes' approach, a system which required two members of staff to review foetal heart tracings (CTG). There were no serious incidents in 2015 concerning CTG misinterpretation and no clinical incidents reported in 2016. The trust has had an ongoing contract with K2, an e-learning programme for all midwives and doctor on CTG interpretation to complete each year. In October 2016, 107 midwives (63%) and 21 (70%) of doctors have completed K2 training in the last 12 months. K2 data was reported twice a year with the next formal report due in January 2017, the service was confident that remaining staff will have completed the required learning.
- Risk assessments were completed for higher risk women wishing to have a home birth. This involved a Supervisor of Midwives and the consultant.

Midwifery staffing

- The service met the national benchmark for midwifery staffing set out in the Royal College of Obstetricians and Gynaecologists (RCOG/RCM) guidance 'Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour' with a ratio of 1 midwife to 27 births, which was better than the RCOG recommendation of 1 midwife to 28 births.
- Current staffing levels were reviewed using a model to measure acuity. This was calculated in care hours per patient day and resources were managed accordingly. The recommended staffing levels for CIC were identified as 22 births to 1 midwife.
- Issues with maternity staffing were reported each month. There was an escalation plan which was implemented to provide the necessary staff cover. Community midwifery team leaders reviewed workloads and moved staff to cover activity during hours. There was a process to review workloads out-of-hours with the lead midwife in the hospital making the decision to bring the on-call community midwives into help. There was a process to review workloads out-of-hours with the lead midwife in the hospital making the decision to bring the on-call community midwives into help. There were no cancelled homebirths due to staff shortages between September and December 2016.
- Between July and September 2016 qualified and unqualified nursing and midwifery staffing fill rates were above 80%.
- There was no supernumerary delivery suite co-ordinator within the staffing establishment on either hospital site. This was not in line with RCOG guidelines which stated that 'to ensure 24-hour managerial cover, each labour ward must have a rota of experienced senior midwives as labour ward shift coordinators, supernumerary to the staffing numbers required for one-to-one care'. This gap was identified on the maternity risk register since 2014.
- As at 30 September 2016, the trust reported a vacancy rate of 0% in maternity and gynaecology services.
- Between April 2015 and March 2016, the trust reported a bank and agency usage rate of 1.3% and a turnover rate of 8% in maternity and gynaecology services.
- The unit used a recognised communication tool: Situation, Background, Assessment and

Recommendation (SBAR). Staff reported the details of any patient they had provided care for during their shift, including any risks which may be present. We observed an evening midwifery handover which was detailed.

Medical staffing

- Between 1 June 2016 and 30 June 2016, the proportion of consultant staff reported to be working at the trust were lower (worse) than the England average. The proportion of junior (foundation year 1-2) staff reported to be working at the trust were higher (better) than the England average.
- Between March 2015 and August 2016 CIC had an average of 40 hours consultant cover on the labour ward. This met the RCOG recommendations.
- There was consultant cover from 8am to 5pm performing elective procedures and ward round cover for patients in the postoperative phase. There was an on call Consultant Obstetrician physical presence on the labour ward from 8:30am to 5pm. There was a consultant obstetrician on-call between 5pm and 8.30am. Middle grade cover was 24 hours a day, seven days a week on site (12 ½ hour shifts) SHO cover was twenty four hours a day seven days week on site (12 ½ hour shifts).
- The labour ward lead said there were two vacancies at registrar level; one vacancy was being covered by a staff grade. There was currently six staff covering the medical rota which was vulnerable if someone went off sick. The service was in the process of advertising additional posts.
- There was a non-consultant grade, resident anaesthetist, 24 hours a day seven days a week. Out-of-hours duties included cover for emergency operating theatre and obstetric anaesthesia (not critical care this was a separate rota). There were three morning consultant sessions per week in obstetric anaesthesia (effectively an elective caesarean section list). Cover during all other weekday daytime sessions was as described for out-of-hours. Consultant on-call cover all out-of-hours times was non-resident. Out-of-hours duties included cover for emergency operating theatre and obstetric anaesthesia (not critical care this was a separate rota). There was one weekly obstetric anaesthetic outpatient consultant clinic with a consultant clinical service lead, with job planned supported professional activities (SPA) time.
- Staff we spoke with said they had experienced no delays in getting hold of middle grade staff, consultants or an anaesthetist.
- Between April 2015 and March 2016, the trust reported a turnover rate of 37% in maternity and gynaecology.
- Between April 2015 and March 2016, the trust reported a bank and locum usage rate of 26%.

Major incident awareness and training

- There were escalation processes to activate plans during a major incident or internal critical incident such as shortfalls in staffing levels or bed shortages.
- Medical staff and midwives undertook training in obstetric and neonatal emergencies at least annually.

Are maternity and gynaecology services effective?

Good

We rated effective as 'good' because:

- Women's care and treatment was delivered in line with evidence based practice. Where policies or procedures did not meet guidance, or posed a risk these were on the risk register and staff were aware of them.
- Care outcomes were meeting expectations in most areas, and where improvements were required the service had taken action.
- A formal preceptorship programme was in place for newly qualified midwives. This ensured appropriate support while developing skills and competencies and was a positive step in developing an integrated workforce. The majority of staff had received an appraisal.
- There were support systems for new mothers in feeding their baby. The service had achieved stage 1 of the United Nations Children's Fund (UNICEF) Baby Friendly Initiative (BFI) Accreditation Scheme.
- Women were provided with options for pain relief. Anaesthetist response times within 30 minutes for epidural analgesia were 96.7%.
- Midwifery and medical staff worked together ensuring women received care which met their needs.

- Staff had received training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Consent processes were effective and followed legislation and guidance.

However:

- There was a maternity audit schedule for 2016 however there was currently no effective process to ensure that cyclical improvement was established and ongoing. This was identified in an external review of Governance: Maternity Services report.
- Although junior doctors we spoke with said they were satisfied with the training and support they received, the General Medical Council National Training Scheme 2016 showed some outliers for maternity relating to a supportive environment**,** clinical supervision and adequate experience. There was an action plan and monitoring to ensure improvement.
- There was no practice development midwife due to retirement of the previous post holder. The clinical lead for obstetrics said the service was working towards appointing to the post.

Evidence-based care and treatment

- From our observations, records and through discussion with staff we found that policies were in line with the National Institute for Health and Care Excellence (NICE).
- Records showed women received care in line with NICE Quality Standard 22, covering antenatal care of pregnant women up to 42 weeks of pregnancy, in all settings that provided routine antenatal care, including primary, community and hospital based care.
- For women who planned for or needed a caesarean section, this was managed using NICE Quality Standard 32.
- Care of women was in line with Royal College of Obstetricians and Gynaecologists (RCOG) guidelines (including 'safe childbirth: minimum standards for the organisation and delivery of care in labour') with the exception of safe childbirth 4.4 (Paediatric Staffing Levels) that 'on-site' clinicians must have access to senior colleagues who have advanced skills for immediate advice and urgent attendance (within 10 minutes) when required. This was identified on the risk register.
- There was a maternity audit schedule for 2016 however there was currently no effective process to ensure that cyclical improvement was established and ongoing. This was identified in the review of Governance: Maternity Services report (Fleming, 2016).
- Where policies or procedures did not meet guidance, or posed a risk these were on the risk register and staff were aware of them. An example was the standard procedure developed due to the lack of a dedicated second theatre for obstetrics.
- There was a guideline development group. Staff confirmed they were consulted on guidelines. Guidelines were approved by the divisional governance group. We looked at 26 policies and guidelines relevant to maternity and gynaecology and found four were under review and three were out of date. The guidelines followed evidence based practice.
- The service was part of the Saving Babies in North England (SaBine) project. Currently, NCUH detection of SGA babies compared favourably with national statistics, (with a detection rate of 40.5% against 39.1% nationally. There was an ongoing audit in relation to missed small for gestational age (SGA) babies. The audit currently produced individual patient classification which was actioned at a local level. The service was working towards providing a more meaningful report with action and learning using the new Perinatal Institute audit template.
- The NHS screening programme sets key performance indicators (KPI) for antenatal and new-born screening programmes. The service had a number of areas identified for improvement following a quality assurance visit. The screening midwife said most of the actions were completed with one outstanding action relating to cohort data not being robust in all antenatal programmes. This would be resolved with the introduction of a new patient administration system next year.

Pain relief

- Women were provided with information to make them aware of the pain relief options available to them. Most women we spoke with said they had received sufficient pain relief.

- Women were offered pain relief options which included oral, injectable, medical gasses and epidural. There were no alternative pain relief therapies offered. A midwife with an interest in hypnobirthing was preparing a business case to introduce this service.
- An epidural service was introduced since the last inspection. An audit of anaesthetist response times within 30 minutes for epidural analgesia for the last six months at CIC was 96.7%.

Nutrition and hydration

- Breastfeeding initiation rates for deliveries that took place in CIC for April 2016 to October 2016 were 63% against a trust target of 68%.
- An infant feeding co-ordinator worked across sites four days a week and one day in the community.
- At the time of inspection, the trust had achieved stage 1 of the United Nations Children's Fund (UNICEF) Baby Friendly Initiative (BFI) Accreditation Scheme. A stage two assessment was booked for July 2017.
- Teenage mothers were encouraged to express and store breastmilk. An initiative introduced by the teenage pregnancy specialist midwife. There were facilities for storage of milk when women came into the unit. The service promoted confidence in the ability to breastfeed.
- There was access to breastfeeding peer supporters, however due to a recruitment embargo there were not many peers still in post.
- Snacks were offered to women 24 hours a day as required, and staff were able to order extra food and snacks for pregnant women as required.
- Women told us they had a choice of meals and these took account of their individual preferences including religious and cultural requirements. Women we spoke with said the quality of food was good. There was a dining area for mothers and families on the post-natal ward.

Patient outcomes

- There were no risks identified in: maternal readmissions; emergency caesarean section rates; elective caesarean sections; neonatal readmissions or puerperal sepsis and other puerperal infections. (Hospital Episode Statistics April 2012 to May 2015).
- Between April 2015 and March 2016 the total number of caesarean sections was similar to the expected England average. The standardised caesarean section rates for elective sections were similar to expected and rates for emergency sections was similar to expected.
- The percentage of deliveries by method was similar to the England average for the majority of methods. The trust had a greater percentage of low forceps cephalic delivery (6.9%) compared to the England average (3.3%).
- The number of women with successful vaginal births after caesarean section was mostly better than the trust target of above 70% per month.
- There were no maternal deaths between April 2016 and October 2016. There were two neonatal deaths.
- North Cumbria maternity services perinatal mortality (foetal deaths after 24 completed weeks of gestation and death before 7 completed days) rates compare favourably with UK rates as described in the Mothers and Babies: Reducing Risk through audits and confidential enquiries across the UK (MBRRACE) report (2016). NCUH rate is 4.76 per 1000 births, (which was up to 10% lower (better) than the national UK average)
- The rate of third and fourth degree tears was better than the trust target of less than 5% per month.
- Post-partum haemorrhage (>2000ml) was better than the trust average of below 1% with the exception of June and October 2016 which was 1.4% and 3%.
- There were two maternal readmissions between April 2016 and October 2016.
- Unexpected term admissions of babies to NNU were better than the trust target of below 9%.
- New-born blood spot screening showed avoidable repeat rates were 2.7% which was slightly worse than the national target of 2%. The screening midwife told us that the 0.7% related to babies tested in the tertiary centres. Staff completed a competency assessment if they had repeated problems with avoidable repeat screening tests.

Competent staff

- There was a formal preceptorship programme for newly qualified midwives. This ensured appropriate support whilst developing skills and competencies.
- There was rotation of midwives from delivery suite into the community and the day assessment unit to develop a fully integrated service.

- There was no practice development midwife due to retirement of the previous post holder. The clinical lead for obstetrics said the service was working towards appointing to the post.
- A scoping exercise of what training and updates were needed for essential midwifery skills was completed so that training was planned appropriately.
- Community midwives competency requirements were being reviewed to ensure they were supported when they were required to work in a hospital setting.
- The service was considering an advanced midwifery practitioner role to enhance maternity care.
- There was a plan to develop a database to allow senior medical staff to view locum staff competencies.
- Between April 2015 and March 2016, 90% of medical, nursing, midwifery, and non-clinical staff within maternity and gynaecology had received an appraisal.
- The 'North of England Local Supervising Authority's (LSA) annual report to the Nursing and Midwifery Council September 2016' showed the trust had met the required standard for two rules partially met compliance in three rules and not met one rule which required the urgent review of systems and processes for the safe and secure storage of records. Some of the other criterion within the standards also needed to be addressed.
- The caseloads held by supervisors of midwives (SOM) were in line with the recommended ratio of 15 midwives for each supervisor. All midwives had 24-hours access to supervisors. The LSA report confirmed that for the practice year 2015/2016 94% of midwives had an annual review which was not compliant with the requirement of 100%.
- Student midwives told us they felt supported and had regular teaching and mentoring. There was good consistency and experience from mentors. Students received a varied range of practical experience and felt part of the team. All student midwives had a named SOM and knew how to contact a supervisor.
- Two new staff said they had completed a trust and local induction prior to starting work.
- There were limited staff opportunities with secondments to broaden experience of other units. This had been identified in the trust Maternity Service Assurance report in response to recommendations of The Morecambe Bay Investigation.
- Junior doctors we spoke with said they were satisfied with the training and support they received, particularly that given by consultants. There was a good induction process and mandatory training was provided. Doctors did not express any concerns with workloads. They said the college tutor was very supportive.
- The results of the General Medical Council National Training Scheme Survey 2016 for obstetrics and gynaecology showed that the trust was 'within expectations' for induction and local teaching but 'below expectations' for a supportive environment**,** clinical supervision and adequate experience.

Multidisciplinary working

- Midwifery and medical staff worked together ensuring women received care which met their needs. Women and staff we spoke with provided examples of multidisciplinary working in practice, for example working with multiple allied health professionals and medical specialities to support women during pregnancy and childbirth
- Staff confirmed they could access advice and guidance from specialist nurses/midwives, for example infant feeding, twin pregnancy, mental health services and diabetes.
- Midwives at the hospital and in the community worked closely with GPs and social care services while dealing with safeguarding concerns or child protection risks.
- The health visitors and the community midwifery team worked together to identify and report potential risks to hospital staff. Risks were notified to health visitors, and community midwives had access to pathways about vulnerable women.
- Staff confirmed there were systems to request support from other specialties such as physicians, consultant microbiologists and pharmacy.
- There were no transitional care cots on the post-natal ward for babies requiring additional support however staff worked closely with children's services to care for babies who required additional clinical interventions. Obstetric staff said they received good support from the neonatal unit and could obtain advice at any time.

Seven-day services

- Out-of-hours' services were available in emergencies. All women could report to the hospital in an emergency through either A&E or maternity reception.
- The pregnancy day assessment unit was a Monday to Friday service. Outside of these hours and at weekend women attended the maternity ward.

- Physiotherapy provided a seven day service and 4pm to 8.30am on call service. Access was available to pharmacy and diagnostic services.

Access to information

- All local and national policies were available on the trust intranet for staff to access. Senior staff informed us they were responsible for updating pathways when new policies were approved.
- Staff told us there were processes to ensure medical and hand held records travelled with women in the event of a transfer.
- Communications with GPs summarising antenatal, intrapartum and postnatal care was recorded in medical records.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Women confirmed they had enough information to help in making decisions and choices about their care and the delivery of their babies.
- Consent forms for women who had undergone caesarean sections detailed the risk and benefits of the procedure and were in line with Department of Health consent to treatment guidelines.
- There was a system to ensure consent for the termination of pregnancy was carried out within the legal requirements of the Abortion Act 1967. We looked at a sample of consent forms during our inspection and found these records met legal requirements.
- Staff had a good understanding of relevant legislation about consent, for example applying Gillick competencies for children under 16 years of age to give consent to care and treatment without the need for parental permission.
- The trust reported as at 31 August 2016 Mental Capacity Act (MCA) training had been completed by 97% of staff in maternity and gynaecology.
- Deprivation of Liberty Safeguards training had been completed by 100% of staff required to undertake this training in maternity and gynaecology.

Are maternity and gynaecology services caring?

Good

We rated caring as 'good' because:

- The NHS Maternity Friends and Family Test for August 2016 showed the number of women who would recommend the maternity service was similar or better than the national average. High recommendation rates were also reflected in the 'Two Minutes of Your Time' patient experience survey.
- We observed staff interacted with women and their relatives in a polite, friendly and respectful way. There were arrangements to ensure privacy and dignity in clinical areas.
- All women we spoke with were positive about their treatment by clinical staff and the standard of care they had received. Women told us they had a named midwife. They felt well supported and cared for by staff, and their care was delivered in a professional way.
- Women were involved in their choice of birth at booking and throughout the antenatal period. Women said they had felt involved in decisions about their care during labour, and for feeling they were **spoken to** in a way they could **understand** during labour and birth.
- There were effective and confidential processes for women attending the gynaecology ward. Women received emotional support where required; appropriate specialist bereavement and midwifery support was provided which met the individual circumstances of women.

Compassionate care

- Between September 2015 and August 2016 the trust's Maternity Friends and Family Test (antenatal) performance (% recommended) was generally similar to than / to the England average. In latest month, August 2016 the trust's performance for antenatal was 97% compared to a national average of 95%.
- Between September 2015 and August 2016 the trust's Maternity Friends and Family Test (birth) performance

(% recommended) was generally similar to than / to the England average. In latest month August 2016 the trusts performance for birth was 98% compared to a national average of 96%.

- Between September 2015 and August 2016 the trust's Maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally similar to than / to the England average. In latest month August 2016 the trusts performance for postnatal ward was 98% compared to a national average of 93%.
- Between September 2015 and August 2016 the trust's Maternity Friends and Family Test (postnatal community) performance (% recommended) was generally similar to than / to the England average. In latest month August 2016 the trusts performance for postnatal community was 98% compared to a national average of 97%.
- The trust maintained a stable test performance for all four areas during the period September 2015 to August 2016. The trust performed better than the national average in the latest month.
- The trust scored 'about the same' as other similar size trusts in all 16 indicators in the CQC Survey of Women's Experience in Maternity Care 2015.
- The service carried out its own 'two minutes of your time' patient experience survey. Results for maternity between April and September 2016 showed a consistently high response of women recommending the services.
- All women we spoke with were positive about their treatment by clinical staff and the standard of care they had received. Women told us they had a named midwife. They felt well supported and cared for by staff, and their care was delivered in a professional way.
- Women said they received 1:1 care in labour. The CQC Survey of Women's Experience in Maternity Care 2015 showed the trust scored about the same as other similar size trusts for women '**not** being left alone by midwives or doctors **at a time when it worried them'.**
- We observed staff interacted with women and their relatives in a polite, friendly and respectful manner. There were arrangements to ensure privacy and dignity in clinical areas.
- We observed that the midwife call systems were within reach and women said that staff responded to the call bells quickly.

Understanding and involvement of patients and those close to them

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

Emotional support

- Bereavement policies and procedures were in place to support parents in cases of stillbirth or neonatal death; a specialist midwife supported families from their initial loss, throughout their time in hospital and when they returned home.
- There were effective and confidential processes for women attending the gynaecology ward. Staff supported women to make informed choices about their termination of pregnancy options.
- Specialist midwives for substance misuse, mental health, safeguarding and teenage pregnancy provided support to women in clinics and at home.
- There was ongoing assessment of women's mental health during the antenatal and postnatal period. Referral could be made to the joint mental health practitioner/ midwife led perinatal mental health clinic.
- A postnatal listening service had been introduced to provide an opportunity for women to talk to staff, following the birth of their baby, in case of any issues they wished to discuss.

Maternity and gynaecology

Are maternity and gynaecology services responsive?

Good

We rated responsive as 'good' because:

- The service was working in partnership with other organisations to develop local maternity services and develop strategies to improve care for women during pregnancy.
- Access and flow such as clinic waiting times were managed appropriately. There was access to investigation, assessment, treatment and care at all stages of the maternity pathway.
- Services were planned, delivered and co-ordinated to take account of women with complex needs, there was access to specialist support and expertise.
- There were processes in place for women to make a complaint. There had been ten complaints in maternity and gynaecology services in the past 12 months. Learning from complaints was used to improve the service.

Service planning and delivery to meet the needs of local people

- The service worked with clinical commissioners, other stakeholders and lay members to develop local maternity services in response to 'Better Births Together' projects and feedback to the Success Regime, Sustainable Transformation Projects and NHS England processes.
- The service was aware of its risks and the need to ensure that services were planned and delivered to meet the increasing demands of the local and wider community.
- The service worked with Public Health and Cumbria County Council to develop the breastfeeding strategy for Cumbria. Other themes in the Public Health Strategy included alcohol use in pregnancy, domestic abuse, smoking and maternal obesity.
- The specialist midwives worked closely with various external agencies to involve families and support them to access appropriate groups during and post pregnancy.

Access and flow

- Between Q4 2014/15 and Q1 2016/17 the bed occupancy levels for maternity were generally lower than the England average, with the trust having 47.2% occupancy in Q1 2016/17 compared to the England average of 60.1%.
- Between March 2016 and August 2016, there were no closures of the maternity unit at CIC. There were contingency plans for the delivery suite in the event of the unit becoming full.
- Women received an assessment of their needs at their first appointment with the midwife. The midwifery package included all antenatal appointments, ultrasound scans and routine blood tests. Midwives were available on call 24 hours a day for advice. Community midwives were integrated into the service. Women with high-risk pregnancies attended consultant-led clinics.
- The introduction of a healthcare assistant led clinic for glucose tolerance tests had improved waiting times for women and reduced workload for midwives in the Day Assessment Unit.
- Termination of Pregnancy (TOP) clinics were held every Thursday afternoon and treatment was provided on Saturdays. Referrals were from GP and nurse practitioners there were no self-referrals. Medical terminations were up to 18 weeks and surgical terminations up to 14 weeks. Up until last year some were being deferred for one week due to occasional lack of capacity. Due to the changes in management of miscarriage there was now more capacity for TOP women, very few if any needed to be deferred unless through choice or too early to confirm the pregnancy.
- Discharge arrangements for women following a TOP included access to a 24 hour helpline. A detailed discharge letter was sent to the GP and there was a review of contraception in clinic. For example Intrauterine Contraceptive Devices could be fitted.
- There were guidelines and protocols to trial new methods of induction of labour and for out-patient induction of labour. This would enable low-risk women to go home during the process and reduce demand on hospital beds.
- Midwives performed examination of the new-born. Data showed 99% compliance for examination within 72 hours.

Maternity and gynaecology

- At the end of November 2016 the proportion of patients waiting within 18 weeks to start treatment in gynaecology was 92.7% against the NHS operational standard of 92%.
- The number of inpatient and day case gynaecology procedures that were cancelled on the day for a non-clinical reason between 1 July 2016 and 31 December 2016 was 18; the highest number (11) was due to unavailable theatre staff.
- Between April and October 2016, the service achieved 92% of booking appointments for delivery before 12 completed week's gestation against a target of 90%.

Meeting people's individual needs

- There was a joint mental health practitioner and midwife led perinatal mental health clinic. This had reduced the number of women attending consultant led clinics and provided a more women focussed service.
- The service had introduced vaginal birth after caesarean section workshops.
- There were designated nurses who administered medication for medical termination of pregnancy. Women would see the same nurse in clinic which ensured continuity of care. Partners were able to stay.
- There were guidelines for smoking cessation. Clinical midwifery managers had ordered CO monitors for each clinical area so that women could be screened at each contact in line with national recommendations.
- Specialist consultant led clinics were held for women with a high body mass index, diabetes, mental health and twin pregnancies.
- There were processes to identify women with learning disabilities. The service liaised with the learning disability nurse and staff encouraged family and key workers to be involved in the care pathway.
- There were processes to ensure disposal of pregnancy remains were handled sensitively. Women were provided with a choice of how they would like to dispose of pregnancy remains, following pregnancy loss or termination of pregnancy.
- There was a range of information leaflets available to women. Staff told us these leaflets were available in different languages if required. There was access to interpreters or use of a translation phone service for women who did not speak English.
- The screening midwife was informed of all high risk results and liaised with the consultant and antenatal midwives to refer women for further testing or counselling.
- There was a lead midwife for bereavement who offered support to parents who had lost a baby. There were memory boxes available with items to serve as a memory of the baby.
- There was a newly refurbished bereavement suite which included the provision of a private room and use of cold cots to keep the baby with parents for as long as the parents required. Staff offered women the chaplaincy service to provide extra support.

Learning from complaints and concerns

- We reviewed a sample of complaints and found that women were informed of timescales, apologies had been given, a meeting with the consultant was arranged and an action plan agreed.
- CIC: There were 10 complaints; three related to the delivery /labour ward, three to maternity wards and four related to gynaecology. The main theme was about aspects of clinical treatment. Outcomes from the complaints included peer review and improved communication.
- Staff said the learning from these was shared during ward meetings, informal discussions and the monthly governance newsletter.

Are maternity and gynaecology services well-led?

Requires improvement

We rated well-led as 'requires improvement' because:

- There remained no clear vision or formal strategy for the future of maternity services due to the review of the Cumbria wide provision and managers were awaiting the outcome of the consultation.
- Although there was some improvement with cross site working the cohesiveness of the two hospital sites for maternity services was not fully embedded.
- There was some improvement in strengthening of governance processes but the service identified that there were no indicators or metrics to ensure performance and understanding of risk or governance

roles. There continued to be gaps in how outcomes and actions from audit of clinical practice were used to monitor quality and systems to identify where action should be taken.

However:

- Senior leaders in maternity and gynaecology were aware of the challenges in the service. Action had been taken where possible to mitigate risks however some actions were dependent on the outcome of the Success Regime.
- Communication with women who used the service had improved. The Maternity Services Liaison Committee was involved in the consultation on the future of maternity services in West Cumbria. Some further involvement was required in service development and co-design.
- The service had made some changes to improve maternity care for women.

Vision and strategy for this service

- There was currently no formal strategy in place for maternity services due to the review of the Cumbria wide provision and managers were awaiting the outcome of the consultation. The Head of Midwifery said that the goal was to include maternity services with the trust's nursing and midwifery strategy**.**
- The Better Births Together benchmarking exercise was completed with the Clinical Commissioning Group looking at a community midwifery model. The vision was to develop a community hub and transfer services such as ultrasound in to these**.** The Associate Director of Midwifery (ADOM) indicated that midwifery led care was not well defined in the trust and there was a need to change the ethos and re-engage with staff with a low risk philosophy.

Governance, risk management and quality measurement

- The service acknowledged that governance processes were not fully embedded and required strengthening.
- A governance manager worked across sites and was responsible for two risk midwives at each site. The governance manager did not have a job description for the role they were undertaking.
- The role of the risk midwives was two days a week to monitor reported incidents and complete incident reviews. The ADOM acknowledged that there were no key performance indicators or metrics to ensure performance and understanding of risk and governance roles.
- The ADOM reported that a meeting was arranged to discuss governance responsibilities with the consideration for one full time risk midwife across both sites.
- The governance manager met weekly with the ADOM, clinical and business unit governance lead to discuss incidents, the risk register and monitor actions.
- A number of continuous audits occurred in the service but these were not always presented or analysed. For example, an increase in induction of labour rates was identified as a concern however no actions or themes were reported following the audit. The clinical lead for obstetrics said a business case was being developed to have a designated midwife audit lead working four days a week along with a commitment to release medical staff to participate in audit.
- The service had reintroduced cross site incident reviews to improve impartiality. The service had tried this previously however staff were not always available and delays occurred.
- In response to a review by NHS England about an increased level of serious incidents reported, a maternity assurance report was completed by the ADOM outlining themes and trends. The report was presented to the Trust Board in November 2016, Trust Quality Committee and shared with staff. The report identified key areas where further detailed work and action was required.
- There was an action plan in response to the Perinatal Mortality Review (2013) and the learning from the perinatal mortality review day (2014). The action plan (version 5 January 2017 received post inspection) showed that most areas were completed, three areas; scanning slots, review of the intra-uterine transfers and communication and continuity of care showed work was continuing.
- The maternity dashboard followed the RCOG guidance and was used as a tool for monitoring the number of incidents and trends. These were reported to the monthly trust Safety and Quality Committee meeting. Learning points were shared with staff in the maternity news magazine.
- There was a maternity risk register which contained all risks identified, with control measures and gaps in the

control. Where gaps were identified assurance actions were documented. The risks were reviewed within an identified timescales however some risks had been present since 2014.
- The service had produced a Maternity Service Assurance and mapped actions to the report of The Morecambe Bay Investigation which was presented to the Trust Board in April 2016. Actions were completed with some further work identified for staff opportunities with secondments to broaden experience of other units.

Leadership of service

- The maternity and gynaecology service sat in the Emergency Surgery and Elective Care Business unit. The unit was managed by a Divisional Associate Medical Director, Associate Director of Midwifery, Chief Matron and Associate Chief Operating Officer. There was a clinical director for obstetrics and gynaecology covering both sites and a deputy clinical director who was also the obstetrics and gynaecology lead for West Cumberland Hospital. The ADOM was ten months in post.
- There were three clinical midwifery managers covering each site that were accountable to the ADOM.
- We found the leadership team were aware of the challenges for the service and these were reflected in the maternity risk register, action had been taken where possible to mitigate risks however some actions were dependent on the outcome of the Success Regime.
- Midwifery staff were positive about their immediate line managers who they said were supportive and approachable. The ADOM was visible on the wards.

Culture within the service

- Staff described a good culture at CIC. New staff to the unit said staff were friendly and supportive, and that they had been encouraged to present new ideas to improve services. Student midwives said they were exposed to a wider range of experience at CIC with more opportunities for learning and being taken seriously.
- Consultants on the unit worked closely as a team, staff described doctors as being approachable.
- Junior doctors felt that women received good care. They described the unit as 'close knit', a good atmosphere and communication between teams including paediatrics was good.
- There was limited cross site working however there was some improvements made since the last inspection and some cross site meetings, standard guidelines and sharing of information was taking place.
- Between April 2015 and March 2016, the service reported a sickness rate of 4% for nursing and midwifery staff and 0.6% for medical staff.

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Public engagement

- The service took account of the views of women through the Maternity Services Liaison Committee (MSLC). The minutes June and July 2016 showed women's experience, Success Regime options, engagement and service design issues were discussed.
- The MSLC were involved in the consultation on the future of maternity services in Cumbria.
- The chair of the MSLC told us there was good engagement with groups in the community. The MSLC visited hard to reach groups and post-natal groups to gain women's feedback. The chair said they would like more involvement in service development, co-design and guideline development**.**
- A user representative sat on the labour ward forum.
- There was a 'You Said We Did' board which showed that action had been taken in response to feedback from women, for example women having skin-to –skin in theatre and recovery following a caesarean section and post-natal discharges direct from the labour ward.

Staff engagement

- Some staff said they were aware about the reconfiguration of maternity services. Some had been to a roadshow or attended focus groups. Others said they had received information on the intranet and communication board.
- The ADOM wanted to support the team to deliver caring staff who were flexible. They told us staff engagement sessions had been held and were well received by midwives when vision and ideas for service provision were discussed.
- A monthly governance and risk management newsletter was sent to all staff. Each ward had a 'take five board' which provided quick feedback on learning from low level incidents**.**
- The service held a Whose Shoes? Improving Maternity Experience workshop. This was a values-led, bespoke

approach to change management. It was used to support transformation to a more person-centred, integrated culture of care and support. Key themes included continuity, empowering women, choice, expectations, support and consistency. An action plan to develop these areas was in place.

- Staff could share their views on the caesarean section strategy. This was part of the 'Pathways to Success – a self-improvement toolkit focusing on normal birth and reducing caesarean section rates'. The first survey was undertaken some time ago and was on the theme of 'Caesarean section - keeping birth normal'. The next survey on 'keeping first pregnancy and birth normal' was currently ongoing with the completion date of January 2017.

Innovation, improvement and sustainability

- Plans for the future of maternity services were still under discussion at the time of our inspection with a number of service options under consideration. The outcome of the consultation was not yet known.
- The service was aware of the challenges and risks to sustain the service particularly around staffing and other quality issues. Action had been taken where possible to mitigate these however some actions were dependent on the outcome of the Success Regime.

Services for children and young people

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

Information about the service

Services for children and young people at Cumberland Infirmary included a 16-bed children's ward and 8-bed short stay assessment unit. A children's outpatient department was adjacent to the children's ward and there was a special care baby unit (SCBU) with 12 commissioned cots.

The service was last inspected in March 2015 and was rated 'good' in all domains. Inspectors noted there had been improvements in risk management, safeguarding procedures and nurse staffing. There was a visible, child centred culture within the service and staff provided good care. A shortage in medical staffing was highlighted. During this inspection, inspectors reviewed medical and nursing staffing in line with the trust's workforce strategy as well as escalation and contingency plans in these areas. The service was under review with a number of models being considered and evaluated in order to better meet the needs of the population.

An unannounced focussed inspection took place in September 2016. The inspection team reviewed the safe and well-led domains. Although the service was not rated at this time, inspectors found staff had maintained good incident reporting processes, safeguarding procedures and nurse staffing levels. Documentation and record-keeping was good and the service had good local processes to monitor changes in a child's condition. There was a clear strategy for the remodelling of services provided by the child health business unit and staff felt supported by the local management team. However, inspectors noted issues in relation to medical staffing had not been resolved and found a deteriorating compliance against national standards on SCBU.

During this inspection, we visited the children's ward and outpatient department, SCBU and provisions for children and young people in the urgency care department. We spoke with 22 members of staff and nine families. We reviewed 16 sets of care records, including prescription charts. We also looked at nine case notes specifically in relation to safeguarding children and young people.

Services for children and young people

Summary of findings

We rated this service as 'good' because:

- The leadership, governance, and culture promoted the delivery of high quality person-centred care. Staff were competent and had the skills they needed to carry out their role effectively and in line with best practice. Managers were visible and there was a real strength, passion, and resilience across medical and nursing teams to deliver high quality care to children, young people and their families.
- Staff told us they were proud to work for the trust and promoted a patient-centred culture. Children, young people, and parents felt that medical staff communicated with them effectively, kept them involved and informed about care and treatment, promoted the values of dignity and respect, and were kind and compassionate.
- Staff protected children and young people from harm and abuse. Medical and nursing staff understood and fulfilled their responsibilities to raise concerns and report incidents, and managers took appropriate action to investigate and share learning.
- Medical and nursing staff followed appropriate processes and procedures to safeguard children and young people. The trust was represented at local safeguarding children board meetings and other sub-groups. Clinicians shared learning from serious case reviews and care records showed staff provided very good standards of care.
- Children and young people received effective care and treatment, planned and delivered in line with current evidence-based practice and legislation. Children's services participated in national and local audits, and other monitoring activities including service reviews and accreditation schemes. Managers shared the outcomes from audits and actions plans were developed to address areas of concern.
- Children's services were organised to meet the needs of children and young people. Managers and healthcare professionals from the team worked collaboratively with partner organisations and other agencies to ensure services provided choice, flexibility and continuity of care.

However:

- The unit did not meet all Royal College of Paediatric and Child Health (RCPCH) – Facing the Future: Standards for Acute General Paediatric Services (2015 as amended) within contracted hours. Despite ongoing recruitment campaigns, the trust had struggled to recruit appropriate clinicians. The current paediatric consultant team voluntarily worked in excess of their programmed activities to ensure children and young people were safe, however staffing constraints meant this was done in their own time. In a letter to CQC, the trust formally acknowledged our concerns and outlined the actions taken to address the current shortfall, which included robust handovers and ward rounds, and on-site consultant presence plus out-of-hours support.
- Due to staff shortages in the special care baby unit, the trust could not provide a qualified in specialty (QIS) senior nurse on every shift. Paediatric consultants supported the nurse-led unit, which mitigated the risk to babies, however this also contributed to their own increasing workload. The trust formally acknowledged our concerns in the same letter, highlighting the mitigating actions taken to ensure babies received safe care. In addition to senior QIS nurses working extra shifts, the trust planned to support less experienced neonate nurses complete advanced neonatal nurse practitioner courses, and ensure all senior staff completed neonatal life support training.

Services for children and young people

Are services for children and young people safe?

Requires improvement

We rated safe as 'requires improvement' because:

- The unit did not meet all Royal College of Paediatric and Child Health (RCPCH) – Facing the Future: Standards for Acute General Paediatric Services (2015 as amended) within contracted hours. Consultants job plans provided for 10-11 programmed activities a week however in reality most were voluntarily working in excess of this. To keep children safe, clinicians worked outside of their contracted hours. Despite ongoing recruitment campaigns, the trust had been unable to recruit to the substantive posts, leaving the unit in a precarious and fragile position. In a letter to CQC, the trust formally acknowledged our concerns and outlined the actions taken to address the current shortfall, which included robust handovers and ward rounds, plus on-site consultant presence and out-of-hours support. The trust had also secured long-term contracts for consultant locums.
- Paediatric consultants had also become increasingly involved in providing support to the nurse-led SCBU as there were not enough senior nursing staff to ensure babies were safe at all time. The unit did not have a qualified in speciality (QIS) band 7 senior nurse on every shift. Top mitigate the risk, medical staff provided clinical support however, this created additional work that affected job plans and programmed activities. In the same letter to CQC, the trust formally acknowledged our concerns, highlighting the mitigating actions taken to ensure babies received safe care. In addition to senior QIS nurses working extra shifts, the trust planned to support less experienced neonate nurses complete advanced neonatal nurse practitioner courses, and ensure all senior staff completed neonatal life support training.
- Although the ward areas and general environment was very clean and child-friendly, we found discrepancies in the cleaning rota in the children's outpatient department. Large gaps between the recorded dates suggested the area had either not been cleaned or the information had not been recorded appropriately.
- Staff did not consistently report incidents relating to a known or ongoing theme such as staffing concerns in SCBU or the unavailability of patient records. Staff told us they did not believe anything would change because of an additional incident and felt they did not always have enough time to report every occurrence.
- Although patient notes were legible and included appropriate information, medical staff did not consistently record their signature, name and designation on all of the records we reviewed.
- Mandatory training compliance was low. Although medical and nursing staff told us they had completed all of the required training, statistical evidence provided by the trust contradicted this. Managers told us they had planned for all staff who had not completed all training modules to do so by the end of the year.
- The new patient database system in A&E did not have capacity to flag children and young people who had repeatedly attended the department, children who were looked after or those subject to a protection plan. This meant staff had to rely upon parents and carers to provide an honest history of the child's health.

However:

- Staff protected children and young people from avoidable harm and abuse. There were systems and processes to safeguard children and young people. Staff took a proactive approach to safeguarding and focused on early identification. The trust had the appropriate statutory staff in post that were active and engaged in local safeguarding procedures and worked with other relevant organisations.
- Managers and staff discussed incidents regularly at weekly risk meetings and during daily safety huddles when appropriate. They took appropriate action to prevent them from happening again. When something went wrong children, young people and families received a sincere apology.
- Managers regularly reviewed staffing levels to ensure children and young people were safe at all times, and there was a clear escalation process in place.
- On a day-to-day basis, staff assessed, monitored and managed risks to children and young people and this included risks to children who had complex health needs, or who were receiving end of life care.
- All areas were visibly clean. Domestic and nursing staff followed cleaning schedules and updated cleaning logs. There were no cases of clostridium difficile (C. diff),

methicillin resistant staphylococcus aureus (MRSA) and methicillin sensitive staphylococcus aureus (MSSA) in the previous 12 months prior to the inspection. However, we did find discrepancies in the cleaning rota in the children's outpatient department. Large gaps between the recorded dates suggested the area had either not been cleaned or the information had not been recorded appropriately.

Incidents

- The trust had an incident reporting policy and staff reported incidents of harm or risk of harm using the risk management reporting system. Medical and nursing staff told us they felt very confident reporting incidents and near misses.
- There were 50 incidents reported between May 2016 and August 2016 relating to children's services at Cumberland Infirmary. Of these, the majority of incidents (42%) did not cause any injuries while 12% were classified as minor. Twelve incidents did not have a final classification, as they were still under review when we received the information.
- All four incidents reported in the children's outpatients department were due to the unavailability of case notes. Staff we spoke with told us this was an ongoing problem. They explained they did not always report this as an incident due to time constraints and a lack of conviction that anything would be done about it.
- Staff on the children's ward reported the majority of incidents (62%) while 34% related to the special care baby unit (SCBU). There was no common underlying theme from incidents reported by the children's ward. However, a prevailing theme within SCBU was lack of medical equipment, specifically specialist infusion feeding pumps. Managers we spoke had since resolved the issue and staff had access to new pumps, which the unit was also in the process of procuring.
- We saw evidence of learning from incidents. For example, following an incident of wrong diagnosis, clinicians noted additional assessments should be included in all male abdominal examinations.
- Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. Between October 2015 and September 2016, the trust reported no incidents which were classified as Never Events for children's' services.
- In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SI) in children's services, which met the reporting criteria set by NHS England between October 2015 and September 2016. The incident reported was classed as a treatment delay. The investigation reports included a thorough investigation and root cause analysis, which identified the risks, and highlighted areas of good practice.
- Staff we spoke with understood the duty of candour requirements. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. We saw examples demonstrating where staff had followed the procedure in relation to the serious incident investigations, which included interaction with the family.
- Senior staff held weekly risk meetings to review incidents, which included staff from the children's ward and the special care baby unit (SCBU). Every month, managers reviewed emerging themes and trends from incidents at a unit governance meeting. In addition to meetings, staff also had access to a ward communications book. This included outcomes from incidents and meeting minutes. Incidents and lessons learned were also included in the performance dashboard.
- Staff we spoke with told us, although they normally received feedback individually about an incident they reported, they were not always able to attend the weekly risk meeting as it took place at the same time as the consultant's ward round. The ward manager was aware of the conflict and told us she planned to change the time of the meeting so more staff nurses could attend.
- On SCBU, the medical and nursing team completed incident debriefs to share learning from events. We heard how the unit had identified babies transferred from maternity were losing body heat causing them distress which required additional nursing care. The unit worked with maternity colleagues to ensure babies were prepared for transfer and to develop a hypothermia care bundle for those babies at risk.

- SCBU shared learning with colleagues from other trusts as part of the wider Northern Neonatal Network (NNN) at regional meetings held each quarter. The NNN aimed to improve outcomes for babies born and cared for across the network region, providing trusts with an opportunity to share good practice.
- Medical and nursing staff discussed paediatric deaths at monthly mortality and morbidity meetings. Managers told us there had been no cases in the last three months. Paediatric community deaths were reviewed in line with the Local Safeguarding Children's Board recommendations and were discussed at the Child Death Overview Panel, attended by the named doctor for child protection.

Safety Thermometer

- Safety Thermometer is used to record the prevalence of patient harms at the frontline, and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.
- The service had adapted and developed an audit tool called 'paediatric clinical indicators' for use across the business unit to monitor and measure 'harm free' care. Staff used the tool in conjunction with clinical audit measures and patient satisfaction surveys to obtain a holistic view of performance and quality.
- Senior staff audited compliance against the tool's 12 key clinical indicators (communication, elimination, manual handling, food and nutrition, infection control, medicines management, pain management, patient observation, privacy and dignity, tissue viability, record-keeping and discharge standards) on a monthly basis.
- On the children's ward between June 2016 and August 2016, clinical indicator compliance averaged 93% (against the trust 'green' rating of 95%). The minor discrepancy was noted in the completion of a property disclaimer, which was omitted from paediatric documentation. SCBU compliance was 96%.
- Ward information boards also displayed ward performance data. Information included percentage scores in relation to cleanliness, infection prevention and control, cannula care and management, hand hygiene, appraisals and mandatory training. The units also shared outputs from 'ideas/issues/successes' and POPPY data (a review of services for the parents of premature babies). On the ward, there were very good compliance results against hand hygiene, cleaning schedules and patient experience surveys with results all in excess of 90%.

Cleanliness, infection control and hygiene

- All areas we visited were visibly clean. There were handwashing facilities at the entrance of each clinical area and we observed staff and visitors using them appropriately upon entering and leaving the ward. Antibacterial hand gel dispensers were also available at various locations within each ward or unit and staff carried personal hand gels, attached to their uniform.
- Domestic and nursing staff followed cleaning schedules and updated cleaning logs. However, in the children's outpatient department (COPD), the cleaning rota was generic (for example, room 3634 or waiting area) and not broken down into specific cleaning tasks or equipment. There was only one healthcare assistant (HCA) working within the COPD. Although they knew exactly what they needed to clean, staff covering the department in her absence would not be aware of the cleaning duties. The HCA told us they always cleaned examination equipment (equipment that was in direct contact with patients) after the clinic had ended, including speculae for scopes and blood pressure cuffs.
- The cleaning rota and checklist indicated the OPD should be cleaned weekly however, when we reviewed the documentation, we saw large gaps between the recorded dates. This suggested the areas had either not been cleaned or the information was not being recorded appropriately.
- Infection prevention and control (IPC) was part of the trust's mandatory training programme and the compliance target was 95%. Nurses and healthcare assistants had currently achieved 69% and medical staff had achieved 67%. Managers told us they were confident all training would be complete by the end of the current year.
- On the children's ward, the play specialist was responsible for cleaning toys. They told us there was a toy cleaning policy and they cleaned toys daily in line with the documented procedure.
- We saw personal protective equipment was readily available to staff to use and we observed staff using it appropriately. We also observed staff adhering to 'bare below the elbow' guidance, in line with national good hygiene practice.

- The unit recorded no cases of clostridium difficile (C. Diff), methicillin resistant staphylococcus aureus (MRSA) and methicillin sensitive staphylococcus aureus (MSSA) in the previous 12 months prior to the inspection.
- Staff regularly took part in IPC audits. Hand hygiene audits showed staff from the children's ward and SCBU achieved consistently high results. Between January 2016 and August 2016, both units achieved 100% every month in 'Spray and Glow' audits. IPC nurses confidentially sprayed ward surfaces with UV solution and revisited the area the following day to confirm surfaces had been appropriately disinfected and decontaminated.
- We saw evidence of appropriate waste segregation and clinical waste disposal units. Staff were aware of the importance and risks involved in handling of sharps. We observed staff safely disposing of needles in appropriate sharp bins and arranging disposal when full.

Environment and equipment

- Access to the children's ward and to SCBU was restricted. Staff monitored visitors entering and leaving the respective unit and granted access via a secure entry system.
- We saw evidence of processes to ensure equipment was safe. Staff completed environmental and equipment checks as part of their daily work and formally through the audit process. Checks included equipment cleanliness (such as commode, drug fridges, and mattresses), accessibility, storage, and integrity. The trust environmental report showed the children's ward and SCBU compliance averaged in excess of 95% between April and June 2016. Staff displayed audits findings on ward noticeboards. The audit identified some wear and tear to fittings and where cleaning needed to be improved
- Resuscitation trolleys held appropriate equipment, which was suitable for the needs of children. Staff completed a daily log to confirm the daily resuscitation equipment check was completed. We reviewed the logs and found no omissions. Staff had received training to use the equipment and their competency recorded.
- The trust's medical electronics department was responsible for the maintenance of all devices and equipment. Equipment we checked had been safety tested. Staff we spoke with told us they knew who to contact if they needed to report any faults and felt confident the system was robust.
- The environment across all areas where children and young people accessed care and treatment was good. The children's ward was very child-friendly and included a large playroom for younger children and a separate room for adolescents. Children and young people did not have access to Wi-Fi on the ward however staff told there were plans to introduce the facility at both hospitals.
- Children attending the accident and emergency department waited in a separate area that was equipped to meet their needs and there were also dedicated treatment rooms.
- The children's outpatient department was a self-contained unit adjacent to the children's ward. All seven consulting rooms were child friendly, toys were readily available (for all age groups), and equipment was suitable for children of different ages, such as various sizes in blood pressure cuffs.
- The children's ward was equipped with new high flow oxygen machines, which reduced the number of transfers of babies suffering from bronchiolitis to the regional tertiary care centre for additional care and treatment.

Medicines

- The trust had a policy for the administration and storage of medicines and staff we spoke with told us they followed standard procedures. There was dedicated pharmacy support across the service.
- Staff received training on medicines management as part of their local induction into the clinical areas. Managers had introduced a number of local medicines based competencies, for example, in administering intravenous medications. Ward managers assessed and monitored competencies against agreed best practice standards.
- Medicines were securely stored and handled safely. Storage cupboards and fridges were tidy and locked. Staff recorded and monitored the minimum and maximum fridge temperature appropriately, and explained the procedure they followed if there was a problem. There were two refrigerators in SCBU which were clearly labelled confirming which was for medicine storage and which was for the storage of milk.
- We reviewed eight prescription charts. Overall, staff completed the charts accurately and the writing was legible. Staff recorded the date and their signature,

allergies were documented, medication that was omitted or not administered had a documented reason, and antibiotics were prescribed as per guidelines. Staff also recorded the weight of the child.
- The children's ward included a 'take home' cupboard that stored medications such as antibiotics and analgesia. This facilitated a timely discharge when children were ready to go home, as families did not have to wait for the pharmacy team to fulfil any medication requests.

Records

- We reviewed eight sets of care records. Overall, we saw notes were legible and staff completed them accurately and included appropriate information such as, consent, risk assessments, and nutritional status. There was evidence of consultant review within 14 hours in all cases. However, we found doctors did not consistently sign the signature sheets and did not print their name and designation against entries in the notes. This meant note entries did not differentiate between different grades of doctors.
- On the children's ward, medical records were stored securely in a locked office with a key-code entry system. Nursing notes and charts were stored safely in folders behind the nurse's station but were not in a locked storage unit. In SCBU, notes were stored on a trolley and kept in the staff office, which was unlocked.
- The children's ward and SCBU completed case note reviews as part of the NHS Litigation Authority (NHSLA) audit. Managers audited 10 case notes each month against 30 key indicators ranging from demographics to examination findings and treatment plans. The summary from an audit in SCBU recommended staff should date all entries and record the time, and ensure a management plan was included in the notes each day. Managers completed action plans to address shortfalls in audit compliance.
- Patient records were stored off site and not in the hospital. Staff from the children's outpatient department told us that notes were not always readily available for children attending clinics. Although staff had reported some incidents, they told us there were some occasions when they had not due to time constraints. Staff from the children's ward also expressed concerns about the delay in receiving patient notes however did acknowledge the process was beginning to improve.

Safeguarding

- The trust had a safeguarding children policy. Staff we spoke with felt the safeguarding team had a high profile across the organisation and could explain what actions they would take if they had concerns about a child or young person. The named nurse reviewed all of the safeguarding referrals sent to them from staff. Staff we spoke with showed us evidence of the referrals they made and of the feedback they received from the safeguarding team. Staff also used the CWILTED (condition, witness, incident, location, time, escort, description) assessment tool to identify potential abuse when a child or young person was triaged by a member of staff.
- The trust had the necessary statutory staff in post, including the named nurse and named doctor. The director of nursing was the nominated executive lead for safeguarding and attended Local Safeguarding Children Board meetings. All members of the team attended relevant sub-groups ensuring information and good practice was shared internally and externally. For example, the team produced a safeguarding children newsletter that included the findings and learning from five recent serious case reviews. The named doctor had also delivered a series of presentations to staff.
- There had been two recent serious incidents. Both related to misdiagnosis, one of a child with a fracture and the other a non-accidental injury. Learning from this incident resulted in a new protocol for the identification of non-accidental injury in the immobile child. This was currently in draft awaiting ratification by the trust safeguarding board.
- The safeguarding team participated in safeguarding audits to monitor safeguarding standards. The named nurse conducted monthly dip-sample audits of case notes and we reviewed the latest safeguarding self-assessment audit submitted to Cumbria Clinical Commissioning Group. The trust was fully compliant with the majority of standards, which included leadership, governance arrangements, policies, procedures and systems, and inter-agency working. Standards against which the trust was non-compliant had an action plan in place and progress was being made within agreed timescales.

- Medical and nursing staff routinely discussed safeguarding concerns, including children who were subject to a child protection plan, at daily handover meetings on the ward or unit.
- The local authority (LA) provided a weekly list of children looked after and those on a child protection plan. Although the system used by the LA was compatible with the trust electronic system, children from out of the area were not as easily identified.
- In addition, the system in A&E did not have the capacity to flag this information, or children who frequently attended A&E. This meant there was reliance upon nursing and medical staff to manually interrogate the system or contact the safeguarding team if they had any concerns. Staff also had to rely upon the parent or carer to provide an honest medical attendance history as healthcare professionals could only make an assessment based upon the current visit. Senior managers were aware of the risk although it was not included in the child health business unit risk register provided to us by the trust.
- The named nurse had instigated an initiative to introduce safeguarding children champions on the children's ward, SCBU, A&E and maternity. Safeguarding champions, who ranged from band 5 to band 7 staff grades, had also received training to provide safeguarding supervision to nursing staff.
- The named nurse's professional development included one-to-one supervision with the safeguarding designated nurse and external supervision/mentorship from a designated nurse in another area. The named nurse had also accessed level 4 safeguarding children training and attended regional safeguarding forums.
- National guidance states all clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns should all be trained at Safeguarding Children Level 3.
- The trust set a target of 95% for completion of safeguarding training in 2016/17. Although all clinicians we spoke with told us they had completed the required training, data provided to us by the trust showed only 50% of medical staff had completed Safeguarding Adults Level 1 and Safeguarding Children Level 3 so far in the current year.
- All nursing and healthcare assistant staff had completed Safeguarding Children Level 3 and 95% had competed Safeguarding Children level 3. The majority of staff had completed Safeguarding Adults level 1 (76%). Although all of the staff we spoke with on the children's ward were trained to level 3, the healthcare assistant, who worked directly with children and young people, and the senior nurse on the unit, had only received Level 2 training.
- The safeguarding team had developed a work plan, which identified a series of safeguarding actions, one of which was to improve the overall training compliance across the trust in relation to safeguarding children. The team was working in conjunction with the learning and development department to identify those staff who had not received training and to ensure training statistics were recorded accurately.
- We reviewed nine sets of care records from the children's ward and paediatric A&E, specifically in relation to safeguarding children and young people. We saw evidence of CWILTED assessments, good communication between staff and families and appropriate inter-agency working, including urgent child protection referrals to children's social services. Three cases we reviewed were initially identified as adult cases in A&E where staff had recognised that the adult had childcare responsibilities, which meant a child was potentially at risk. Overall, the care record notes demonstrated very good standards of care provided by staff.

Mandatory training

- The trust set a target of 95% for completion of the majority of mandatory training. Mandatory training courses for medical and nursing staff included information governance, fire safety, infection control health and safety and paediatric basic life support.
- All of the staff we spoke with told us they had completed all of their mandatory training for the year.
- However, information provided by the trust showed the average compliance from medical staff for information governance and fire safety was low at 17%, and well below the trust target. Compliance from nurses and healthcare assistants was higher though still below the trust target at 65% and 62% respectively.
- The average compliance for paediatric basic life support was 67% for medical staff and only 35% for nurses and healthcare assistants.

- Managers told us they expected all staff to have completed mandatory training by the end of the current year and a schedule was planned for the upcoming year. The ward manager told us nursing staff from the children's ward would complete all of their training for the next year over a scheduled two-week period.

Assessing and responding to patient risk

- The children's ward and staff from the A&E department used the paediatric early warning scores (PEWS), an early warning assessment and clinical observation tool. This included a clinical observation chart, coma scale and additional information such as the pain score tools with an assessment table to assist clinical staff in determining what action nursing and medical staff should take for an ill child. We spoke with medical staff and nurses who demonstrated a clear awareness of how to assess patient risk and what action they would take in response. PEWS charts were audited every month and staff from the children's ward achieved consistently high results.
- Daily handovers took place and included discussions about patient safety as well as detailed information sharing about each child. Based on the SBAR principles (situation; background; assessment and recommendation), the meeting highlighted any risks and enabled medical and nursing staff to reinforce plans to monitor deteriorating patients, for example, increasing observations or 1:1 nursing care. During each day, staff took part in safety huddles on the ward, which focused on assessing and responding to individual patient risk.
- Clinicians transferred children who required paediatric intensive care to the regional tertiary care hospital. In the event of a child deteriorating and, for example, requiring intubation, staff from the intensive care unit would stabilise the patient with support from a paediatrician (with or without paediatric nurse) until medical staff had secured appropriate retrieval or transfer arrangements to the tertiary hospital.
- The majority of surgical procedures for children and young people took place at Cumberland Infirmary and surgeons operated a dedicated child-only list on one full day, every two weeks. This did not include children under one years old or under 10 kilograms in weight who were instead transferred to the local tertiary care centre. In some cases, surgeons listed children on the same day as adults.
- Managers told us the numbers were low compared to those on the dedicated day. However, when we reviewed surgical lists between June 2016 and November 2016 we found only 77 children had surgery on the dedicated 'children's day'. This compared with 665 children who received surgery as part of a mixed adult/children theatre list during the same period. Of those, 133 were trauma and emergency cases while 526 were elective. The main type of elective procedure was extraction of multiple teeth, which accounted for 49% of all sessions.
- There was no separate recovery ward for children post-surgery, which meant children were cared for alongside adults. Staff told us children were segregated from adult patients and the beds were not alongside each other. Nurses caring for children on the recovery ward were not registered children's nurses although had received training in paediatric life support.
- The trust had a transfer of patient policy (including intra and inter hospital transfers) which included a section for the care and management of paediatric and neonatal patients. SCBU was part of the northern neonatal network, which provided specific transfer guidelines for the movement of babies who required high dependency or intensive care. This included arrangements for baby retrieval, preparation for transfer, and transport requirements.
- The neonatal unit did not use a new-born early warning trigger and track (NEWTT) tool. However, in our review of care records, we saw staff had taken appropriate action when a baby had shown signs of deterioration. The unit also followed the National Institute for Health and Clinical Excellent (NICE) guidelines for the assessment, treatment and management of babies with risk factors for infection or clinical indicators of possible infection.
- The trust had a policy for the management of sepsis and paediatric sepsis six pathway for children under the age of five and between the ages of five and 11. We saw evidence of the UK Sepsis Trust-endorsed paediatric sepsis screening and action tool and a senior nurse told us one of the consultants had delivered training to the medical team.

Nursing staffing

- The children's ward accommodated 24 children (inclusive of a four-bedded day ward referred to as 'Rainbow room' for direct GP admissions and open

access for children with long-term chronic conditions) between Monday and Friday, up to 7.00pm. Bed occupancy was reduced by one third to 16 beds after 7.00pm on weekdays and at weekends.

- Children's services took into account guidance from the Royal College of Nursing (RCN) in relation to paediatric nurse staffing levels. The RCN standard for bedside deliverable hands-on care recommends one nurse to three children (1:3) under two years of age, and one registered nurse to four children (1:4) over 2 years of age, and one nurse to five children (1:5) over the age of five years.
- The trust used the Safer Nursing Care Tool (endorsed by National Institute for Health and Care Excellence) to assess safe staffing levels for the children. Managers forward planned nurse rotas to allow for early identification of a staffing shortfall and completed a twice-daily acuity review to manage changing patient need. There was a clear escalation process in place should a shortfall occur. Ward managers told us they obtained support from the wider unit, asked existing staff to extend or work additional shifts and requested staff from the nurse bank.
- The ward used the trust e-rostering system, and planned for four registered nurses on shift during weekdays, three at weekends, and two registered nurses overnight. In August 2016, fill rates for the children's ward confirmed an average of 87% for registered nurses during the day and 100% at night.
- We reviewed staffing rotas from June to September 2016 and noted eight shifts where the ward did not fully meet establishment. We also reviewed the rotas from October to December 2016. On average, there was at least one day each week where there were three registered children's nurses per shift instead of four. During the winter months, the ward manager explained they had introduced a 'twilight' shift from 7.00pm until 1.00am. However, this was not a rostered shift and the ward manager relied upon nurses to volunteer to work extra hours.
- The ward manager confirmed most of the registered children's nurses had received advanced paediatric life support (APLS) training, and there was always at least one nurse on duty per shift.
- The RCN 'Defining Staffing Levels for Children and Young People's Services' (2013) guidelines recommend one member of nursing staff should be supernumerary and external to the nurse rota. The ward manager confirmed the children's ward did not meet this RCN standard. The ward manager only had one management day a week and was part of the main rota at all other times.
- SCBU also used the trust e-rostering system and planned for two registered nurses and one healthcare assistant during the day and two registered nurses at night. Managers recorded neonatal nurse staffing levels twice daily on BadgerNet (a single record of care for all babies within neonatal services, and used widely across the country).The data was replicated onto the trust's acuity tool which enabled managers to view actual staffing levels and patient numbers.
- Neonatal nurse staffing at Cumberland Infirmary met the British Association of Perinatal Medicine (BAPM) recommendations most of the time. BAPM recommends a staffing ratio of one neonatal nurse to four babies (1:4) in units providing level one special care. In August 2016, fill rates for SCBU confirmed an average of 107% for registered nurses during the day and 99% at night.
- As the unit was nurse-led, there should have been a qualified in specialty (QIS) band 7 senior nurse on every shift. However, out of eight senior nurses, four had recently left the service, which meant the unit struggled to ensure there was adequate cover. The lack of a senior nurse meant two band 6 nurses were rostered on each shift. Staff told us they had initially reported nursing shortages as incidents however, they also acknowledged this had lapsed over recent months as they became used to the normalcy. An escalation policy and pathway for staffing was displayed in the staff office and was available on the trust intranet. However, not all staff were aware of it and one nurse told us following the policy 'did not make any difference'.
- We reviewed evidence from the previous four weeks rota activity. This showed there were 24 shifts (early and late) without a senior nurse. Staff told us this was filled by a bank nurse. To mitigate the risk, consultants provided clinical support to ensure the safety of babies on the unit. This included out-of-hours cover during the night.
- The average vacancy rate for the service across both sites was 4.8% (as of Sept 16).
- The average turnover rate across both sites in 2015/16 was 8%, which was the same as the overall trust average.

- In 2015/16, the trust reported a bank and agency usage rate of 1.08% in children's services. The Cumberland Infirmary reported an average rate of 1.02%. Nursing staff told us agency nurses were not used in SCBU, only one regular bank nurse.
- The average sickness rate for the service across both sites in 2015/16 was 4%. This was better than the overall trust average.

Medical staffing

- According to the Health and Social Care Information Centre, medical staffing skill mix varied in comparison to England average. Overall, the service had a significantly lower proportion of consultant grades (23% compared to 39% average) and a lower number of registrar grades (42% compared to 47%) than the England average. The service had a significantly greater number of middle career grades (doctors with at least three years' experience as senior house officer or at a higher grade) and junior doctors than England average. The total whole time equivalent (WTE) for medical staffing at both hospital sites was 14.
- In September 2016, the trust reported a vacancy rate of 21% in children's services, across both sites in Carlisle and Whitehaven. The trust relied upon locums to support the children's ward and outpatient department, and SCBU. Between April 2015 and March 2016, the trust reported a locum usage rate of 25%. The turnover rate during the same period was 46%
- Cumberland Infirmary had a full complement of consultants in post (7 WTE, inclusive of a recent appointment). In addition, there were two GP trainees, a specialist trainee, a locum trust doctor, five medical students, and a paediatric nurse practitioner.
- The majority of consultant job plans provided for 10-11 programmed activities a week however in reality most were voluntarily working in excess of this, in the region of 11-12.5. This meant the consultant team did not meet all Royal College of Paediatric and Child Health (RCPCH) – Facing the Future: Standards for Acute General Paediatric Services (2015 as amended) within their contracted hours. Specifically, the unit did not meet:
  - Standard 1: a consultant paediatrician is present and readily available in the hospital during times of peak activity, seven days a week.
  - Standard 3: every child who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician within 14 hours of admission, with more immediate review as required according to illness severity or if a member of staff is concerned.
  - Standard 4: at least two medical handovers every 24 hours are led by a consultant paediatrician.
- Recruitment to substantive posts was ongoing however, managers told us they had very clear expectations and would not appoint clinicians who did not meet the specific criteria of the role.
- The medical team operated a consultant of the week (COW) rota from 9.00am to 5.00pm and a hot week where cover was provided out-of-hours from 5.00pm to 9.00am the following day. We reviewed paediatric rotas from June to August 2016 showing consultant cover, staff and middle grade attendees, COW and on-call staffing arrangements. Two junior doctors were rostered each day with one junior overnight. There were no rota gaps.
- Clinicians provided consultant presence from 9.00am until 7.00pm every weekday and 9.00am until 12.00pm at weekends, with on-call arrangements thereafter. All staff confirmed on call cover to be effective with support easily accessible when required. Junior medical staff and nurses reported no problems contacting a consultant during the night and at weekends. Consultants have also become increasingly involved in providing support to the nurse-led SCBU due to the lack of senior band 7 nurses.
- Junior doctors told us their senior colleagues were accessible and approachable. They commented they felt "safe, supported, and involved". Consultants and senior paediatric doctors welcomed contact out-of-hours in the event of concern about a child or for treatment advice and told us they were happy to attend the unit when required.
- Consultant-led medical handovers took place every day, in the morning and evening. The handovers were well attended. All children were discussed and each summary included a detailed review of the child, an update on progress, ongoing treatment plans and an opportunity for junior medical staff to learn and ask questions. Doctors showed they had an in-depth knowledge of each child and their family.
- Between April 2015 and March 2016, the trust reported a sickness rate of 0.2% in children's services. This was better than the overall trust average.

Services for children and young people

Major incident awareness and training

- The unit had a paediatric service escalation plan and a staffing contingency plan to provide guidance and support to staff in the event of a major incident. Staff on the children's ward confirmed an awareness of the escalation plans.
- The unit took part in a multi-agency table-top exercise in July 2016 to test the resilience of such plans. The exercise primarily focussed on services at West Cumberland Hospital however, the impact upon the Cumberland Infirmary formed a key part of the exercise discussions. The exercise identified a number of areas for future consideration and improvement such as the need for more depth and detail for long-term loss of staff, more training, and awareness across the unit to embed the plans and fully integrate the paediatric policies into the wider trust framework.

Are services for children and young people effective?

Good

We rated effective as 'good' because:

- The trust had systems and processes in place to review and implement National Institute for Health and Care Excellence (NICE) guidance and other evidence-based best practice guidance. Polices and guidelines were available on the trust intranet and ward managers held a file centrally within each service area.
- We reviewed information that demonstrated children's services participated in national audits that monitored patient outcomes when these were applicable.
- Readmission rates were better or similar to the England average in most cases. They were worse for children under one year old readmitted within two days of discharge following an emergency admission. They were also worse for children and young people between 1 and 17 years who had multiple readmissions for epilepsy. However, the children's ward maintained an 'open door' policy for children with chronic conditions. Families were encouraged to return to hospital if they had further concerns about their child.
- Results from the national neonatal audit programme identified several areas of good practice and some outcomes exceeded the national average. There were also areas for improvement and staff had developed an action plan to address the concerns.
- There were effective arrangements for young people transitioning to adult services or between services. Needs were assessed early, with the involvement of all necessary staff, teams and services and staff applied Gillick guidelines appropriately in relation to obtaining consent. Arrangements reflected individual circumstances and preferences.
- Children and young people had access to effective pain relief and staff used evidence-based pain-scoring and assessment tools to assess the impact of pain. Non-pharmacological methods were also utilised to distract and calm children before, during, and after the administration of treatment.
- There was evidence of positive multidisciplinary working across various disciplines and specialties.
- Nursing and medical staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. Staff had received an annual appraisal and received support and personal development.

However:

- Outcomes for children and young people suffering from diabetes were worse than the England average according to data published in the latest national diabetes audit. However, statistics from the trust's diabetes annual report showed outcomes were improving for children under ten and were better than the England average. Approximately one third of children receiving treatment for diabetes were in the 15-19 year old age group, which was a higher proportion than other regions in the country. Staff we spoke with acknowledged the challenges to support young people in managing their long-term condition and told us this remained a high priority for the service. Young people also remained in the children's service for longer than expected, due to limitations in the adult diabetes service, which staff explained was a contributory factor.
- The trust did not have a dedicated paediatric anaesthetist lead. Following the departure of the previous post-holder, the trust planned to appoint a clinician from within the current consultant anaesthetist

team. A senior clinician acknowledged the trust would need to establish robust training and support to ensure the new lead was able to develop and maintain the specialist skill base required to fulfil the role effectively.

Evidence-based care and treatment

- Services for children and young people at Cumberland Infirmary adhered to guidelines from the Royal College of Nursing (RCN), the National Institute for Health and Care Excellence (NICE) and other professional guidelines such as the British Association of Perinatal Medicine. Policies and guidelines were available on the trust intranet and ward managers also held a file centrally within each service area.
- Children's services participated in national audits such as diabetes and paediatric pneumonia. We also saw evidence of local audit activity to assess compliance with NICE quality standards. The audit plan for 2016/17 included NICE CG 89: when to suspect child maltreatment and NICE CG149: antibiotics for early onset neonatal infection.
- The neonatal unit had achieved stage one for the UNICEF Baby Friendly Initiative and the team was aiming to achieve stage two in 2017. Both units at Cumberland Infirmary and West Cumberland Hospital were also working towards achieving accreditation with the Bliss Baby Charter, a scheme to ensure babies received the best neonatal care and treatment.

Pain relief

- Children and young people had access to a range of pain relief if needed, including oral analgesia and patient-controlled analgesics. We saw evidence of a pain scoring system and completed pain assessments in the care records we reviewed.
- Other non-pharmacological methods were also utilised by staff across the service. The children's ward had a dedicated play specialist who told us they used age appropriate play and activities as a means of helping to prepare children for procedures. For example, staff used 'Buzzy the bumble bee', a sensation distraction tool to help minimise the pain of a cannula insertion or needle injection.
- Staff in the special care baby unit did not use a specific pain assessment tool and instead used oral sucrose analgesia, administered pre-procedure, for new-born infants undergoing painful procedures. The use of sucrose as an analgesia is common practice across the UK and the rest of the world. The team told us they recognised that sucrose, 'non-nutritive' sucking, breastfeeding and physical comfort all had a role to play in providing relief from the pain associated with certain procedures.
- One family gave feedback to the trust explaining children did not always understand their pain medication. In response, a pharmacist now visited the ward each day to speak with relevant children and families to give them an opportunity to ask questions and seek clarification about the medication.

Nutrition and hydration

- The children's ward used the STAMP (Screening Tool for the Assessment of Malnutrition in Paediatrics) nutritional tool. It is a simple five-step tool to identify if a child's condition has any nutritional implications, what the child's nutritional intake is plus their weight and height. Based on the results from the first three steps, the overall risk of malnutrition is calculated and a care plan developed as appropriate.
- We reviewed evidence from STAMP audits conducted in April, May, and June 2016. Outcomes showed the children's ward was not compliant in the completion of the screening tool for every patient. The ward manager told us they had taken appropriate steps to improve the process and had shared this with staff.
- A dedicated paediatric dietician met with families upon admission to discuss any special dietary needs. Dieticians also worked with the ward housekeeper to discuss requirements and make appropriate recommendations to meet the needs of the patients.

Patient outcomes

- Children's services participated in national audits to monitor and improve patient outcomes, such as diabetes and epilepsy. We saw evidence of clinical audit summary forms, assessing compliance against NICE guidelines, which highlighted the standard of current practice and included recommendations.
- According to the 2014/15 National Paediatric Diabetes Audit, the median HbA1c level (which indicates how well an individual's blood glucose levels are controlled over time) was worse than the England average which meant, proportionately, fewer children receiving treatment at Cumberland Infirmary had their diabetes under control (Hba1c<58 mmol/mol).

- Approximately one third of children and young people with diabetes were in the 15-19 year age group, which was a higher proportion than nationally). Amongst this age group, the median HbA1c was 77.5mmol/mol, a rise from the preceding 6-months. Data from the trust's diabetes annual report 2015/16 showed the median HbA1c level children under ten years old was better than the England average. Senior clinicians explained although limitations in the Adult diabetes service meant young people were staying longer than expected in the children's service, improving the care for young people remained a high priority for the service.
- Between March 2015 and February 2016, the readmission rate for children under one, within two days of discharge following an emergency admission, was 4.6%. This was worse than the England average (3.4%). The 1-17 age group was the same as the England average, at 2.8%. The readmission rate for children aged between one and 17, within two days of discharge following an elective admission, was 1.7%. This was similar to the England average (0.6%). We spoke with staff and managers who all explained the 'open door' policy for children with chronic long-term conditions. This meant families were encouraged to return to hospital if they had further concerns about their child and was a contributing factor to a higher than average readmission rate.
- Between April 2015 and March 2016, the trust performed better than the England average for the percentage of patients aged 1-17 years old who had multiple emergency readmissions (two or more) for asthma (14% compared to 17%). The trust performed worse than the England average for the percentage of patients aged 1-17 years old who had multiple emergency readmissions for epilepsy (36% compared to 29%). There was no available data for under one's and the number of multiple emergency readmissions for diabetes was less than six.
- The trust participated in the national neonatal audit programme (NNAP). Results from the 2015 audit identified a number of areas of good practice. The neonatal unit at Cumberland Infirmary was compliant with the NNAP standard for 98-100% of babies to have their temperature recorded within an hour of birth. There was also a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission in 99% of all cases. This was also better the northern neonatal network (NNN) and national averages (of 93% and 88% respectively).
- There were also areas for improvement. The proportion of babies <33 weeks gestation who were receiving any of their own mother's milk at discharge from SCBU was 54%. Although this was worse than the national average of 65%, it was better than the NNN average of 46%. In addition, 94% of babies with a gestational age of < 32 weeks or < 1501g at birth had undergone retinopathy screening which meant the unit was 6% below target. The trust had an action plan to address all of the areas of concern.

Competent staff

- In 2015/16, only 33% of medical staff had received an appraisal compared with 78% of nursing staff from the children's ward and 85% from SCBU. Current data for 2016/17 showed this had improved to 100%, 82% and 85% respectively. Managers told us all staff, with the exception of those on maternity leave or long-term sickness absence, would receive an appraisal by the end of March 2016.
- We found medical and nursing staff were competent to carry out their roles. Staff told us they received appropriate professional development and supervision. Nurses were encouraged to develop their knowledge in specialist areas. For example, one nurse had expressed an interest in epilepsy and had spent a day at the local tertiary care hospital as part of her learning and development. Junior doctors we spoke with told us they had an educational supervisor and attended regular teaching sessions. All staff told us they felt supported in their role.
- Medical and relevant nursing staff had received appropriate advanced paediatric life support training and we noted there was at least one trained nurse on every shift. Healthcare assistants told us they had received training in basic paediatric life support.
- A registered children's nurse (RCN) triaged children who presented at the accident and emergency department. There was only one RCN in the department however; the trust was currently recruiting am additional band 6 post. When the RCN was unavailable, a senior doctor assessed all children.
- Anaesthetists and theatre staff were competent to care for children and young people during surgery.

Standards produced by the Royal College of Anaesthetics state every consultant anaesthetist should perform a minimum of 25 paediatric anaesthesia cases per annum. A senior clinician confirmed the team met this standard. Paediatric consultants also provided additional support where necessary. Within the remit of non-specialist surgery, the clinical director told us they were confident the team provided a safe and effective service.

- Until recently, the trust had a paediatric anaesthetist lead who held overall responsibility for sharing guidelines, attended clinical sessions, and maintained regular contact with paediatric surgical services across the North East of England. The trust was in the process of trying to identify a current member of the team to fulfil this highly specialised role. The clinical director acknowledged they needed to ensure arrangements were made to ensure the new lead had sufficient professional leave time to develop and maintain the skill base, and spend an appropriate amount of time in a specialist centre for paediatric surgery.
- There were no paediatric nurses on the recovery ward to care for children after their surgery. However, managers told us all nurses who worked in the unit had received appropriate training in line with paediatric intensive care society standards.

Multidisciplinary working

- Our observation of practice, review of records and discussion with staff confirmed effective multidisciplinary team (MDT) working practices were in place. Medical and nursing staff worked closely together, and with other allied healthcare professionals such as dieticians, speech and language therapists, health visitors and children's community nurses. Staff we spoke with also gave us positive examples of working with child and adolescent mental health services (CAMHS) and social services.
- A senior nurse described the working relationship with the local tertiary care centre as very positive. The ward manager gave examples of working and liaising with the bed manager and the paediatric intensive care unit to arrange the transfer of children from one hospital to the other.
- Junior doctors from the neonatal unit reported relationships with obstetricians were very good. We also spoke with a consultant obstetrician who reiterated the positive working relationship across the teams.
- The pharmacist team supported the children's ward to facilitate timely discharge. The ward had a 'take home' cupboard that stored standard medication such as antibiotics and analgesia. Pharmacists regularly checked and maintained stock levels and worked with ward staff to supply additional medication when required.
- We heard examples of co-ordinated planning and delivery of care between different services and providers. The trust had adopted the NHS 'Ready Steady Go' programme to support young people transitioning from children's services to adult services.

Seven-day services

- Consultants were available out-of-hours and actively encouraged nursing and junior medical staff to contact them if the need arose. Clinicians provided consultant presence until 7.00pm, Monday to Friday, with on-call arrangements thereafter. There were no reported problems accessing out-of-hours support.
- Children's services accessed diagnostic services such as the x-ray department, pharmacy and laboratory services during the weekend. Staff did not raise significant concerns over accessing these services.

Access to information

- Staff we spoke with told us they were readily able to access patient information and reports such as test results and x-rays. Ward clerks supported the children's ward and provided a seven-day service to ensure medical and nursing staff had access to the information and data they needed.
- Staff told us patient records were not always available, as they were stored off-site. Recent improvements meant the transfer of records had improved, for example, one nurse told us when she requested the notes of a child who had been admitted at night, and they arrived the next morning.
- Policies and guidelines were accessible on the trust intranet and staff we spoke with told us they had experienced no problems accessing this information.

Consent

- The trust had a 'consent to examination and treatment' policy, which included information specifically relating to children and young people. Staff we spoke with understood the Gillick competency guidelines and gave

examples of how they had applied it in practice. Staff explained that the consent process actively encouraged young people to be involved in decisions about their care.

- Staff we spoke with understood the Mental Capacity Act 2005 as it related to young people and consent to treatment. If they needed further advice, they told us they would contact the safeguarding team. Data provided by the trust showed 95% of staff from children's services had completed the appropriate training module.

Are services for children and young people caring?

Good

We rated caring as 'good' because:

- Children, young people, and parents told us they received compassionate care and emotional support from nursing and medical staff. There was a strong person-centred culture and staff worked in partnership with patients and their families.
- Parents felt fully informed about their child's condition and treatment, and staff empowered children and young people to be active participants in their own care. Staff also showed determination and creativity to overcome obstacles and deliver high quality, compassionate care.
- Feedback from patient surveys was positive. Children and young people answered several questions relating to their care. The highest scores across all age groups demonstrated staff were kind and treated patients and families with dignity and respect.

Compassionate care

- All staff we spoke with were very passionate about their roles and were clearly dedicated to making sure children and young people received the best patient-centred care possible. Throughout our inspection, we observed medical and nursing staff delivering compassionate and sensitive care that met the needs of children, young people, and families.
- We observed members of staff who had a positive and friendly approach towards children and parents. Staff explained what they were doing and took the time to speak with them, offering reassurance and support.
- In addition to promoting interaction with children and young people through play and activity, the play specialist supported children who were anxious and distressed by accompanying them to outpatient and radiology appointments. In some cases, the play specialist also supported them on the recovery ward following surgery.
- Services for children and young people participated in the national Friends and Family Test. Between January 2016 and January 2017, 83% of respondents said they would be extremely likely to recommend the children's ward, A&E, and the children's outpatient department to friends and family if they needed similar care or treatment.
- The patient experience team regularly gathered feedback from children, young people and families each month. Data was collated from different age groups, parents and carers. Between July 2016 and September 2016, adults caring for children under five years of age completed 188 surveys. Out of a possible score of 10, when asked if staff treated themselves and their child with dignity and respect, the score was 9.8. Other questions related to information, involvement, and care and the children's services team achieved 9.6 out of 10 overall.
- Survey questions for children aged between five and 11 asked children about their care, if staff were kind, if they felt safe and listened to, and if staff helped them to understand what was going to happen. Between July and September 2016, the overall score (out of 10) was 9.3. The highest score (9.6) indicated children felt the staff who looked after them were kind.
- Older children and young people between the ages of 12 and 18 also took part in the surveys. During the same period, 150 surveys were completed. Dignity and respect, and being treated with kindness and compassion received the highest scores. The overall average was 9.0 out of 10, slightly lower than other groups. The two questions which received the lowest score asked teenagers if they were offered time to be seen alone and if they were asked about keeping themselves well and safe.

Services for children and young people

Understanding and involvement of patients and those close to them

- Overall, parents we spoke with felt well informed about their child's condition and treatment. Medical and nursing staff communicated with children, young people and families openly and checked their understanding of the facts that were presented. In one example, a nurse explained to a young child the reasons for the administration of a naso-gastric feeding tube to their baby sibling. The nurse had recognised the child was feeling anxious due to a lack of understanding about the condition and treatment.
- Children and parents told us they saw medical and nursing staff regularly and they always introduced themselves by name.
- During periods of busy activity, one parent told us a nurse reassured her and encouraged her to use the call bell, advising her to 'keep buzzing' if a member of staff did not immediately respond. However, a small number of people we spoke with acknowledged staff did not always respond to call bells in a timely way.
- Parents of young children with diabetes participated in 'Tots-Tennis' events which were supported by nursing and other healthcare professionals from the trust. The events presented opportunities for education from diabetes nurses and dieticians, and psychologists met with families to provide psychosocial support.
- Children and families told us communication between staff and families was good. For example, one parent told us staff 'couldn't do enough' for them when their child was transferred to the local tertiary care hospital for specialist surgery. They felt informed and involved at every stage and staff made sure they were aware of all arrangements.
- Staff from the special care baby unit had developed 'pouches for parents' which comprised an information booklet (including why the child was being cared for on the unit, details of visiting, direct dial contact telephone numbers) and a teddy bear for use by the parents and baby as a bonding tool.

Emotional support

- Parents told us they felt staff understood the impact the condition and treatment had on their children. Parents told us staff constantly offered reassurances and support throughout the treatment process. Medical and nursing staff kept families informed at every stage and children and parents felt empowered to ask questions.
- Parents also told us they felt very confident their children were receiving the best care possible. They felt confident leaving their child on the ward, reassured their child was safe, supervised, and cared for.
- Support was available for children with long-term health conditions. All children and young people with diabetes had an annual assessment of their psychological well-being by the multi-disciplinary team responsible for their care. All newly diagnosed children were offered routine psychology appointments within one month.

Are services for children and young people responsive?

Good

We rated responsive as 'good' because:

- Managers and staff planned and delivered services to meet the needs of children and young people, and worked collaboratively with partner organisations and other agencies.
- Care and treatment was coordinated with other services and other providers, and the facilities and premises were appropriate for children and young people. The service also provided facilities for parents to remain with their child during the night.
- Children and young people were able to access the right care at the right time. Ward occupancy rates were low and there were no reported issues with referral to treatment or waiting times in clinic, and consultants reviewed children within 14 hours of admission.
- The service provided appropriate pathways to support young people transitioning to adult services and ensured appropriate provision of care for children with chronic, long-term conditions and those in receipt of end-of-life care.
- There was an open and transparent approach to handling complaints. Information about how to make a formal complaint was widely available however; families tended to contact the service directly when they had a concern.

Services for children and young people

Service planning and delivery to meet the needs of local people

- Senior managers worked collaboratively with the Cumbria Clinical Commissioning Group (CCG), the West North and East Cumbria Success Regime, Cumbria Partnership NHS Foundation Trust, Cumbria County Council, North West Ambulance Service, NHS England and neighbouring NHS Foundation Trusts to develop a business case to remodel services for children and young people. The primary aim was to ensure services were safe by creating a one-team sustainable integrated service across both acute sites.
- Managers acknowledged developing such an integrated model of care meant the service was better able to respond to the demands upon it. This included the needs of its population, geography, local infrastructure, and recruitment issues, and the evaluation of any reconfigured services would need to involve a 'whole-system' model across multi-agencies. The unit management team had developed several proposals and options to achieve the model, which have since been incorporated into the wider strategy of the Success Regime.
- Managers and staff also worked with other NHS providers to ensure services were flexible, provided choice and ensured continuity of care. For example, the unit had successfully submitted a bid to the Children's Heart Unit Fund (CHUF) to purchase paediatric ECHO probes for new machines that the cardiology team had procured. Senior clinicians were working with representatives from the specialist paediatric centre in Newcastle to establish paediatric cardiology outreach clinics in North Cumbria.
- The facilities and environment in the children's ward and outpatient department were suitable for children and young people. There was also a child-friendly waiting area and treatment rooms in the A&E department. However, children and young people also accessed the main outpatient department for specific clinics. We found the quality of the waiting areas varied. For example, there was no dedicated waiting area or treatment room for ENT clinics however, the facilities for children attending ophthalmology clinics were appropriate. We spoke with a nurse from ENT who told us there were plans to improve the waiting area and treatment rooms to meet the needs of children and young people.

Meeting people's individual needs

- The children's outpatient department provided a range of specialist clinics to meet the needs of children and young people. These included cystic fibrosis, rheumatology, respiratory medicine, ophthalmology, and diabetes. Clinicians also held diabetes outreach clinics in different venues across the county.
- Leaflets for children and families were widely available in the ward and outpatient areas; however, one nurse told us information was not readily available in other languages. In relation to interpreting services, although the majority of staff told us they had not needed to access an interpreter, they could describe the process. There were no reported problems.
- There were appropriate facilities for parents and carers who chose to stay overnight. The children's ward offered a fold away camp bed so parents could sleep beside their child while they were in hospital. There were also facilities for parents and carers to wash and dress. At Cumberland Infirmary, there was a dedicated sitting room where parents and carers could make drinks and snacks.
- There were arrangements to support children and young people with complex needs or who required psychiatric support. The child and adolescent mental health service (CAMHS) was provided by the local community NHS trust. Staff from CAMHS visited the ward once a referral had been received from a clinician. Staff we spoke with told us CAMHS usually visited the same day or the following day if a child or young person had been admitted the previous evening.
- Staff did acknowledge it was difficult to access CAMHS support at a weekend or out-of-hours .The children's ward had experienced a number of inappropriate admissions due to a lack of mental health beds across the county. In the last 12 months, there had been 27 young people admitted inappropriately across both sites. Of these, eight related to CIC. Staff told us that they reported each occurrence as an incident to highlight the ongoing demand for improved provision of care for children and young people suffering from mental health problems. To mitigate any risk and to ensure staff from the children's ward provided appropriate care, nurses had received additional training, which included suicide prevention and mental health in adolescents.
- Clinicians and managers were developing a local specialist epilepsy clinic, supported by a paediatrician

with a specialist interest and a community paediatric epilepsy nurse specialist. The purpose was to improve services for children and families and meet epilepsy best practice standards.

- The trust followed NHS England's 'Ready Steady Go' programme to support young people transitioning to adult services. For example, all young people from age 16, who suffered from diabetes, completed the "Ready" questionnaire prior to attending their first transition clinic. The "Steady" and "Go" questionnaires were provided during the transition clinics to inform discussion and to ensure young people knew what to expect when transferring to the adult diabetes service. Staff provided young people with a welcome pamphlet describing the adult service and a 'Starting Uni with Diabetes' booklet produced by Diabetes UK. Paediatric dietitians were also available to provide input with young people and their families at transition clinics.
- The children's ward had good links with a local hospice caring for children who were in receipt of end-of-life care. Medical and nursing staff met with hospice staff to discuss the needs of children who may require acute care.
- A play specialist was available five days a week. Children and families we spoke with described them as 'fantastic' and we saw children interacting with them positively and confidently. The play specialist also ensured older children were included in all activities.

Access and flow

- Children and young people were admitted to the children's ward through A&E or via a direct referral from a GP. Some children and young people were granted long-term open access to the ward, particularly those suffering from chronic conditions.
- There were 1779 admissions to the children's ward and 228 admissions to the children's assessment unit between June 2016 and November 2016. Out of 2930 available beds during this period, the ward occupancy rate was 54%, which equated to 1578 occupied beds.
- There was an escalation policy when the number of patients exceeded the number of available beds. Staff we spoke with could explain what actions they would take in such an event. Ward managers at both hospital sites also had regular contact with each other throughout each day to maintain oversight of bed capacity on each ward.
- There were 137 admissions to SCBU during the same period. Out of 2484 available cot spaces, the occupancy rate was 37% (911 occupied beds).
- We spoke with children and families in the children's outpatients department who told us they never waited very long see a doctor, in the unit or for an appointment following a referral from their GP. We requested statistical data from the trust in relation to actual clinic referral to treatment times however; we did not receive any information to include in this report.
- A senior nurse told us there had been an increase in the number of children who did not attend (DNA) outpatient appointments. Between June 2016 and November 2016, the DNA rate at Cumberland Infirmary was 16.4% (from 586 attendances). Staff could explain the process outlined in the DNA policy when a child or young person did not attend and told us what action they would take. One of the paediatric consultants was currently undertaking an audit to investigate and identify any themes.
- On all of the records we reviewed, a consultant saw a child or young person within 14 hours of admission.

Learning from complaints and concerns

- Services for children and young people received 45 Patient Advice and Liaison Service (PALS) enquires between August 2015 and July 2016. Cumberland Infirmary received three complaints in the same period, two of which were concluded in a 30-day window. Overall, complaints received by the service were low.
- Parents we spoke with told us they felt they could raise concerns if they felt they wanted to and told us they knew how to make a complaint. There were posters and leaflets in visiting areas about how people could raise concerns. Staff explained, in most cases, parents spoke to nurses on the ward and issues tended to be resolved informally.

Are services for children and young people well-led?

Good

We rated well-led as 'good' because:

- The leadership, governance, and culture promoted the delivery of high quality person-centred care.

- There was a clear strategy for the unit. This was consistent with the trust vision, which was linked to the Success Regime agenda to review proposals for the improvement and sustainability of the service. However, the vision and strategy for the service had not been fully cascaded and completely understood by ward-based staff.
- The service had an embedded governance and assurance structure, which had patient safety, risk management, and quality measurement at its core. Managers understood the key priorities within the unit and developed proposals and action plans to mitigate risk and manage performance.
- Managers and leaders were visible, and there was a real strength, passion, and resilience within ward based staff to deliver quality care to children, young people and their families. Staff told us they were proud to work for the trust and promoted a patient-centred culture.

Vision and strategy for this service

- The Child Health Clinical Business Unit strategy aligned with the trust vision to provide patient- centred and high-quality healthcare services underpinned by the values of patient's first, safe and high quality care, recognition of the importance of wider contribution, responsibility, accountability and respect.
- The management team, in conjunction with trust executives, developed an internal success regime implementation plan in which they highlighted eight objectives to support the changes being considered. These priorities focussed on developing self-care pathways, clarifying routes to access services, development of an integrated approach to the management of the sick child, plans for the management of long term conditions, complex needs and vulnerable children, improving mental health services, improving multi-disciplinary working and optimising the use of telecommunication technology.
- The inspection team noted the options, which had been set out for paediatric services across North, East and West Cumbria as part of the success regime, which were currently being formally consulted on. Proposals included a consultant-led paediatric inpatient service at Cumberland Infirmary and a short-stay paediatric assessment unit and nurse-led unit for low acuity beds at West Cumberland Hospital.
- The leadership team from the unit were clear about the strategic options being considered however, ward staff at Cumberland Infirmary had a varying degree of awareness surrounding the proposals for the future of children's services in the trust.
- Staff we spoke with were all clear in their understanding of the overarching trust vision and values. We saw posters displaying the values in areas around the hospital. Staff at all levels also understood the priorities of their own service.
- Managers reviewed the progress of the business plan at regular unit level governance and operational meetings, involving medical, nursing, and managerial staff groups.

Governance, risk management and quality measurement

- The Child Health Business Unit held cross-site monthly governance and operational board meetings chaired by the governance lead and clinical director respectively. Each group was well attended. The governance group considered compliance, safety, standards, experience, risk, audits, education, safeguarding and exception reports. Attendees developed action plans following each meeting, which they discussed at the next. Minutes from these meetings were accessible on the trust intranet, displayed on wards and discussed at ward level gatherings.
- The operational board held cross-site monthly meetings. Standard agenda items included action logs, finance, performance dashboards, human resource matters, site-specific issues and team brief cascades. Meeting minutes recorded specific actions and lessons learnt, for example, the provision of fire evacuation pods for the wards and SCBU and learning from issues staff had with infusion pumps.
- Nursing and medical staff also represented the unit at the patient safety panel where incidents, incident themes, complaints, and serious incident investigations were discussed.
- The service received good exposure at Board meetings and in view of its positioning within the Success Regime.
- There was a comprehensive risk register across the business unit with 36 identified risks, seven of which were rated 'red'. These included service resilience, a lack of community paediatric clinicians increasing out-patient attendances, transfer of babies who

required high dependency care, lack of 24 hour senior medical cover, unavailability of clinical records for review at clinics and adherence to 'Safer Children (2007) guidelines regarding on-site senior cover.

- Staff regularly reviewed identified risks at governance meetings and managers recorded progress against each risk along with risk controls, gaps in controls and assurance measures within the risk register. There was evidence of re-evaluation of risk grading and ongoing review.
- We saw evidence of an ongoing programme of internal quality audits and NICE guideline reviews undertaken routinely across children's service to ensure safe and effective care. Clinical leads told us they felt the governance and level of audit activity across the service and the trust was very robust. The unit did not have a dedicated consultant to lead on clinical audit however; the unit governance group allocated audit activity and monitored progress.
- Following previous inspection activity, the unit developed a strategic performance improvement plan, identifying key priorities aligned to the domains of safe, effective, caring, responsive and well-led. These plans provided very detailed improvement projects, for example, ward compliance with PEWS and more strategic plans such as integrated working with community based services. The plans used SMART principles (specific, measureable, action, results and timing), outcomes/metrics and considered financial implications of each priority. The unit also extended the reach of the plan to address financial, strategic and partnership working aims.
- There was evidence of good working relationships with other trusts and organisations across the region, for example, community partners, specialist service providers, and neighbouring NHS trusts.
- SCBU worked closely with the Northern Neonatal Network. The team submitted data from the service to BadgerNet, the network reporting system, which informed quarterly analysis reports about neonatal services across the region.
- Unit managers captured quality measurements and key performance indicators on the governance dashboard such as admission data, staffing, incidents, and risks.
- Staff told us they were encouraged to report incidents and near misses, concerns from patients and identify risks to the organisation. However, there was varying levels of confidence from staff in SCBU that managers were taking appropriate action to address the issues raised. Patient Safety issues were cascaded into daily handovers and ward meetings.

Leadership of service

- Staff told us the executive team were visible and had visited the wards. The executive team, senior clinicians, and ward staff completed a detailed '15 Steps' (safety and quality assessment tool) in July 2016.
- Generally, staff felt managers were supportive and part of the team. They felt there was a clear management structure across the unit. If there was any conflict within the service, they would go to their ward manager and seek support.
- Senior staff were clear about their responsibilities toward their staff. They spoke about the importance of listening to staff concerns, being open and honest about the reality of issues affecting their wellbeing such as recruitment difficulties and supporting the ward in the delivery of safe care.
- The unit had recently appointed a new operational service manager, which saw the existing appointee move into the clinical matron role. This transition had caused some disharmony and unsettled a number of staff on SCBU. Staff did acknowledge the new operational service manager to be approachable and open to hearing from staff about a range of issues.
- During this transition, staff in SCBU expressed concerns about the unit leadership not taking timely action to address workforce issues and succession planning at senior nurse level.
- Managers recognised the strength and resilience of their ward based teams and their commitment to the service, especially during difficult periods. They acknowledged a strong 'team' ethos however, some staff felt as though the unit leadership took them for granted with no recognition of their efforts.

Culture within the service

- Medical and nursing staff were, on the whole, proud about working for the trust although they did not always feel valued and respected.
- Staff spoke positively about their role, their team and the care provided. Some of the comments we heard included 'I feel proud to work in this team' and 'I feel as though I deliver great care'. Staff we spoke with

recommended the trust as a place to work. Medical and nursing staff reported no bullying, intimidation or harassment behaviour from managers or colleagues although acknowledged tensions run high on occasions.
- We found the ward culture was positive and everyone agreed the needs of the children and their families were the top priority for the unit.
- Ward based staff worked well together and there were positive working relationships between the multidisciplinary teams and other services involved in the delivery of care for children. Staff also told us they felt safe to question and challenge their peers on the ward.
- Staff felt the organisation could do more to listen to staff concerns to support health and wellbeing as this would bring individual, team and unit benefits.
- We spoke with staff who told us about the physical and emotional pressures they experienced caring for very sick children and babies. Staff talked about the supportive and informal ward based debriefs and reflective practice sessions to help deal with stress associated with the role.

Public engagement

- Medical and nursing staff engaged daily with the children and young people in their care and ensured parents were included. We saw evidence of positive and caring interactions between staff of all grades with the children and their families.
- Staff invited formal and informal feedback from children, young people, and families through ward satisfaction and patient experience surveys. The child, parent, or both could complete a number of the surveys and staff displayed the feedback on accessible notice boards in a child-friendly format. Recognising that some children were too poorly to put their thoughts in writing, staff also engaged with them face-to-face to capture their views.
- SCBU had set up parent support and breast-feeding support groups. The unit had built strong working relationships with Surestart and Barnardos.

Staff engagement

- The unit provided GMC Survey findings for 2016 (trainee responses regarding training programmes under four categories of learning environment and culture, governance, support to learners and developing and implementing curriculum and assessment). There were varying results across the domains. In 11 of the 15 sub-sections, the unit achieved the same results as other trusts. In the remaining four, the unit were below outcome in two (clinical supervision) and above outcome in two (local and regional training).
- Staff told us they were encouraged to participate and contribute to new developments in the service. Staff on SCBU had proactively participated in the BLISS accreditation application process (a scheme to ensure babies received the best neonatal care and treatment).
- The trust communications team distributed regular bulletins, newsletters and uploaded trust information onto the intranet for staff access.

Innovation, improvement and sustainability

- The unit was actively involved and engaged in the trust quality improvement plans 2016/17. This identified 17 work streams which required a more detailed improvement focus. In children's services, the unit concentrated on improving the management of the deteriorating child (use of PEWS and sepsis policy), workforce planning and recruitment, reporting incidents and supporting a safe and learning culture.
- The unit was involved in some limited cost improvement projects (CIPs) around a review of administrative functions, and continually monitored and reviewed financial spend.
- SCBU was working towards BLISS accreditation. The pre-BLISS visit assessment confirmed overall compliance in excess of 93% which indicated the team would be successful in its bid. The formal visit from BLISS champions and auditors was pending at the time of our inspection.
- The unit was successful in achieving the 'UNICEF UK Baby Friendly Initiative' Stage 1 in recognition of its work to meet key neonatal care standards.
- The unit had secured funding to develop PEWS and SBAR cards for all paediatric staff as a personal reference source to improve patient safety and effective communications.
- The unit was working closely with partners under the Success Regime to review children's services to ensure an improved and sustainable model of care for the local people.

End of life care

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

Information about the service

Cumberland Infirmary is part of North Cumbria University Hospital Trust (NCUH). Patients at the end of life were nursed on general hospital wards. Between April 2015 and March 2016 there had been 1,185 in-patient deaths across the three hospital sites within the trust as a whole.

The Specialist Palliative Care Team (SPCT) service at NCUH is commissioned by Cumbria Clinical Commissioning Group and is delivered in the Trust by staff from Cumbria Partnership NHS Trust. The Specialist Palliative Care Team (SPCT) at Cumberland Infirmary comprised of one 0.8 whole time equivalent (WTE) consultant post shared with the community and the Loweswater Suite with two sessions per week of hospital support. One 0.8 WTE staff grade doctor who mainly worked in the Loweswater Suite, and two WTE Macmillan nurse.

An End of Life Care team was established at NCUH and consisted of a Lead Bereavement Nurse, chaplain and a bereavement officer.

The (SPCT) worked collaboratively with clinical teams to support end of life care and there were good working relationships throughout the two hospitals particularly with the acute oncology services. The SPCT offered a five-day a week service. Cover after 5.30pm and at weekends was provided via telephone advice by the local Eden Valley Hospice.

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

During this inspection we visited a number of inpatient wards including acute, elderly care, respiratory, general medicine, oncology, gastroenterology and general surgery. In addition we visited the chapel, the bereavement office, and the hospital mortuary. We observed care and viewed thirteen care records including three where patients were being cared for using the care of the dying patient (CDP) care plan. We spoke with three patients and two relatives. We also spoke with a range of staff including the SPC consultant, SPC clinical nurse specialists, the chaplain, a mortuary manager, one porter, and ward-based medical and nursing staff. In total we spoke with 18 staff members. We looked at policies and procedures and reviewed performance information about the trust.

End of life care

Summary of findings

During our last inspection of End of Life Care Services at Cumberland Infirmary in April 2015 we rated 'requires improvement' overall. At this inspection there was evidence of ongoing improvement. We rated the service as 'good' overall with effective as 'requires improvement' because:

- Staff delivering end of life and specialist palliative care understood their responsibilities with regard to reporting incidents. Staff we spoke with told us that when an incident occurred it would be recorded on an electronic system for reporting incidents.
- We viewed mortuary protocols and spoke with mortuary and porter staff about the transfer of the deceased. Staff told us that the equipment available for the transfer of the deceased was adequate and we saw that this included bariatric equipment.
- The trust had developed a care of the dying patient (CDP) care plan that provided prompts and guidance for ward based staff when caring for someone at the end of life. We observed the use of these and saw that information was recorded and shared appropriately and that the plans were completed.
- We saw that the specialist palliative care nurses worked closely with medical staff on the wards to support the prescription of anticipatory medicines The guidance the specialist nurses provided was in line with the end of life care guidelines and was delivered in a way that focused on developing practice and confidence in junior doctors around prescribing anticipatory medicines.
- The palliative care end of life communication training (Sage and Thyme) is part of the mandatory training for all staff at Cumberland Infirmary.
- We observed the use of McKinley syringe drivers on the wards and saw that regular administration safety checks were being recorded. Ward staff told us that syringe drivers were available when they needed them.
- The trust had also introduced the "Care after Death" document. The document provided a standard operating procedure for healthcare staff to understand end of life extends beyond death to provide care for the deceased person and support to their family and carers.
- An early warning scoring system was in use throughout the trust to alert staff to deteriorations in a patient's condition. Patient's recognised as being at the end of life had their care plan transferred to the care of the dying patient framework when they were expected to die within a few days.
- The Trust had an organ donation policy, which adhered to national guidelines. The framework process made reference to specialist nurses, clinicians and nursing staff supporting the family throughout the process.
- Staffs were able to demonstrate compassion, respect and an understanding of preserving the dignity and privacy of patients following death. Mortuary staff told us there was always a member of staff on call out-of-hours. This service was available for families who requested to visit during an evening or a weekend.
- Porters had face to face mortuary training that included the transfer of the deceased including promoting dignity and respect and an understanding of bereavement.
- The chaplaincy service provided spiritual support for patients and their families together with the Bereavement Nurse Specialist
- The trust ensured that there was timely identification of patients requiring end of life care on admission. Systems were in place where a patient admitted who was known to the palliative care team would generate an alert to the team.
- We observed staff caring for patients in a way that respected their individual choices and beliefs and we saw that records included sections to record patient choices and beliefs so that these were widely communicated between the teams.
- An Integrated End of Life and Bereavement group was now in operation. This was headed by the Deputy Director of nursing the members of the group the SPCT, chaplaincy, the bereavement lead, education and training and consultant medical staff.
- The trust had developed "Welcome to Hospice at Home – West Cumbria" initiative. All services provided are free of charge This service included the provision daytime and night nursing care, Respite Care - day, evening or night and also volunteer support in the home They can also refer patients to

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other services within the organisation including complementary therapies for patients, carers and those bereaved, one to one or group support, bereavement support and Lymphedema support. All services provided are free of charge
- The specialist palliative care team developed a care pathway tool for patients in all areas of the hospital. This was to ensure that patients who required end of life care. Patients were identified at the earliest opportunity and to facilitate the most appropriate care in the most appropriate place for each patient.
- A clear vision had been established where 'All people who die in Cumbria are treated with dignity, respect and compassion at the end of their lives and that regardless of age, gender, disease or care setting they will have access to integrated, person-centred, needs based services to minimise pain and suffering and optimise quality of life.
- The aim of this strategy is to provide a framework for the delivery of services that will allow all adults in Cumbria who are approaching the end of their life, "to live as well as possible until they die" in accordance with their own wishes and preferences.
- The Lead Bereavement Nurse and the chaplain had leadership roles in terms of end of life care and raising awareness of aspects of their service across the trust. This involved attending meetings and working collaboratively across services and departments to raise awareness of end of life care issues.
- There was a commitment at all levels within the trust to raise the profile of death and dying and end of life care. This included improving ways in which conversations about dying were held and engaging with patients and their families to ensure their choices and wishes were achieved.
- Discharge coordinators were available to support the process of rapid discharge at the end of life and the trust had recently implemented a community service where patients could be supported by trust staff in their own homes where care packages were difficult to access in the community.

However:

- For patients who did not have mental capacity, DNACPR forms we viewed at this inspection were inconsistently completed. We saw DNACPR forms that did not provide evidence of a best interest decision or a mental capacity assessment being undertaken and recorded. In a letter to CQC, the trust formally acknowledged our concerns and outlined the actions to be taken to address this issue.
- The trust had not achieved two indicators in the End of life care Audit: Dying in Hospital in 2016
- The trust had not achieved three organisational indicators, in the End of Life Care Audit – Dying in Hospital 2016.
- The trust had not produced an action plan to address areas where performance was lower than the England average at the time of our inspection with key responsibilities and timelines for achievement.
- The trust could not provide the number of referrals to the SPCT.
- Both the SPCT and on general wards supported patient's to die in their preferred location. However the trust did not collate or hold the data that would demonstrate the number of patients who died in their preferred location. This was held by the Clinical Commissioning Group; however the trust could not provide this information.
- There was no regular audit of the CDP to demonstrate that the trust supports patient's to die in their preferred location.
- Specialist palliative care was not provided across a seven day service.
- The trust did not have formal contract meetings with members of the Cumbria Healthcare Alliance to monitor that the service being commissioned and provided is of an appropriate standard in terms of quality and meeting patient need.

End of life care

Are end of life care services safe?

Good

We rated safe as 'good' because:

- There were no serious incidents reported between September 2016 and August 2016.
- Staff were aware of reporting procedures and the importance of thorough analysis of incidents, duty of candour and sharing lessons learnt.
- The trust had adult safeguarding procedures, supported by mandatory staff training. Staff knew how to report and escalate concerns about patients who were at risk of neglect and abuse.
- Clinical areas were visibly clean, personal protective equipment and hand sanitiser was readily available and used.
- Waste was handled and disposed of in accordance to trust policy
- The mortuary was secured, monitored and accessible only to relevant staff. Mortuary records were complete and accurate.
- Appropriate anticipatory prescribing of medicines was used at the end of life.
- There was good identification of patients at risk of deterioration and identification of patients in the last days of life.
- Equipment was generally available for the care of patients at the end of life.
- Patient records were recorded on an electronic system, allowing notes to be clear, organised and legible.
- Staff assessed and responded to patient risks.

Incidents

- There had been no Never Events (a Never Event is a serious incident that is wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers).
- Staff delivering end of life and specialist palliative care understood their responsibilities with regard to reporting incidents. Staff we spoke with told us that when an incident occurred it would be recorded on an electronic system for reporting incidents.
- Each member of staff that we spoke with told us they were encouraged to report incidents, near misses and any incidents that had caused actual harm via the trust electronic incident reporting system.
- Feedback was given back through e-mail at ward meetings during handover and weekly updates. There were no incidents reported which specifically related to the care of patients at the end of their life.
- There had been no end of life care related Never Events reported in the last 12 months
- Staff told us that if an incident was related to a patient at the end of life then the palliative care team would be involved in the investigation and subsequent learning as a result.
- Staff we spoke with had an awareness of their responsibilities in relation to Duty of Candour.

Environment and equipment

- We visited the wards and found there were infection control and prevention systems in place to keep patients safe with appropriate signage around the wards.
- We saw staff had access to personal protective equipment (PPE), such as gloves and aprons and were seen to be using the equipment and facilities
- We saw there were hand wash basins, liquid soap, paper towels, hand gels and protective equipment available.
- We viewed mortuary protocols and spoke with mortuary and porter staff about the transfer of the deceased. Staff told us that the equipment available for the transfer of the deceased was adequate and we saw that this included bariatric equipment.
- The body store fridges were temperature monitored and alarmed. We saw that if the alarm was triggered this would alert reception staff who would contact the mortuary staff.
- We saw the mortuary was well equipped and that the capacity was adequate. We saw specialist equipment that included bariatric trolleys. We looked at records relating to cleaning rotas and equipment checks and saw these were updated regularly.
- We observed the use of McKinley syringe drivers on the wards and saw that regular administration safety checks were being recorded.
- We observed the use of McKinley syringe drivers on the wards and saw that regular administration safety checks were being recorded. Ward staff told us that syringe drivers were available when they needed them.

End of life care

Medicines

- Anticipatory end of life care medication (medication that patients may need to make them more comfortable).was appropriately prescribed. We saw that the specialist palliative care nurses worked closely with medical staff on the wards to support the prescription of anticipatory medicines The guidance the specialist nurses provided was in line with the end of life care guidelines and was delivered in a way that focused on developing practice and confidence in junior doctors around prescribing anticipatory medicines.
- We spoke with staff on the wards and the SPCT team who told us the system was effective and staff were confident patients would receive the appropriate medication even at short notice.
- There were clear guidelines on the trust's intranet for medical staff to follow when writing up anticipatory medicines for patients. The guidance included different treatment options for a range of symptoms that could be experienced at the end of life. This is medication that patients may need to make them more comfortable.
- We spoke with members of staff with regards to anticipatory medicines. These staff told us that patients requiring end of life care were written up for anticipatory medications. We examined the records of three patients receiving end of life care and found that anticipatory medicines had been appropriately prescribed.
- We observed staff witnessing, checking the identity of the patient and recording the administration of pain medicines to a patient at end of life.

Records

- The trust had developed a care of the dying patient (CDP) care plan that provided prompts and guidance for ward based staff when caring for someone at the end of life. We observed the use of these and saw that information was recorded and shared appropriately and that the plans were completed.
- Care plans reflected national guidance and included risk assessments such as those for the risk of falls or pressure area damage.
- The trust used a DNACPR (do not attempt cardio-pulmonary resuscitation) form that was used across Cumbria. They had audited the use of the forms in 2016 and had identified areas for improvement including the recording of discussions around DNACPR.
- We viewed 29 forms and they were generally completed well. All forms were kept at the front of the patient's notes, included clear documentation and clinical reasoning for the DNACPR decision. Decisions were appropriately recorded by a clinician and had been countersigned by a consultant.
- Records within the mortuary were comprehensive and included processes for appropriate checking.

Safeguarding

- We spoke with two members of staff in the specialist palliative care office about protecting people from the risk of abuse. The specialist palliative care team knew how to contact the safeguarding team via the Rainbow Centre. They also knew they could contact the local safeguarding team in and out-of-hours.
- Staff could give examples of what constituted a safeguarding concern and how they could raise an alert. Staff could give examples of what constituted a safeguarding concern and how they could raise an alert.

Mandatory training

- The Specialist Palliative Care Team (SPCT) service at NCUH was provided by the Cumberland Partnership Foundation Trust and was not directly employed by North Cumbria University Hospital Trust (NCUH).
- The palliative care end of life communication training (Sage and Thyme) is part of the mandatory training for all staff at Cumberland Infirmary.
- Sage and Thyme training included advanced communication skills training.
- Porters had face to face mortuary training that included the transfer of the deceased including promoting dignity and respect and an understanding of bereavement. One porter we spoke with told us that the training they received had helped them to feel more confident when transferring the deceased.

Assessing and responding to patient risk

- The hospital used a recognised national early warning score (MEWS) to monitor patients at risk of deteriorating clinical conditions. This was monitored through the electronic records system.
- We observed the use of general risk assessments on the wards, including those relating to the risk of falls, malnutrition and dehydration, the use of bed rails and the risk of pressure damage.

End of life care

- Assessment of risk in relation to nutrition and hydration, pressure ulcers and falls.
- Nursing, medical and therapy staff recorded daily changes to patients' conditions in their notes. In the community, advice and support regarding deteriorating patients was available from the SPCT.
- Patients were referred to the SPCT by staff on the wards by telephone or paper based referral. Nursing staff told us that if they were unsure they could ask for advice from the team and they were always helpful and supportive.
- Ward staff told us the SPCT team had a visible presence on the wards. Any changes to patient's conditions generally instigated a visit by the SPCT. We saw patient's daily notes by nursing, medical and therapy staff with updates on any changes recorded clearly.
- The SPCT held a weekly team meeting to discuss ongoing patient care.
- An early warning scoring system was in use throughout the trust to alert staff to deteriorations in a patient's condition. Patient's recognised as being at the end of life had their care plan transferred to the care of the dying patient framework when they were expected to die within a few days.

Nursing staffing

- The Cumbria Partnership Trusts' Specialist Palliative Care Team (SPCT) provided nursing services to North Cumbria University Hospitals NHS Trust through the Northern England Strategic Clinical Network (NESCN) agreement.
- The SPCT worked collaboratively with clinical teams to support end of life care. The SPCT aim was to provide the best quality of life for patients and their families.
- In addition to specialist palliative care nurses the trust had appointed a Bereavement Liaison Nurse Specialist and also a bereavement officer.
- Specialist palliative care nurses worked closely with ward based nurses and wards had end of life care link nurses.
- Specialist palliative care attended ward rounds to provide support to ward staff around end of life care issues.

Medical staffing

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

Major incident awareness and training

- The trust had a major incident awareness plan which detailed how all departments to respond in the event of a major incident.
- Staff had an understanding of the major incident plan.

Are end of life care services effective?

Requires improvement

We rated effective as 'requires improvement' because:

- For patients who did not have mental capacity, DNACPR forms we viewed at this inspection were inconsistently completed. We saw DNACPR forms that did not provide evidence of a best interest decision or a mental capacity assessment being undertaken and recorded. In a letter to CQC, the trust formally acknowledged our concerns and outlined the actions to be taken to address this issue.
- The trust had last completed a DNACPR audit in 2015.
- The trust had not achieved two indicators in the End of life care Audit: Dying in Hospital in 2016
- The trust did not achieve three organisational indicators, in the End of Life Care Audit – Dying in Hospital 2016.
- The trust had not produced an action plan to address areas where performance was lower than the England average at the time of our inspection with key responsibilities and timelines for achievement.
- Specialist palliative care was not provided across a seven day service.

However:

- We saw a care of the dying patient document that was being consistently used as a guide to delivering good quality end of life care.

End of life care

- Patients in need of end of life care were identified at an early stage in their care and staff were alerted to patients admitted who were known to the team Patient's symptoms including pain were managed and medication was prescribed for anticipatory medicines
- Patients were properly assessed and supported with their nutritional needs.
- Patients, and their relatives, gave positive feedback about the quality of care and the resources available at the hospital.
- EOLC provision involved the chaplaincy, who addressed the spiritual needs of people of all faiths, or none.

Evidence-based care and treatment

- The trust had introduced a 'caring for the dying patient' (CDP) care plan. The plan had been adapted from strategic clinical network guidance and was based on national guidance. Sources included the supporting documentation and care plans for End of Life care we saw had been developed by the Northern England Strategic Network.
- We saw that the CDP documentation had included national guidance from sources such as the Leadership Alliance for the Care of Dying People, the Department of Health End of Life care Strategy, and the National Institute of Clinical Excellence (NICE).
- The guidance included identifying patients at the end of life, holistic assessment, advance care planning, coordinated care, involvement of the patient and those close to them and the management of pain and other symptoms.
- The CDP document had been implemented to replace the Liverpool Care Pathway that had been discontinued in 2014.
- The trust had introduced the "When Someone is Dying Booklet". This booklet provided information for families and others in relation to caring for a person at the end of their life. This booklet contained information concerning symptoms that may be experienced, the care and support which may be given and also some questions that have been frequently asked at this difficult time.
- The trust had also introduced the "Care after Death" document. The document provided a standard operating procedure for healthcare staff to understand end of life extends beyond death to provide care for the deceased person and support to their family and carers.
- The trust participated in the End of life care Audit: Dying in Hospital 2016. We looked at the results from 'Is there documented evidence in the last 24 hours of life of a holistic assessment of the patient's needs regarding an individual plan of care'? The National Care of the Dying Audit in Hospitals (NCDAH) March 2016 showed that the trust performed below the national average in this area at 44% compared with the national average of 66%.
- The Trust had an organ donation policy, which adhered to national guidelines. The framework process made reference to specialist nurses, clinicians and nursing staff supporting the family throughout the process.

Pain relief

- Patients who were considered to be in the last days/ weeks of life were appropriately prescribed anticipatory medicines for the symptoms sometimes experienced at the end of life, including pain.
- Staff told us there were adequate stocks of appropriate medicines for end of life care and that these were available as needed both during the day and out-of-hours.
- We found that patients received good pain relief. Patients and relatives told us that their pain was under control and we saw that pain relief was administered in a timely manner. We did not observe any patients in pain during our inspection.
- Patients and relatives we spoke with told us that the nursing staff supported them well in managing their pain.
- Patients within end of life care services had their pain control reviewed daily. Regular pain medication was prescribed in addition to 'when required medication' (PRN), which was prescribed to manage any breakthrough pain.
- Care plans included pain assessment prompts and clear records of pain assessments.
- 'Just in case' medicines were prescribed appropriately for patients at the end of life.

Nutrition and hydration

- The 'MUST' Nutritional Screening and Assessment Tool was used. Staff were aware that nutrition and hydration plans at the end of life were focused on quality of life issues.
- The CDP document included an assessment of patient's nutrition and hydration status and guidance that it is the patient's choice to eat and drink, even if they have swallowing difficulties.

End of life care

- We observed staff on the wards offering patients food and drinks and encouraging relatives to be involved in that part of a patient's care as appropriate, including the administration of mouth care when a patient was no longer able to eat and drink.
- Palliative care staff worked closely with ward staff in the assessment of patient's needs in relation to nutrition, hydration and mouth care.
- Staff we spoke with told us they were led by the patient's wishes at the end of life with regard to nutrition and hydration. Staff gave us examples of where catering staff had worked with them to provide patients with food that they wanted and prepared food in a way that they could tolerate.
- The trust had completed a nutrition and hydration audit in Q3 2016. The audit provided evidence that 100% of patients had a documented assessment of their ability to eat in the last 24 hours of life, 24 % of patients were supported to eat, whilst 22% attempted to eat in their last 24 hours of life.
- Staff told us that snacks were available for patients throughout the day and night.

Patient outcomes

- The trust participated in the End of life care Audit: Dying in Hospital 2016 and performed similar to the England average for three of the five clinical indicators. The two indicators below the England average were:
- The trust scored 35% compared to the England average of 56% for 'Is there documented evidence that the needs of the person(s) important to the patient were asked about?'
- The trust scored 44% compared to the England average of 66% for 'Is there documented evidence in the last 24 hours of life of a holistic assessment of the patient's needs regarding an individual plan of care?'
- The trust answered yes to five of the eight organisational indicators. The trust answered no to the following questions:
- 'Did your trust seek bereaved relatives' or friends' views during the last 2 financial years (i.e. from 1 April 2013 to 31 March 2015)?'
- 'Was there face-to-face access to specialist palliative care for at least 9am to 5pm, Monday to Sunday?'
- 'Does your trust have one or more end of life care facilitators as of 1 May 2015?'
- The trust had not produced an action plan to address areas where performance was lower than the England average at the time of our inspection.
- Ward staff said the specialist palliative care team (SPCT) normally responded within 24 hours to referrals.
- The trust ensured that there was timely identification of patients requiring end of life care on admission. Systems were in place where a patient admitted who was known to the palliative care team would generate an alert to the team.

Competent staff

- The trust provided end of life communication skills training (Sage and Thyme) mandatory training to all staff.
- The specialist palliative care team provided a range of specialist training to general staff caring for patients at the end of life. This included training on symptom control, spiritual support, bereavement support and communication skills.
- There were formal seminars for medical students, Foundation Year 1 doctors, Foundation Year 2 doctors, and Specialist Registrars on a variety of topics, such as symptom control and communication skills, including 'breaking bad news'.
- Ward staff told us that the specialist nurses would support them in caring for patients at the end of life when needed, all staff told us the specialist team were accessible and supportive.
- Porters received training on induction and on an ongoing basis from mortuary staff around the transfer of the deceased to the mortuary. This included aspects of dignity and respect and well as communication with the bereaved.

Multidisciplinary working

- Weekly MDT meetings were held at where trust specialist palliative care staff would attend to discuss their most complex patients.
- We were told that the palliative care consultants on the West Cumberland and Cumberland Infirmary sites used a video conference MDT based in the community for complex cases and peer support.
- Specialist palliative care staff would attend regular ward based meetings including 'board rounds' as part of their routine visits to review patients on the wards. This enabled them to work closely with medical and nursing staff on the wards to support patients at the end of life.

End of life care

- Consultant staff from the SPCT attended some of the MDT meetings such as oncology and respiratory meetings.

Seven-day services

· The trust provided access to Specialist Palliative Care 9-5 five days a week and therefore did not provide a seven day face to face service.

- Cover after 5.30pm and at weekends was provided via telephone advice operated by Cumberland Partnership Foundation Trust.
- Out-of-hours telephone support was also provided by the Eden Valley Hospice.
- The chaplaincy service provided pastoral and spiritual support, and was contactable out-of-hours on a 24 hour basis.

Access to information

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a policy in place relating to consent. This included advance decision making, mental capacity guidance and best interest decision making and the use of Independent Mental Capacity Advocates (IMCAs).
- Staff we spoke with had all undertaken MCA and Deprivation of Liberty Standards (DoLS).
- We viewed 29 forms and found 16 of those were generally completed well. Of the other 13 forms we viewed, for patients who did not have mental capacity, records were inconsistently completed. We saw DNACPR forms that did not provide evidence of a best interest decision or a mental capacity assessment being undertaken and recorded.

Are end of life care services caring?

Good

We rated caring as 'good' because:

- Relatives we spoke with told us their loved ones had all their care needs met by dedicated staff and they were involved with their loved ones care and felt supported in making decisions as a family.
- The mortuary department provided out-of-hours support for families who requested a viewing of their relative.
- Staff were very supportive to both patients and those close to them and offered emotional support to provide comfort and reassurance.
- Care and support was clearly a priority for patients and relatives.
- In all interactions staff treated patients and relatives with dignity and respect.
- Staff were motivated to offer care that was kind and promotes people's dignity. Relationships between people who use the service, those close to them and staff were strong, caring and supportive. These relationships were highly valued by people and their families.
- Patients and their relatives had good emotional support from the specialist palliative care team, chaplaincy, and bereavement office and ward staff.
- We saw staff maintained the privacy and dignity of patients. They took opportunities to further inform the patient and their family of the situation.

Compassionate care

- Staff were caring and compassionate. We observed communication between staff and patients and their relatives and saw that staff were caring and respectful.
- We observed staff caring for patients in a way that respected their individual choices and beliefs and we saw that records included sections to record patient choices and beliefs so that these were widely communicated between the teams.
- The trust provided Sage and Thyme communication skills training for all staff.

End of life care

- We spoke with mortuary staff who told us they work closely with family members regarding care after death and all mortuary staff had attended bereavement training.
- Staff were able to demonstrate compassion, respect and an understanding of preserving the dignity and privacy of patients following death. Mortuary staff told us there was always a member of staff on call out-of-hours. This service was available for families who requested to visit during an evening or a weekend.
- We saw a dedicated chaplain for Cumberland Infirmary who demonstrated a good understanding of the issues relating to end of life care and showed compassion and respect. We spoke with the chaplain who told us they had recently joined the trust. One of their aims was to increase the number of volunteers. The recruitment of chaplaincy volunteers would involve interviews, disclosure and barring service (DBS) checks, and reference checks prior to them starting in their roles.
- Families and friends of patients at the end of life could access car parking concessions and open visiting was available.
- We saw that the care of the dying patient document used by the trust included prompts to assist them with patients and their relatives.
- We saw that bereavement packs were available in the ward areas with information about access to support.

Understanding and involvement of patients and those close to them

- Patients and family members we spoke with told us they felt involved in the care delivered.
- Staff discussions with patients and relatives about care issues were clearly recorded in patients' notes.
- The caring for the dying patient document used by the trust included prompts for discussing issues of care with patients and relatives.
- We observed multiple discussions between patients and nursing, medical and allied health professionals that were caring and considered the wishes of the patient.
- The trust produced an Audit report for compliance of end of life care against the standards of priorities for care of the dying person. There was documented evidence that 50% (an increase of 17% from the previous year) of patients had the opportunity to have questions or concerns listened to and 46% (an increase of 13% from the previous year) were given the opportunity to have questions about their concerns answered.

Emotional support

- The chaplaincy team worked with ward staff and other professionals for patients receiving end of life care.
- The Lead Bereavement Nurse and attended the Bereavement and End of Life Group meetings and was instrumental in developing the end of life strategy and documentation.
- Chaplains would sometimes accompany relatives to the mortuary and we saw that chaplaincy support was a part of the trust major incident plan. Chaplaincy staff told us they were available to provide emotional support to patients, relatives, visitors and staff alike.
- The chaplaincy service provided spiritual support for patients and their families together with the Bereavement Nurse Specialist.
- The specialist palliative care team, the chaplaincy staff and ward based staff provided emotional support to patients and relatives.
- During our inspection we visited the newly renovated bereavement centre we were told this would be opening within the next month.
- Staff in all ward areas told us they had sufficient staffing levels which enabled them to provide end of life care which included emotional support.
- Throughout our inspection we saw that staff were responsive to the emotional needs of patients and their visitors.

Are end of life care services responsive?

Good

We rated responsive as 'good' because:

- The palliative care team was available for referrals throughout a patient's treatment and was easily contactable.
- Members of the EOLC team and staff with experience in caring for end of life care patients attended specialist training, such as dementia awareness
- End of life patients had access to side rooms when they were available.

End of life care

- The bereavement team provided a follow up scheme for additional support for families.
- End of life care patients were identified in a timely manner.
- The hospital had a discharge team who were proactive to discharge patients, who wished to die at home, as quickly as possible.
- The mortuary provided care for the individual needs of the deceased patient and their families.
- The trust had developed "Welcome to Hospice at Home – West Cumbria" initiative.

Service planning and delivery to meet the needs of local people

- Referrals to the SPCT could be made any time during a patient's treatment. This allowed early involvement of the SPCT and time to facilitate the most appropriate care and treatment. The SPCT encouraged referrals from nursing, medical and allied health professional staff from across the trust.
- An Integrated End of Life and Bereavement group was now in operation. This was headed by the Deputy Director of nursing the members of the group the SPCT, chaplaincy, the bereavement lead, education and training and consultant medical staff.
- The hospital had a discharge team that facilitated fast track discharge and end of life care planning for those patients wishing to die at home.
- We also noted that wards allowed open visiting times for relatives of end of life care patients. Pull out beds and comfortable chairs were available for visitors to stay the night. This ensured family and friends could spend unlimited time with the patient.
- A Bereavement Team has now been established headed by the Bereavement Nurse Specialist, along with Bereavement Officers who had recently been recruited to support this.
- Both the SPCT and on general wards supported patient's to die in their preferred location. However the trust did not collate or hold the data that would demonstrate the percentage of patients who died in their preferred location. This information was held centrally at the Clinical Commissioning Group.

Meeting people's individual needs

- Staff told us that they had been able to arrange rapid discharges for patients when required. The discharge liaison team are able to provide support with this when necessary.
- We saw evidence within the care records observed that the patients preferred place of death is discussed. Staff told us that rapid discharge is available and they receive support from other agencies in order to achieve this for patients.
- We saw evidence of how staff were meeting the holistic needs of palliative and end of life care patients. The trust gave this as a core priority of the End of Life Steering group. We saw evidence of how this has been implemented through the EOLC team's core documentation. The documentation contained a holistic assessment of all patients accessing specialist palliative care (holistic admission pro-forma and distress thermometer). The service introduced caring for the dying patient document which emphasised holistic needs. Cancer nurse specialists completed holistic assessments for all their patients at specific points in their journey.
- Staff carried out holistic assessments of patients' needs at the end of life. This included their emotional and spiritual needs and their preferred place of care.
- Patients who were in the last days and hours of life were identified and support from the specialist palliative care team was accessible, with staff reporting that they would respond on the same day for urgent referrals.
- Discharge coordinators were available to support the process of getting people home, including for those patients at the end of life. Staff consistently told us that where care packages were accessible in the community they could get patient's home in a matter of hours if necessary.
- The trust had developed "Welcome to Hospice at Home – West Cumbria" initiative. All services provided are free of charge This service included the provision daytime and night nursing care, Respite Care - day, evening or night and also volunteer support in the home They can also refer patients to other services within the organisation including complementary therapies for patients, carers and those bereaved, one to one or group support, bereavement support and Lymphoedema support. All services provided are free of charge.
- The trust produced a quarterly Bereavement and Chaplaincy Newsletter.

End of life care

- Information was available in the form of a bereavement leaflet that included contact numbers for relatives of a variety of support agencies they could contact should they need to.
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Access and flow

- Face to face palliative care was available Monday to Saturday 9am to 5pm including bank holiday Mondays. At other times a hospice telephone advice was provided on an on call basis.
- The SPCT worked closely with the specialist discharge team to discharge people to their preferred place of dying if they were not on the rapid discharge plan.
- Referrals to the specialist palliative care team came through by phone and in writing but that a good deal were picked up through routine ward visits.
- Ward staff told us they had referred patients to the team, both reported that the response was prompt and the support from the team had been valuable and beneficial to patients.
- The specialist palliative care team developed a care pathway tool for patients in all areas of the hospital. This was to ensure that patients who required end of life care. Patients were identified at the earliest opportunity and to facilitate the most appropriate care in the most appropriate place for each patient.
- Ward staff spoke positively of the fast track discharge system and felt delays were due to getting external care in place, rather than any trust procedures.
- The trust recorded through the CDP document how patients could be supported to die in their preferred location. However, the trust did not audit these figures. Patients were identified as requiring end of life care in a timely manner. We noted that this was discussed at both ward hand over meetings and the daily multidisciplinary palliative care meetings.
- Porters made patient transfers to the mortuary a priority and a timely manner. Wards were sometimes flexible on these times if the families wished to remain and spend time with the deceased.
- We also noted that the mortuary transfer was sensitive and discrete, porters used a concealment trolley.
- The number of referrals to the SPCT was provided to the Clinical Commissioning Group and the Cumbria Partnership however the NCUH trust did not hold this data.

Learning from complaints and concerns

- Information was available for patients on how to complain or feedback about the service experienced.
- Staff we spoke with told us that if a patient or relative had concerns about care being delivered they would try and address the issue at the time in order to resolve the concerns as quickly as possible.
- People were signposted to the Patient Advice and Liaison Service (PALS) where concerns were unable to be resolved at ward level.
- Between April 2015 and March 2016 there were no complaints about end of life care services.
- Members of the specialist palliative care team told us they would be involved in investigations and supporting learning from complaints if these centred on patients at the end of life.

Are end of life care services well-led?

Good

We rated well-led as 'good' because;

- There was clear leadership from the specialist palliative care team and from ward based nursing staff.
- There was active involvement strategically from the Executive Director of Nursing and deputy chief nurse.
- There was a formal strategy in place for end of life services which noted a lack of audit plan for this service
- Regular meetings of the End of Life Bereavement Group ensured good management overview of the service.
- We found that staff on the ward areas shared the visions and values that the specialist palliative care team were working to promote.
- The culture was seen to be that End of Life care is 'everybody's business' and all staff shared a priority to ensure the care provided was right for the patient.

However:

- The trust could not provide the number of referrals to the SPCT.
- Both the SPCT and on general wards supported patient's to die in their preferred location. However the trust did not collate or hold the data that would

demonstrate the number of patients who died in their preferred location. This information was held centrally with the Clinical Commissioning Group; however the trust could not provide this information.
- There was no regular audit of the CDP to demonstrate that the trust supports patient's to die in their preferred location.
- The trust did not have formal contract meetings with members of the Cumbria Healthcare Alliance to monitor that the service being commissioned and provided is of an appropriate standard in terms of quality and meeting patient need.

Vision and strategy for this service

- A strategy had been developed by NCUH with the aim to provide opportunities available for people to talk about and record their wishes in relation to their own end of life. The provision of integrated, person-centred, needs led end of life services across Cumbria. The equitable access to high quality end of life services across Cumbria, regardless of disease, condition, age, ethnicity, religious belief, disability, gender or place of care
- A framework for the delivery of services was in place that would allow all adults in Cumbria who are approaching the end of their life, "to live as well as possible until they die" in accordance with their own wishes and preferences.
- The framework within the strategy aims to provide end of life care services to support people with advanced progressive illness in the last six months to year of their lives. These services should meet the end of life care needs of both patient and family throughout the last phase of life and into bereavement. It includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support.
- A clear vision had been established where 'All people who die in Cumbria are treated with dignity, respect and compassion at the end of their lives and that regardless of age, gender, disease or care setting they will have access to integrated, person-centred, needs based services to minimise pain and suffering and optimise quality of life. These services will respond sensitively to the dying person's wishes and preferences. Carers and families are provided with appropriate information and support to enable them to function effectively leading up to and after death.
- An Integrated End of Life and Bereavement group was now in operation. This provided representation around Education and Development, the implementation of the CDP and the introduction of the co-ordination of the bereavement services.

Governance, risk management and quality measurement

- Specialist palliative care reports within the directorate of medicine.
- There was a trust wide risk register but not one specific to end of life care. At the time of our inspection there were no risks specific to end of life care identified.
- There was representation from the SPCT at regular mortality review meetings. Their remit was to support the review of the quality of care and decision making at the end of life.
- The End of Life and Bereavement Group oversees the delivery of the priorities within its strategy and reports to the Safety and Quality Committee.
- There was an end of life care executive and clinical lead. We found they had an active role in end of life care and its plans and improvements.
- The trust produced a board report for end of life or palliative care.
- The trust recorded through the CDP document how patients could be supported to die in their preferred location. However, the trust did not audit these figures.
- The number of referrals to the SPCT was provided to the Clinical Commissioning Group and the Cumbria Partnership however the NCUH trust did not hold this data.
- The trust did not hold formal contract meetings with the Cumbria Healthcare Alliance and the trust could not provide details around service delivery of the SPCT. The SPCT were directly employed by the Cumbria Health Alliance. Whilst the SPCT held their own data around the number of referrals into the team the trust did not have access to this data.

Leadership of service

- There was clear leadership in end of life care across the trust. The Executive Director of Nursing was the executive lead for end of life care, and there was evidence of clear nursing leadership with management and involvement bereavement service and chaplaincy.
- The Bereavement Nurse Specialist and the chaplain had leadership roles in terms of end of life care and raising

awareness of aspects of their service across the trust. This involved attending meetings and working collaboratively across services and departments to raise awareness of end of life care issues.
- We saw more examples of the development of End of Life Care services through the role of the Bereavement Nurse Specialist. This included the development of the Education and Training Strategy and the introduction of the bereavement offices. This role was evolving and we saw good progression of the service whilst the position had only been existence for a short period of time.
- There was a clear commitment to quality end of life care across wards within the hospital and we saw ward managers and staff alike focused on improving and developing end of life care in general ward settings.

Culture within the service

- Staff were consistently positive about delivering quality care for patients at the end of life.
- There was a commitment at all levels within the trust to raise the profile of death and dying and end of life care. This included improving ways in which conversations about dying were held and engaging with patients and their families to ensure their choices and wishes were achieved.
- Staff were open and honest and admitted when things went wrong, in line with duty of candour regulations.
- We saw emails off different departments sending thank you notes to each other on the service they provided.
- There was evidence that the culture of end of life care was centred on the needs and experience of patients and their relatives. Staff told us they felt able to prioritise the needs of people at the end of life in terms of the delivery of care.
- We observed good joint team working with the SPCT and ward staff. Staff told us there were opportunities to learn and that the delivery of high quality end of life care services within the trust was a priority.

Public engagement

- The chaplaincy had co-ordinated and developed the Bereavement and Chaplaincy newsletter. The aim is to share developments and news from the Chaplaincy and Bereavement teams.
- The bereavement follow up service also gives the opportunity for bereaved families to talk to hospital staff for advice and support, in the weeks following a death.

Staff engagement

- Staff we spoke with told us they felt they had an opportunity to feedback to management and that they felt listened to.
- The mortuary team had regular debriefs; staff felt this reduced stress after upsetting cases.
- The chaplaincy team regularly engaged ward staff with the aim of raising awareness, improving conversations and engaging staff in discussions around end of life care.

Innovation, improvement and sustainability

- All staff we spoke to were passionate to do their best for patients and continuously improve.
- The use of the Swan scheme which is discussed in the document service introduction and mission statement, and the teaching that also discusses this and bereavement nursing, which in itself is also innovative. The Swan logo is a reminder that there are bereaved families who need extra care and support; that dignity and respect is needed and that care and compassion for the patient and their loved ones is essential; to be kind and considerate when dealing with bereaved families, and to have an understanding that bereaved people may need more time and patience.
- Discharge coordinators were available to support the process of rapid discharge at the end of life and the trust had recently implemented a community service where patients could be supported by trust staff in their own homes where care packages were difficult to access in the community.
- The trust had developed “Welcome to Hospice at Home – West Cumbria” initiative. All services provided are free of charge This service included the provision daytime and night nursing care, Respite Care - day, evening or night and also volunteer support in the home They can also refer patients to other services within the organisation including complementary therapies for patients, carers and those bereaved, one to one or group support, bereavement support and Lymphoedema support. All services provided are free of charge.

Outpatients and diagnostic imaging

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

Information about the service

The outpatient departments held clinics for various specialities throughout the trust across the different hospital sites. Diagnostic imaging was available at Cumberland Infirmary and West Cumberland Hospital. Clinics were held in the main outpatient department and departments such as Ophthalmology.

The trust had 488, 353 outpatient appointments between April 2015 and March 2016. Of these, 321, 336 appointments were held at Cumberland Infirmary and 124, 856 appointments were held at West Cumberland Infirmary. All other appointments were held at other trust hospitals such as Workington community hospital, Penrith hospital and Cockermouth Community Hospital.

During our inspection we visited the main outpatient department, dermatology, ophthalmology and physiotherapy.

Diagnostic imaging services were mainly provided from two locations: Cumberland Infirmary and West Cumberland Hospital with a limited service at Workington Community Hospital, Penrith Hospital and Cockermouth Community Hospital. Diagnostic imaging at Cumberland Infirmary provided plain film x-rays, ultrasound, CT, MRI, and interventional treatments. The acute clinical work including fluoroscopy was concentrated at Cumberland Infirmary and West Cumberland Hospital. The service offered a range of diagnostic imaging, image intensifiers in theatres, and interventional procedures. The trust provided diagnostic imaging figures for all sites for each modality.

Staff at Cumberland infirmary carried out; 15508 CT scans, 7971 MRI Scans, 14915 non-obstetric ultrasound scans, 9857 obstetric scans, 2425 nuclear medicine procedures, 3101 fluoroscopy procedures, 65850 plain film x-rays.

Diagnostic imaging services were available for inpatients and trauma patients 24 hours a day, every day of the year. Outpatients and those referred by their GPs could access plain film and ultrasound services from Monday to Friday between 9am and 5pm and for MRI and CT there were appointments from 8am to 8pm on weekdays. The service provided extra appointments for evenings and weekends to meet demand. Diagnostic imaging services staff organised and booked appointments for procedures and follow ups.

During the inspection at CIC we spoke with four patients, two relatives, and 40 staff members, including managers, doctors, nurses, allied health professionals, and support staff, some of whom worked across the three hospital sites. We observed the diagnostic imaging and outpatient environments, checked 22 records which were a mixture of electronic and paper based, equipment in use and looked at information provided for patients. We received comments from people who contacted us about their experiences. We also reviewed the trust's performance data and looked at individual care records and images.

Records we reviewed confirmed that there continued to be a steady increase in demand for diagnostic services.

Outpatients and diagnostic imaging

Summary of findings

We rated this service as 'good' because:

- An electronic incident reporting system was in place. Staff we spoke with could describe how they report incidents.
- The environment was suitable, clean and tidy. Hand gel dispensers were available for use in all areas visited and staff adhered to the 'bare below the elbow policy' in services visited.
- We found equipment to be checked appropriately and medicines checked were found to be in date and securely stored. Medical records availability had been identified as an issue at previous inspections; at this inspection we found that improvements had generally been maintained.
- Staffing levels and skill mix were ascertained by the department managers. Actual staffing levels were mostly in line with the planned staffing levels in most areas.
- Staff used evidence based guidance and followed national guidance. We found a number of staff members had undertaken additional courses and training to enhance competency in the services. Staff had access to the systems and information they required for their role.
- 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.
- Staff provided compassionate care and ensured patient privacy and dignity was respected whilst using the services. Patient feedback was positive about the services. Diagnostic services were delivered by caring, committed and compassionate staff.
- The service offered clinics throughout the week and on weekends to ensure patients are seen and to meet demand. Additional clinics were added to manage demand for the services. Interpreter services were accessible and available if required.
- Management could describe the risks to the service and the ways they were mitigating these risks, however we found that not all risks identified were on the risk register.
- Staff were mostly positive about their roles, local leadership, and the team work. Daily huddles in the outpatient department had increased information sharing between staff and were found to be useful.

However:

- Mandatory training completions did not achieve the trust target of 95%.
- There were staff shortages in the orthopaedic practitioner staff group and the oncology outpatients.
- There was no formal clinical supervision in main outpatients and ophthalmology outpatients.
- There was no current strategy for outpatients; however staff told us that they were developing one.
- Performance measurement information was limited.
- The trust did not measure how many patients waited over 30 minutes to see a clinician in outpatient departments.
- Turnaround times for inpatient plain film radiology reporting did not meet Keogh standards, which require inpatient images to be reported on the same day.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good

We rated safe as 'good' because:

- The departments used an electronic system to report incidents. Staff we spoke with knew how to use the system if they needed to and staff would notify their manager when an incident had occurred. Managers and governance leads investigated incidents and shared lessons learned with staff.
- There had been one serious incident reported involving diagnostic imaging at the trust regarding a diagnostic delay. This had been investigated and a new process implemented across the trust to prevent a future recurrence.
- Areas we visited were visibly clean and tidy. Hand gel dispensers were in place throughout the outpatient services.
- Radiology departments were clean and hygiene standards were good. Staff had access to personal protective equipment in all the areas we inspected and staff knew how to dispose of all items safely and within guidelines. Staff ensured equipment was clean and well maintained.
- Medicines were found to be stored securely.
- Accessibility to medical records data showed that between April 2016 and June 2016, 93.5% of records were available at the start clinic. Records were securely stored and when issues around record security were raised with staff in ophthalmology outpatients, we found during our unannounced inspection this had been rectified and notes were securely stored.
- Patient records were completed and available, and diagnostic imaging contributed to efficiency and effectiveness for outpatient services, such as the availability of test results and timely access to information. We also found that improvements in the processes for reporting and learning from incidents were maintained.
- Actual staffing levels matched the planned staffing levels in general across the services with the exception of orthopaedic practitioners; however the trust was taking action to mitigate the risk.
- The trust had reviewed its staffing investment to develop the allied health professional workforce to meet the growing demand for services. Diagnostic imaging was working proactively to train staff to work across modalities and to take on extended roles. National shortages meant that recruitment was difficult but there had been some improvements.

However:

- Safeguarding levels were below the target of 95%. Most completion rates for mandatory training were below the 95% across outpatients.
- The imaging equipment quality assurance process had not been carried out in full between November 2015 and June 2016. Although this had been reinstated at the time of our inspection, there were still some checks outstanding.
- We found that although recruitment had been successful in some areas, there remained a shortage of radiographers and radiologists.
- There were vacancies in Oncology outpatients. This was on the risk register and the service was using agency staff to assist in staffing shortages.
- There was a lack of consistency in the completion of records in outpatients.

Incidents

- The trust had an incident reporting system which could be accessed through the computer system in the department. Staff we spoke with confirmed this was where they would report incidents as well as notifying their managers.
- There had been 195 incidents reported between May 2016 and August 2016 across all hospitals which provide outpatients and diagnostic imaging across the trust. At CIC there were 118 reported incidents. These were a mixture of diagnostic imaging and outpatient incidents. Ten incidents were reported in outpatients, ninety reported incidents were logged from diagnostic imaging and seventeen incidents were reported in the endoscopy unit. Ninety five reported incidents were categorised as negligible and minor. Twenty one incidents were categorised as moderate and two were categorised as major.
- There had been one Never Event reported in the last 12 months in outpatients, however this had occurred at

West Cumberland Hospital. This had occurred in Ophthalmology outpatients, Ophthalmology outpatients was one service operating across the two hospital sites with the same management team.

- The Never Event had been reported through the incident reporting system and an investigation had been conducted. The service had introduced new measures to help prevent the event occurring again. This included implementing a new form which staff had to complete prior to a procedure for intravitreal injections. Management confirmed duty of candour had been carried out and this was documented in the incident investigation report. A recommendations section was completed on the serious incident investigation report and an action plan was attached.
- The services reported two serious incidents (SI's) in outpatients between October 2015 and September 2016. These incidents were related to a surgical or invasive procedure and one of the serious incidents related to a diagnostic incident.
- During our inspection we saw information attached to the daily communication board from an incident that had occurred elsewhere in the trust. We were told this would be discussed as part of the daily huddle before clinics. Managers told us this is where shared learning from incidents would be discussed.
- Most staff we spoke with were aware of duty of candour.

Diagnostic imaging:

- There had been no 'Never Events' in the diagnostic imaging department.
- The diagnostic imaging department had reported one serious incident that met the Strategic Executive Information System (STEIS) criteria. This related to a delay in reporting and a subsequent delay in treatment. Staff had incorporated a new vetting protocol into the booking system to prevent this occurring in future.
- There had been two recent radiological incidents reported under ionising radiation medical exposure regulations IR(ME)R at the trust. Both were attributed to CT imaging and were thought to have been caused by referrer errors. The diagnostic imaging safety team had carried out an investigation and implemented a new process where the referrer must use a free text box to manually add the patient's name and date of birth.
- Staff at Cumberland Infirmary, Carlisle had reported two near miss incidents
- Incidents were discussed at the monthly governance meetings and we saw minutes of meetings that confirmed this. There was evidence of discussions about RCA (root cause analyses) being carried out, serious incidents and monitoring of action plans.
- Radiology discrepancy incidents were discussed by case review with radiologists and reporting radiographers. Sonographers discussed discrepancies formally in their own meetings. Medical staff took the opportunity to learn and work as a multidisciplinary team with referrers and clinical teams. Outsourcing reporting companies carried out discrepancy and quality assurance reviews as part of their service level agreements (SLA) with the trust.
- Staff we spoke with knew that they should be open and honest with patients if anything went wrong with their treatment or care. Departmental managers took responsibility for ensuring that the duty of candour processes were carried out appropriately.

Cleanliness, infection control and hygiene

- Areas visited were visibly clean and tidy. There was hand gel available in the areas visited and access to personal protective equipment such as gloves were available in clinic rooms.
- Staff complied with the 'Bare below the elbow' policy.
- The outpatient department had a daily check list on the wall in each clinic and treatment room which was to be completed daily to confirm that cleaning had been completed by staff and equipment listed was available. We found these to be completed during our inspection.
- The outpatient department was cleaned daily by a domestic staff member.
- Cardiology outpatients were included in the infection, prevention and control audit and between January 2016 and June 2016, the department achieved 100%.
- During our inspection we saw a main outpatient department performance board. This showed that hand hygiene rates were 100%.

Diagnostic imaging:

- Personal protective equipment (PPE) such as gloves, masks and aprons was provided and used appropriately throughout the imaging department and, once used, was disposed of safely and correctly. We observed PPE being worn when treating patients and during cleaning or decontamination procedures. All areas had stocks of hand gel and paper towels.

- The department's different areas such as changing rooms and reception were clean and tidy and we saw staff maintaining the hygiene of the areas by cleaning equipment in between patient use, reducing the risk of cross-infection or contamination.
- Processes were in place to ensure that equipment and clinical areas were cleaned and checked regularly.
- The department quality board showed that the most recent hand hygiene audit had achieved 100% compliance.

Environment and equipment

- Outpatient's was accessed from a main reception which was located in the entrance to the main hospital. Patients would check in at the medical and surgical reception desk and be directed to the main outpatient department where they would check in for the clinic required. Areas we visited were found to be tidy.
- Outpatients had clinic rooms, treatment rooms, access to toilets and disabled toilets which had a call bell, small reception waiting area and a phlebotomy room. There were areas specifically for medicines storage in the department.
- Main outpatients had a dedicated room for patients and families in outpatients. This room provided privacy and dignity to patients.
- Most areas had suitable waiting area space, however some clinics visited did not have enough seats for the number of patients attending. Where this happened, staff would bring additional seats to ensure patients and visitors had a seat in the waiting areas.
- Management told us of the challenges of not having enough space and the effect this could have on capacity.
- We checked refrigerator temperature logs and found these to be completed appropriately. There was a crash trolley available in the dermatology outpatient area and one available in the cardiology department which staff told us they had easy access to.
- Check in was by receptionist at the outpatient clinics, The reception desks provided enough space between the desk and the people waiting to ensure patients could not be overhead speaking.
- During our inspection, there was a seat in the oncology outpatient department where the section to put patient's feet was broken. Staff told us this had been reported, however it was not marked as out of use. We were told the room where the couch was situated was only used when other rooms were not available.
- Emergency medicine bags located in oncology outpatients were found to be in date.

Diagnostic imaging:

- X-ray equipment was generally aged. A rolling replacement programme for plain film equipment had begun and was due to be completed by March 2017. There was a complete new plain film room being installed and the original four pieces of equipment in other rooms were all due to be replaced. The first was underway during our inspection with the remainder planned in succession to ensure safety and continuous provision of service.
- The department planned to replace the existing CT and MRI equipment in 2017.
- In diagnostic imaging, quality assurance (QA) checks had been reinstated in June 2016 and were in place for all equipment. However, from November 2015 until June 2016 there had been no QA process in place. A new Trust lead radiographer had been appointed and had taken on the QA role throughout the Trust. QA checks are mandatory and based on the ionising regulations 1999 and the ionising radiation (medical exposure) regulations (IR(ME)R) 2000. These protect patients against unnecessary exposure to harmful radiation.
- Staff wore dosimeters and lead aprons in diagnostic imaging areas. This was to ensure that they were not exposed to high levels of radiation and dosimeter audits were used to collate and check results. Results were within the acceptable range as set by IRMER.
- The department provided local rules for each piece of equipment and we saw a user guide for each room.
- Risk assessments were carried out with ongoing safety indicators for all radiological equipment, processes and procedures. These were easily accessible to all diagnostic imaging staff.
- The design of the environment kept people safe. Waiting and clinical areas were clean. There were radiation warning signs outside any areas that were used for diagnostic imaging. Illuminated imaging treatment room no entry signs were clearly visible and in use throughout the departments at the time of our inspection.

- Crash trolleys throughout the departments were all locked and tagged and we saw checklists to show staff made regular checks of contents and their expiry dates.
- There was sufficient seating to meet demand. The department had designated trolley areas and wheelchair spaces. There were separate areas for inpatients and outpatients. This made sure that the privacy and dignity of patients was preserved.

Medicines

- We found medicines to be managed securely. The medicines refrigerators were locked and the medicines we checked were in date.
- Main outpatients stocked a small amount of medicines.

Diagnostic imaging:

- In the diagnostic imaging department some interventional procedures required sedation and pain relief. These medicines were prescribed and administered by the consultant radiologist carrying out the procedure. All medication used, including contrast agents, was stored and documented appropriately.
- Radiology specialist nurses ordered medicines and liaised with pharmacy.
- Monthly stock checks were made and expiry dates were checked. We saw evidence of dated and signed checklists and drugs we checked were all in date.
- The department manager maintained a list of PGDs (patient group directions) for drugs used commonly in the department were in place for contrast agents. PGDs are authorised by doctors and pharmacists to allow non-medical staff to supply and administer specified medicines to patients.
- We saw records to show staff had been trained to administer contrast.

Records

- In past inspections, there had been concerns raised regarding the availability of medical records for use in the outpatient clinics. This had improved at the previous inspection and we found these improvements had been generally maintained. Management told us they had recently altered the way they audit records, this had started during the week of our inspection.
- Information provided by the trust for Cumberland Infirmary showed that between April 2016 and June 2016, 93.52% of case notes were available at the start of clinic and between July 2016 and September 2016, 94.38% of notes were available at the start of clinic.
- Management told us that staff would complete an incident form if all medical records for the clinic had not arrived in time for clinic. Incident data provided by the trust showed that there had been incident forms logged in the last 12 months regarding the availability of medical records.
- The medical record storage centre had recently moved off site and records were delivered to the clinics daily. Staff told us this had led to some challenges such as records arriving late for clinics.
- Management told us there were regular operational meetings where medical records were discussed and the medical record management were in attendance at these meetings.
- Records in main outpatients were stored securely in locked cupboards when clinics had finished and behind a locked door in a room when being delivered and were being made ready for the clinics that day. Locked trolleys were available for use to transport records around the outpatient department securely.
- The ophthalmology department had access to these locked trolleys also. Medical records were stored during the day in a records room which staff and management told us was not left unattended during the day. However when clinics had finished records were stored in an open trolley at reception whilst they awaited collection, this did not always ensure the appropriate security of records in the department, however during our unannounced inspection we found that these had been moved to a locked office since the storage was raised at our inspection.
- The services had recently introduced an electronic system which allowed clinics to view outpatient letters electronically.
- During the unannounced inspection we viewed three sets of records in outpatients and found that these varied in consistency in respect of completion, for example, one checklist was fully complete, however, the others were incomplete or only partially completed.

Diagnostic imaging:

- Diagnostic imaging records and reports were digitised, stored electronically and available to clinicians across the trust via electronic records systems; CRIS (Computerised Radiology Information System) and PACS (Picture Archiving and Communications System).
- We looked at ten electronic patient records and all were completed correctly.
- Risk assessments were carried out with ongoing safety indicators for all radiological equipment, processes and procedures. These were stored electronically and were easily accessible to all diagnostic imaging staff.

Safeguarding

- Most staff we spoke with could describe how they would report a safeguarding report. Staff told us that they would ask their managers for advice, and most staff told us that they would report to the safeguarding team in the trust. Staff we spoke with were not always aware of the level of safeguarding training they had received.
- Safeguarding mandatory training levels varied. The trust had a safeguarding target of 95%. Safeguarding training compliance as at August 2016 showed that the trust were at 77% completion rate for safeguarding adults level 1 and 76% for safeguarding children level 2. Safeguarding children level 1 compliance was at 100%. These figures relate to medical staff, nursing staff and healthcare assistants in outpatients.

Diagnostic imaging:

- In diagnostic imaging trust records showed that 53% of staff had completed level 1 safeguarding adults and children training and 66% had completed level 2. These courses were completed once every three years and the business unit manager told us all staff who were due to complete this year had time booked in duty rotas to complete their training before the end of the financial year.
- Staff had a good understanding of safeguarding vulnerable adults or children principles and processes. Staff we spoke with knew that there was a policy on the intranet and staff within the organisation who they could speak with for advice. Staff had referred two cases to the trust safeguarding team when they were concerned about individuals attending from the emergency department. All of the staff we spoke with said they would escalate any concerns to their manager in the first instance.

Mandatory training

- Mandatory training was a mixture of face to face training and online training. Staff we spoke with confirmed there mandatory training was mostly up to date.
- Mandatory training targets were 95%. Nursing and Healthcare assistant compliance levels were mostly below the target. Equality and diversity training was the only mandatory training course which achieved the target with 100% compliance. Information governance compliance was the lowest rate with 42% completion, fire and safety compliance rate was 51%, infection control compliance was 72%, health and safety compliance was 73% and adult basic life support training compliance was 61%.
- Medical staff completion rates were generally below the target of 95%. Only equality and diversity achieved the target with a compliance rate of 100%. Information governance training compliance was 75%, fire safety training was 75%, infection control training compliance was 75%, health and safety training compliance was 63% and adult basic life support training compliance was 86%.
- The trust set the target of 95% completion of training by the end of March 2017.

Diagnostic imaging:

- Mandatory training was well managed. The diagnostic imaging departments had systems and processes to ensure staff training was monitored.
- Records showed and mangers told us compliance with mandatory training in radiology across the trust was 79%. There were plans and training scheduled to ensure staff met the trust target of 95% before the end of the financial year.
- Staff we spoke with confirmed they had attended mandatory training. Managers had access to an online system to identify staff mandatory training completion rates and would use this system to ensure staff had completed or were booked on mandatory training.

Assessing and responding to patient risk

- Staff we spoke with in outpatients could describe the action they would take if a patient deteriorated in the clinics. Staff told us they would seek advice from the

doctor and assess the patient and/or take the patient to the emergency department if required. Staff we spoke with were aware of the crash team being available in the hospital.

Diagnostic imaging:

- The department had a process for prioritising the urgency of diagnostic imaging referrals and requests. All urgent referrals were flagged and escalated to ensure they were given an early appointment. All other requests were triaged and appointments were allocated accordingly. This process had been amended following a serious incident where an urgent referral had not been identified and the procedure had not been booked, leading to a delay in treatment.
- Diagnostic imaging policies and procedures in the diagnostic imaging department were written in line with the Ionising Radiation (Medical Exposure) 2000 regulations. IR(ME)R to ensure that the risks to patients from exposure to harmful substances were managed and minimised.
- The Radiation Protection Advisor (RPA) and medical physics expert (MPE) were contracted from a local NHS Trust to support all North Cumbria University Hospitals NHS trust sites. The RPA and MPE visited and provided advice remotely as required.
- There were named certified Radiation Protection Supervisors (RPS) on each site to give advice when needed and to ensure patient safety at all times.
- The Administration of Radioactive Substances Advisory Committee (ARSAC) certificate holder for the Medical Physics elements of diagnostic imaging was employed by the trust within the Medical Physics department at Cumberland Infirmary, Carlisle. The role of the ARSAC advisor is to be contactable for consultation and provide advice on aspects relating to radiation protection concerning medical exposures in radiological procedures.
- Arrangements were in place for radiation risks and incidents defined within the comprehensive local rules. Local rules are the way diagnostics and diagnostic imaging work to national guidance and vary depending on the setting. Policies and processes were in place to identify and deal with risks. This was in accordance with (IR(ME)R 2000). Local rules for each piece of radiological equipment were held within the immediate vicinity of the equipment.
- Staff asked patients if they were, or may be, pregnant in the privacy of the x-ray room. Therefore preserving the privacy and dignity of the patient. This was in accordance with the radiation protection requirements and identified risks to an unborn foetus. We saw different procedures were in place for patients who were pregnant and for those who were not. For example patients who were pregnant underwent extra checks and if the x-ray was still necessary, could wear a lead apron to protect their unborn baby.
- Staff told us that the risks of undergoing an x-ray whilst pregnant were fully explained to patients.
- We observed and records showed diagnostic imaging staff used the WHO safer surgical checklist for all interventional procedures.

AHP Staffing

- Physiotherapy had a staffing document showing the planned against actual staffing levels and where there were differences an area for mitigation was described. There were vacancies in the physiotherapy team. The June 2016 to October 2016 staffing document showed that there were three whole time equivalent vacancies with one having been appointed to and other vacancies were generally less than one whole time equivalent within the different teams. The document had a mitigation section, which highlighted that bank staff were used to enhance staffing levels.

Diagnostic imaging :

- At the time of our inspection, within the diagnostic imaging departments, there were sufficient radiographers, clinical support workers, and nursing staff to ensure that patients were treated safely. There were current vacancies and these were being recruited to.
- Managers told us they were supportive of staff and planned to recruit more qualified radiographers to support a new shift system. Staff we spoke with were able to corroborate this.
- There had been difficulties in recruitment of qualified radiographers in the past and managers told us these were improving slowly. This was in line with the national picture regarding radiographer recruitment.
- Managers were carrying out succession planning whereby current junior and general radiology staff were undergoing training to specialise in modalities including CT and ultrasound.

Outpatients and diagnostic imaging

- The radiology department had nurses and health care assistants who assisted with interventional procedures.
- The trust had appointed radiographer advanced practitioners who were undergoing training for their role. Managers were aware that radiographer training was helping to reduce the burden on radiologists but this affected radiographer numbers and further staff were required to backfill as staff qualified in advanced roles.
- Sonographers reported their own ultrasound scans at the time of each procedure. A lead sonographer was responsible for ultrasound across all sites.
- Due to the shortage of sonographers the trust had looked at development of knowledge and experience of existing staff and had identified radiographers to train to a sonographer role. Radiologists carried out ultrasound examinations out-of-hours.
- Radiographers undertook fluoroscopy including barium swallows and video fluoroscopy in corroboration with speech and language therapists (SALT) to identify swallowing problems for stroke patients. CT radiographers undertook CT colon imaging.

Nursing staffing

- During our inspection we found that there had been difficulty with ensuring staffing levels in some services were at their planned established amount. Management told us outpatient registered nurse staffing was generally suitable, however some staff groups, for example orthopaedic practitioners were required to attend the West Cumberland Hospital site each morning five days a week to support the service there. This had led to the service at Cumberland Hospital being a staff member down during these periods.
- Managers told us there were generally no concerns regarding nurse and healthcare assistant staffing levels in the main outpatient department.
- Staffing levels and skill mixed were managed by department managers. The services had recently changed to a new electronic roster system and managers were now required to complete the roster a month at a time. This was still new and staff and managers were still getting used to the change in practice.
- Outpatients had a vacancy rate of 5% as at September 2016 and between April 2015 and March 2016 the trust reported a turnover rate of 4% in outpatients. Between April 2015 and March 2016, the trust reported a sickness rate of 5% in outpatients. Bank and agency use between April 2015 and March 2016 was 0.3% in outpatients.
- Ophthalmology nurse staffing planned levels for CIC were 1.8 WTE for the band 7 role, and the actual level was 1.8. The planned level for the band 6 role was 6.99 and the actual was 5.55 WTE. The actual staffing level for band 5 nursing staff was 8.45 and the actual was 8.4 WTE. The planned staffing level for healthcare assistant staffing was a total of 4.41 WTE; the actual level was 2.89.
- Haematology outpatient nurse actual staffing levels were 4.4 whole time equivalent each month between April 2016 and November 2016 and the planned staffing level was 4.4 whole time equivalent. Oncology outpatient nurse actual staffing levels varied each month between April 2016 and November 2016, these varied between 11.68 whole time equivalent and 14.53 whole time equivalent. The planned staffing level was 13.27 whole time equivalent.
- Staffing vacancies and sickness were highlighted on the Oncology and Haematology risk register. The risk register detailed that agency staffing were used to assist in staffing shortages and sickness absence in oncology services.

Diagnostic imaging:

- There were four specialist nurses to support interventional radiology procedures. Nurses sometimes travelled between hospitals to support interventional lists.
- Radiographer helpers moved between modalities to provide help and support to staff and patients where required.

Medical staffing

- Medical staffing was managed by the individual speciality delivering the service in outpatients.
- During a previous inspection consultant ophthalmologist staffing levels were raised as an issue. During this inspection we were told that new consultant ophthalmologists had been recruited. Three consultants had been recruited with one in post and two still to start at the trust. The service was still reliant to an extent on

locum medical staffing in ophthalmology and there were three locums across the service. During our inspection there were five doctors on duty in Ophthalmology outpatients in Cumberland Infirmary.

- Ophthalmology medical staffing consultant planned staffing levels were 8.5 whole time equivalents (WTE) and the actual staffing level was 8.3 WTE. Middle grade and junior medical posts were at full establishment for ophthalmology outpatients. Medical staff for ophthalmology worked across both hospital sites.
- As at September 2016, outpatients reported a vacancy rate of 26% and a staff turnover rate of 23% between April 2015 and March 2016. Between April 2015 and March 2016, medical staffing had a sickness rate of 5% in outpatients. Bank and agency use in outpatients between April 2015 and March 2016 was 17% in outpatients.
- We received a clinic list rota for oncology and haematology outpatients and this showed that locums were in use at the trust for these services. Out of the eight medical staff listed on the rota for oncology outpatients, two were locum staff. The haematology outpatient clinic list showed there was one consultant vacancy; however it stated that a consultant was starting in the new year.
- The trust provided a document showing actual staffing levels against planned staffing levels. In Haematology, this showed that between April 2016 and November 2016, the planned medical staffing level in haematology outpatients was 3.6 whole time equivalent staff and the actual staff level was 3.2 whole time equivalent each month. In Oncology, this showed that between April 2016 and November 2016, the planned staffing level was 6.7 whole time equivalent and the actual varied each month between 5.86 whole time equivalent and 7.27 whole time equivalent. In November 2016, the planned level was 6.7 whole time equivalent and the actual staffing level was 5.91 whole time equivalent.
- The haematology and oncology risk register included lack of consultant provision on the risk register.

Diagnostic imaging:

- The department contracted the reporting of some X-rays and scans to external companies to enable them to meet the demands on the service. There were formal service level agreements (SLA) in place for this process. Trust consultant radiologists fed reporting discrepancies back to outsourcing companies.
- There was a national shortage of radiologists. However, there was an ongoing recruitment drive to attract radiologists and the trust employed long-term locum consultants to fill gaps.
- The trust hadn't recorded any sickness levels for radiologist staff.
- There was consultant cover across the trust out-of-hours and at weekends.
- At the time of this inspection the trust had an establishment target of 11.7 WTE consultant radiologists. The trust had 7.7 employed consultants in substantive posts. The trust had appointed an associate specialist and there were two part time locums. However, another two WTE locum vacancies remained.
- At the time of this inspection there were sufficient staff to provide a safe and effective service. Managers stressed that the establishment figure had been set some years ago and increased capacity and demand for radiology services would require more consultants now and in future.
- Two specialist radiology trainees were completing four-month placements with the Trust.

Major incident awareness and training

- The trust had an emergency preparedness policy in place.

Diagnostic imaging:

- Staff were aware of the action they should take in the event of a radiation incident. There were standard operating procedures in place.
- The various teams within the diagnostic imaging department had business continuity plans in place. In the event of equipment failure, the trust had agreements with local providers to allow them access to equipment. There were also maintenance contracts in place to ensure that any mechanical breakdowns were fixed as quickly as possible.
- Staff knew their roles in the event of a major incident.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We do not currently rate effective, however:

Outpatients and diagnostic imaging

- Staff we spoke with could describe the national guidance they used. Staff had undertaken further training and development to develop further competency and skills in their work.
- There were multi-disciplinary team (MDT) meetings in some services, for example the ear, nose and throat service held weekly MDT meetings prior to patient appointments.
- Staff had access to the relevant computer systems such as electronic reporting systems and the trust intranet in the outpatients departments.
- Staff we spoke with could describe when they get consent, for example when they get verbal consent. Staff understood about consent and followed trust procedures and practice.
- Diagnostic imaging services ran every weekday for outpatients and GP patients and a full 24hour service was in operation for plain film, CT and ultrasound for inpatients and trauma. Care and treatment was evidence-based and staff followed national guidelines to provide best practice for patient care. Staff were competent and multidisciplinary teams met regularly across a range of services, local networks, and specialties, and included both medical and non-medical staff.
- Radiologists undertook clinical audits to check practice against national standards and to improve working practices.
- Staff knew the various policies to protect patients and people with individual support needs. Staff asked patients for their consent before treating them. Staff were clear about how to support patients when they lacked, or had changes in, mental capacity

However:

- There was no formal clinical supervision in place for outpatient staff.
- Appraisal rates were low at 51% completion across the outpatients service.

Evidence-based care and treatment

- Staff we spoke with were able to describe the national and local guidance they used. For example specialist nurses could describe guidance they used and staff in ophthalmology could describe working to the Royal College of Ophthalmologists guidance.
- Members of the chronic kidney disease team told us that they had multi-disciplinary team (MDT) meetings and held a six-weekly meeting to discuss patients' ongoing care. The virtual fracture clinic team told us they also had MDT meetings to discuss patient outcomes. Staff at the ear, nose and throat (ENT) clinic told us the ENT team had a regular MDT meeting prior to patients arriving for clinics to discuss care and treatment.
- Pro formas and protocols were in place in the fracture clinic, for example, to provide streamlined fracture care.

Diagnostic imaging:

- We saw reviews against IR(ME)R regulations and learning disseminated to staff through team meetings and training.
- The trust had a radiation safety policy in accordance with national guidance and legislation. The purpose of the policy was to set down the responsibilities and duties of designated committees and individuals. This was to ensure the work with Ionising Radiation undertaken in the Trust was safe as reasonably practicable.
- The trust had radiation protection supervisors for each modality to lead on the development, implementation, monitoring and review of the policy and procedures to comply with Ionising Radiation (Medical Exposure) 2000 regulations. IR(ME)R.
- National Institute for Health and Care Excellence (NICE) guidance was disseminated to departments. Staff we spoke with were aware of NICE and other specialist guidance that affected their practice.
- Procedures were in place to ensure the diagnostic imaging department were following appropriate NICE guidance regarding the prevention of contrast induced acute kidney injury.
- Consultant radiologists told us and we observed they used a WHO checklist for every interventional radiology procedure.
- The departments were adhering to local policies and procedures. Staff we spoke with were aware of the impact they had on patient care.
- The diagnostic imaging department carried out quality control checks on images to ensure that the service met expected standards.

Pain relief

- The outpatient department's kept a small stock of medicines, which included pain relief medication.

Outpatients and diagnostic imaging

Diagnostic imaging:

- Diagnostic imaging staff carried out pre-assessment checks on patients prior to carrying out interventional procedures. Pain relief for procedures such as biopsies was prescribed by radiologists and administered safely as required.

Nutrition and hydration

Diagnostic imaging:

- A water fountain was provided for patients' use in the shared waiting area between the outpatients and x-ray departments. However, there was no access to drinks once patients or visitors entered the department. There was a café nearby where people could purchase drinks and snacks.

Patient outcomes

- The follow up to new rate for Cumberland Infirmary, West Cumberland Hospital and Workington Community Hospital was mostly lower than the England average between April 2015 and March 2016. Penrith Hospital and Cockermouth Community Hospital was mostly higher than the England average for follow up to new rate. During March 2016, Cockermouth Community Hospital was more than four times higher than the England average.

Diagnostic imaging:

- All diagnostic images were quality checked by radiographers before the patient left the department. National quality standards were followed in relation to radiology activity and compliance levels were consistently high.
- The radiology quality assurance programme, including radiology audits, had been prioritised by a new lead radiographer. This had not been adhered to fully for a few months following some changes in management. The new programme was underway at the time of our inspection.

Competent staff

- Medical and nursing staff appraisal rates between April 2015 and March 2016 were at 51% for staff who had completed an appraisal. Staff we spoke with told us they had completed an appraisal.
- There was no formal clinical supervision in outpatients. Staff told us they were generally able to attend training and development courses. Some staff we spoke with had completed further training, such as wound care, and other staff were waiting to go on additional training courses, such as the orthopaedic practitioner course. Some staff we spoke with had undertaken the trust's leadership programme.
- Staff in main outpatients worked between the clinic areas. Managers told us this allowed flexibility within the team and service.
- The physiotherapy outpatient department undertook training regularly, for example the whole department had monthly internal training and the junior staff had two to three weekly training. Clinical supervision was used in physiotherapy.

Diagnostic imaging:

- Staff we spoke with confirmed that they received one-to-one meetings with their managers which they found beneficial. Senior staff told us appraisal rates for diagnostic imaging staff were 97% across all sites.
- Medical revalidation was carried out by the trust. There was a process to ensure that all consultants were up to date with the revalidation process.
- Allied health professionals were supported to maintain their registration and continuous professional development.
- Radiology staff were assessed against radiology competencies and medical devices training was provided for new and existing staff. Staff were supported to complete mandatory training, appraisal and specific modality training.
- Students were welcomed in all departments. Radiography students came for elective placements and managers told us they had recruited new graduates from their student cohorts.
- The department provided local rules and MRI safety training trust-wide for medical and non-medical referrers.
- Radiographers were trained to use each piece of new equipment by applications specialists from suppliers.
- Radiographers had been trained for lead roles in CT and MRI.

Multidisciplinary working

- The ear, nose and throat department had weekly multidisciplinary team working meetings. These were prior to the patient's appointments that day. These were attended by consultants, dieticians, nursing staff and specialist nurses.
- There was a one-stop breast clinic which provided an initial consultant appointment, mammography, and biopsy if required.
- The virtual fracture clinic was delivered by a nurse, consultant and registrar.

Diagnostic imaging:

- There was evidence of multidisciplinary working in the imaging department. For example, nurses, radiographers and medical staff worked together in interventional radiology theatres.
- We saw that the diagnostic imaging departments had links with other departments and organisations involved in patient journeys such as GPs and support services. For example the radiology department worked with the Accident and Emergency department to ensure that X-rays, CTs and other scans were carried out and reported in a timely manner.
- Radiologists attended multi-disciplinary meetings to discuss diagnosis and treatment plans for suspected cancer patients.

Seven-day services

- Outpatients generally operated Monday to Friday between 08:00 and 17:00; however, there were weekend clinics across different specialities. These had been introduced to address the capacity and demand issues and were used to assist in reducing waiting times. There were limited evening clinics available, however management told us they would consider evening clinics if requested or required.
- The virtual fracture clinic offered appointments on a Saturday each week.

Diagnostic imaging:

- Diagnostic imaging services including plain film, CT, and ultrasound were available 24 hours seven days a week for trauma and inpatients with an on call radiographer and radiographer helper on site providing overnight cover and a second on-call available if necessary.
- Outpatients and GP patients could attend for x- rays 5 days a week. When demand increased the department could provide additional appointments at the end of planned lists.

Access to information

- Staff had access to computers and the relevant systems in clinics and in the departments. Staff could use the incident reporting system in their departments and had access to a trust intranet.
- Main outpatients had a daily huddle where they would discuss the day and raise anything that would benefit staff and managers. This was located on a board in the department.

Diagnostic imaging:

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Outpatients and diagnostic imaging

- Staff we spoke with could describe where they ask for consent. Staff could describe when they use verbal consent. Ophthalmology outpatients had specific written consent forms which were used to document consent.
- As at August 2016, 99% of clinical staff in outpatients had completed mental capacity act (MCA) level 1 training. Deprivation of Liberty standards training had been completed by 100% of clinical staff.

Diagnostic imaging:

- Diagnostic imaging and medical staff understood their roles and responsibilities regarding consent and were aware of how to obtain consent from patients. They were able to describe to us the various ways they would do so. Staff told us consent was usually obtained verbally although consent for any interventional radiology was obtained in writing prior to attending the diagnostic imaging department.
- Staff we spoke with were aware of who could make decisions on behalf of patients who lacked or had fluctuating capacity. They were aware of when best interest decisions could be made and when Lasting Power of Attorney could be used.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring as 'good' because:

- Staff provided compassionate care and interacted with patients in a caring way. Further care and support was provided to patients when needed and patient survey feedback was positive about the services.
- Patients we spoke with were positive about the services provided and the care provided by the outpatient and diagnostic imaging departments. Care was planned and delivered in a way that took account of patients' needs and wishes.
- Chaperones were available to support patients in outpatients and staff confirmed interpreter services were accessible and available.
- Specialist nurses were available in a number of clinics and were able to give advice and further care to patients in their clinics.
- People were treated respectfully and their privacy was maintained in person and through actions of staff to maintain confidentiality and dignity.
- There were services to emotionally support patients and their families. Staff reacted compassionately to patient discomfort or distress and to suit individual needs. Staff involved patients by discussing and planning their treatment and were able to make informed decisions about the treatment they received.

Compassionate care

- Staff provided compassionate care and interacted with patients in a caring way. Staff provided further care where required, for example if transport had been delayed, staff told us they would stay with the patient and offer a snack pack and drinks whilst they waited for the transport.
- We spoke with four patients during our inspection. Patients we spoke with were positive about the care received and the services provided in outpatients.
- The patient survey carried out by the physiotherapy department showed that the service scored 9.5 out of 10 for patients recommending the hospital to family and friends. The trust scored 10 out of 10 for patients being treated in a courteous and respectful manner.
- During our inspection we saw a main outpatient department performance board. This board highlighted that 96% of patient feedback was positive. The board also highlighted that 99% of patients felt treated with respect.
- Staff told us they ensure privacy and dignity is respected in the services. Staff would reassure patients during their appointments and explain the process in outpatients clearly to patients.

Diagnostic imaging:

- We observed staff behaving in a caring manner towards patients they were treating and communicating with and respecting patients' privacy and dignity throughout their visit to the department.
- Staff ensured that patients felt comfortable and safe in the department and we observed them putting patients of all ages at ease.
- There were gowns available to patients to maintain their dignity and, although these were always offered, we observed some patients preferred not to use them.

Outpatients and diagnostic imaging

- There were designated areas for patients on trolleys to maintain their privacy. Staff asked inpatients in chairs if they would prefer curtains drawn around them for privacy. We observed some patients preferred them left open to be able to see the main waiting area.
- The department had been designed to provide as much privacy and dignity as possible with changing rooms and toilets close to procedure rooms and away from public thoroughfares.
- We spoke with three patients and two people close to them and all said that staff were friendly with a caring attitude. There were no negative aspects highlighted to us.

Understanding and involvement of patients and those close to them

- Staff confirmed they provide chaperones to patients during clinics. Staff told us they used the butterfly scheme for dementia patients.
- Staff told us interpreter services were available across outpatients and diagnostic services.
- In the physiotherapy patient survey, the service scored 9.9 out of 10 for patients feeling involved in decision being made about their care.

Diagnostic Imaging:

- Patients told us that they were involved in their treatment and care. Those close to patients said that they were kept informed and involved by staff. All those we spoke with told us that they knew why they were attending for a procedure or scan.
- Outpatients and diagnostic imaging staff involved patients in their treatment and care. We saw staff explaining treatment. We observed examples in diagnostic imaging of staff giving patients and families time and opportunities to ask questions.
- Radiology reception was situated near to the department entrance and staff frequently checked the entrance areas for trauma patients and inpatients, greeting people and assisting them where required. Staff we spoke with described examples where they would provide further support to patients if required.

Emotional support

- There were clinics which had specialist nurses, such as renal specialist nurses. These nurses were able to provide further advice and support to patients.
- The main outpatient department had a dedicated room which could be used by patients, families and carers. This room provided privacy and dignity away from the main outpatient waiting areas.
- The chronic kidney disease team provided further information and support to patients regarding dialysis transplantation in clinics.

Diagnostic Imaging:

- Staff told us that on request, if someone was anxious about a procedure such as a scan, they could visit the department first to look at the equipment and understand what to expect. This was also available for patients living with a learning disability.
- In the case of children, parents could be in the x-ray room, protected by a lead apron to ensure that the child felt safe. There was a similar process in place to support patients living with dementia or a learning disability who needed extra support in the scanning or x-ray room.
- We observed staff working with a small child and their family to encourage the child to comply with the process for taking an x-ray image. The radiographers spoke to the child and the parents and explained what would happen.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We rated responsive as 'requires improvement' because:

- Referral to treatment time (RTT) data varied across the specialities. The service did have patients which the see by date had been breached.
- There were a number of clinics cancelled within 6 weeks of the clinic across the trust and there was no current action plan in place to address cancelled clinics in outpatients.
- The trust did not measure how many patients waited over 30 minutes to see a clinician in outpatient departments.
- Turnaround times for inpatient plain film radiology reporting did not meet Keogh standards, which require inpatient images to be reported on the same day.

However:

Outpatients and diagnostic imaging

- We found that outpatient and diagnostic services were responsive to the needs of patients who used the services. Extra clinics and imaging sessions were added to meet demand and waiting times for diagnostic imaging appointments were within acceptable timescales. Patients were able to be seen quickly for urgent appointments if required.
- There had been a trend of improvement for diagnostic six week waiting times in diagnostic imaging.

Service planning and delivery to meet the needs of local people

- The 'did not attend' (DNA) rate between April 2015 and March 2016 was lower than the England average for all hospital outpatient sites except Workington Community Hospital where the DNA rate was higher.
- The chronic kidney disease team carried out home visits to patients to discuss different options for dialysis transplantation.
- The orthopaedic outpatient department offered virtual fracture clinics. The virtual fracture clinic was developed to manage patients attending the fracture clinics and attempt to prevent unnecessary attendance. Staff told us this had reduced the number of patients needing to come into hospital for their appointments. These clinics had made further capacity within the orthopaedic outpatient department available.
- Outpatient management told us that, if new clinics were being offered and more staff were required in outpatients, the service would request further clinical nurse and administration support before the new clinics were introduced.
- Outpatient management told us they were considering offering more clinics in the evening at the hospital and that if evening clinics were requested by specialities, they would put these on. Weekend clinics were provided at the hospital to help deal with the demand for the services and address waiting lists.
- The service was considering participation in the nurse cadet scheme to assist the hospital in recruiting more healthcare professionals.

Diagnostic imaging:

- The diagnostic imaging department had good processes in place and the capacity to deal with urgent referrals and additional scanning sessions were arranged to meet patient and service needs.
- Diagnostic imaging reporting and record-keeping was electronic and paperless methods were used to reduce time and administration requirements. Urgent reports were flagged for prioritisation.

Access and flow

- The trusts referral to treatment time (RTT) for non-admitted pathways between September 2015 and August 2016 has been similar to the overall England performance. Eight specialities were above the England average and seven specialities were below the England average. For example, rheumatology was at 96.9% against an England average 93.4% and ophthalmology was at 96.4% against an England average of 93.8% for non-admitted RTT performance.
- Data from the non-admitted RTT performance of specialties below the England average show that Urology is an 88.3% against a 90.3% England average and Trauma and Orthopaedics were at 93.8% against an England average of 90.1%.
- The trusts referral to treatment time (RTT) for incomplete pathways between September 2015 and August 2016 was worse than the England overall performance and worse than the operational standard of 92%. There were ten specialities above the England average for incomplete pathways (RTT) and there were five specialties that were below the England average for incomplete pathways for RTT. For example, dermatology was at 96.7% against an England average 94.2%; however ophthalmology was at 86.8% against the England average of 93.3% for RTT incomplete pathways.
- The trust was performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral.
- At quarter 2 2016/2017 the trust performed better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis. Before quarter 2 the performance showed a downward trend from quarter 3 2015/2016 to quarter 1 2016/2017.
- The trust performed worse than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. At quarter 2 2016/2017 the trust performance was slightly above the England average but still below the operational standard.
- In a previous inspection 6 week diagnostic waiting times were raised as a concern. Data at this inspection

showed that between September 2015 and June 2016, the percentage of patients waiting more than six weeks to see a clinician was higher than the England average, however in July 2016 and August 2016 the waiting times have been better than the England average. Over a 12 month period between September 2015 and August 2016, there had been a trend of improvement.

- During our inspection we found that clinics had been cancelled within 6 weeks in outpatients. The trust were unable to provide the percentage of clinics cancelled, however the number of clinic cancellations within 6 weeks in July 2016 was 98, in August 2016 it was 71 and in September 2016 175 clinics were cancelled within 6 weeks. In July 2016 148 clinics were cancelled over 6 weeks, 168 clinics were cancelled in August 2016 and 286 clinics were cancelled in September 2016. Information provided by the trust showed that the main reasons for cancelled clinics were industrial action, sickness absence, and locum medical staff turnover. There was no current action being taken to address cancelled clinics in outpatients.
- The trust did not measure the percentage of patients waiting over 30 minutes to see a clinician. This meant that the trust could not assess performance in 'the time patients wait to see a clinician in the outpatient clinics' category. Staff did highlight the waiting time on the performance boards in their departments; however this was not regularly audited.
- The trust provided data showing that some areas did have patients where they had breached the see by date. For example, in trauma and orthopaedics, 51 patients had breached the see by date in August 2016 and in cardiology, 47 patients had breached the see by date in August 2016.
- Ophthalmology had a small backlog in the cataract service. This figure was around 50 patients a month, staff and management told us that extra clinics were added each week and some clinic slots were double booked to ensure patients are seen when required. Weekend clinics were also offered to deal with the backlog. Staff told us demand was high in the ophthalmology clinics.
- Physiotherapy waiting times was highlighted as an issue in the previous inspection report. At this inspection, staff told us there were no current issues with waiting times for outpatient appointments in the physiotherapy department. The service had increased capacity by moving from two physiotherapy groups per week to one group and increasing the number of patients in the group. This had increased capacity elsewhere in the service.
- Data provided by the trust for physiotherapy showed that the waiting time in weeks had generally decreased in December 2015 from eight weeks to five weeks in August 2016. Between December 2015 and August 2016, the maximum waiting time was 12 weeks for physiotherapy outpatients.
- Outpatient 'did not attend' (DNA) rates were 11% in September 2016 and this had reduced to 9% in October 2016. These DNA rates included new and follow-up patients.
- There had been challenges achieving the non-admitted pathways in oncology outpatients in October 2016 due to sickness. The service achieved 70% in October 2016, however in November 2016, this was 100%. The service had added capacity to clear the backlog of patients waiting in November 2016.

Diagnostic imaging:

- The department provided a radiology coordinator to assess capacity and demand and make adjustments to staffing where necessary.
- Radiology managers told us diagnostic imaging waiting times, measured over all sites, from all urgent and non-urgent referrals met national targets. Members of the administration team in radiology told us they checked request lists for any urgent referrals before they were vetted by the senior radiographer and radiologist. Average wait times across all modalities including CT, MRI, and fluoroscopy, for outpatients and GP referrals ranged between 8 days and 19 days. The department did not provide figures for average wait times for inpatients. However staff told us most inpatient and emergency patient imaging was carried out on the day of the referral.
- Staff carried out a continuous review of planned diagnostic imaging sessions in relation to demand and 7-day working arrangements. They monitored waiting times and were able to identify any possible breach dates. This enabled the team to take action such as adding extra appointments. They organised additional sessions to accommodate urgent diagnostic imaging requests.

Outpatients and diagnostic imaging

- The department had introduced a CT on-call service for out-of-hours requests. However there was no on-call provision for MRI.
- Turnaround times for radiology reports were monitored and most of those recorded were in line with Keogh national standards. Average turnaround times were reported across all sites as the average number of days between imaging and reporting:
  - Angiography reporting for inpatients ranged from 0.3 days to 3.6 days and urgent outpatients ranged from 0 days to 1 day.
  - CT reporting for inpatients ranged from 0.1 days to 0.4 days and urgent outpatients ranged from 0.4 days to 1.3 days.
  - MRI reporting for inpatients ranged from 0 days to 0.26 days and urgent outpatients ranged from 1.2 days to 3.4 days.
  - Reporting for inpatients ranged from 0.3 days to 3.6 days and for urgent outpatients ranged from 0 days to 1 day.
  - Plain film reporting for inpatients ranged from 5.9 days to 13.8 days and urgent outpatients ranged from 1 day to 4.2 days. This did not meet Keogh standards, which require inpatient images to be reported on the same day.
- Reporting times for urgent and non-urgent procedures consistently met national and trust targets for all scans and x-rays for outpatients.
- Managers told us that they worked closely with staff from other departments and specialties on their performance in providing a good and prompt service to meet targets. These included Accident and Emergency imaging and reporting as well as timely imaging for specialties to support referral to treatment targets.

Meeting people's individual needs

- Outpatients had access to a vulnerable adults and dementia link nurse.
- Staff confirmed interpreter services were available and accessible when required.
- Outpatient appointments time for each patient per appointment was dependant on the individual speciality in outpatients.
- The butterfly scheme was in use for patients who had dementia. Staff told us they regularly communicated information to vulnerable patients and respected their privacy and dignity, for example by ensuring clinic doors were closed and curtains were in use where required.

Diagnostic imaging:

- Patients with complex individual needs such as those with learning difficulties were given the opportunity to look around the department prior to their appointment. Staff could provide a longer appointment or reschedule an appointment to the beginning or end of the clinic.
- There were separate toilets and waiting areas for patients who had received radioactive injections. This reduced the risk of radioactive exposure to visitors and ensured correct waste procedures were adhered to.
- Staff told us the bookings team could produce information for patients in different languages.
- Bariatric equipment was available and accessible.
- Staff were aware of how to support people with dementia. They told us that most patients with dementia were accompanied by carers or relatives and provisions were made to ensure that patients were seated in quiet areas and seen quickly.
- Departments were able to accommodate patients in wheelchairs or who needed specialist equipment. There was sufficient designated space to manoeuvre and position a person using a wheelchair in a safe and sociable manner.
- Patients had access to a wide range of information. Information was available on notice boards and leaflets. There was information that explained procedures such as x-rays. There was information about various illnesses and conditions including where to go to find additional support.
- Patient information leaflets were plentiful, of good quality and up to date.

Learning from complaints and concerns

- The services visited had received 31 complaints over the preceding 12 months. Of these 21 were informal and 11 were formal. The departments kept a log of complaints and all actions taken. This included lessons learned across departments and sites.
- Staff in diagnostic imaging told us that complaints were few and far between, and we found only one, informal, complaint on the department log.
- There was a patient advice and liaison office located near the main outpatient area in the hospital.
- None of the patients we spoke with had ever wanted or needed to make a formal complaint.

Outpatients and diagnostic imaging

- The department displayed a quality board with "You said: We did" comments and changes implemented as a result of patient comments.
- Staff were aware of the local complaints procedure and were confident in dealing with concerns and complaints as they arose. Managers and staff told us that complaints, comments and concerns were discussed at team meetings, actions agreed and any learning was shared.
- Information was accessible on the Trust web site including the complaints policy. We saw information distributed within the departments. Most patients we asked did not know how to make a complaint but said that they would initially complain to the clinician seeing them or at reception.

Are outpatient and diagnostic imaging services well-led?

Good

We rated well-led as 'good' because:

- The diagnostic imaging department had a five year plan in place to ensure that the diagnostic imaging department was future proof.
- There were governance processes in place to ensure that any risks, incidents or complaints were able to demonstrate lessons learned.
- Outpatient managers were able to describe the risks to the services and what they action they were taking to mitigate the risks.
- Staff were mostly positive about local leadership in the service. Staff in diagnostic imaging felt supported by their line managers, who encouraged them to develop and improve their practice. The department supported staff who wanted to work more efficiently, be innovative, and try new services and treatments.
- Staff we spoke with enjoyed their role and overall felt respected and valued by the trust. Staff described good team work and supportive teams.
- Daily staff huddles in outpatients had improved staff engagement and information sharing.
- Staff worked well together as a productive team and had a positive and motivated attitude.

However:

- There was limited public engagement throughout outpatient services.

Vision and strategy for this service

- We found that staff being able to describe the values of the trust varied.
- A strategic overview document provided by the trust highlighted that outpatient services were supplied by the clinical specialities which provide the services. Outpatient services were provided across the five hospital sites at the trust.

Diagnostic imaging:

- The diagnostic imaging department had some new members of the leadership and management team and staff told us they were kept informed and involved in strategic working and plans for the future.
- The management team were keen to tell us about the business plan they were working on to ensure that the department was able to cope with future demands on services. This involved the expansion of the diagnostic imaging department and the purchase of further MRI and CT machines.

Governance, risk management and quality measurement

- During our inspection we found that access to performance measurement and quality measurement information varied. For example, outpatient clinics did not measure the time patients waited in clinic for their appointment.
- Management told us the governance structure for escalating risks was through a number of regular meetings. For example, staff in clinics would raise concerns with local managers, who would then raise them with the outpatient senior managers. This would then be discussed at the monthly governance meeting which was attended by senior managers in outpatients.
- Managers we spoke with were able to describe risks to the services in outpatients such as the orthopaedic practitioner staffing levels, however during our inspection these were not documented on the risk register. Management of outpatients confirmed that they had requested staffing levels was put on the risk register during our inspection. Managers could also describe the action being taken to address risks such as

staffing levels such as training further staff as orthopaedic practitioners. All incidents reported through the electronic incident reporting system were sent to the outpatients managers.
- Medical record provision was still highlighted on the risk register, however data provided by the trust showed that medical record accessibility had improved. Management told us they encouraged staff to complete an incident form when records did not arrive for clinic. Staff also told us they would only see patients if there was adequate information available to see the patient in clinic. Outpatient managed would liaise with medical records around issues of availability in clinics as required.

Diagnostic imaging:

- The department had a risk register that it shared with the outpatient department. Risks were rated high, moderate and low. These had been reviewed regularly. There was evidence of mitigation in place and action taken to reduce risks to patients.
- Serious incidents were discussed at multidisciplinary clinical governance meetings and where appropriate, escalated through the governance committees.
- Department managers carried out investigations of incidents and reported back to teams. Where necessary, policies and procedures were updated in line with guidance received.
- There were governance arrangements which staff were aware of and participated in.
- Staff told us they understood the management and governance structure and how it reported up to the executive board and back down to staff with lessons learned across the trust.
- Consultants took part in radiology reporting discrepancy meetings. These were held to discuss the quality of images and reporting. This forum was used to promote learning.
- Diagnostic imaging had a separate and additional risk management group consisting of modality (specialist diagnostic imaging services for example CT and MRI) leads and radiology protection specialists.
- In diagnostic imaging radiation protection supervisors (RPS), from specialties within the department and across all sites, raised, discussed and actioned risks identified within the department and agreed higher level risks to be forwarded to the divisional manager.
- The organisation had systems to appraise NICE guidance and ensure that any relevant guidance was implemented in practice. In diagnostic imaging these included guidance on biopsy procedures.

Leadership of service

- Staff were positive about local leadership and we were told that most managers were visible and approachable, however staff views on senior management being visible varied. Outpatients managers told us they had an open door policy.
- Outpatient managers reported to senior managers who had responsibility for all trust outpatients services.
- Managers from the outpatient department attended a weekly meeting where they discussed general issues. These meetings were attended by managers from other trust departments.

Diagnostic imaging:

- The trust had employed a lead radiographer on secondment to lead the teams across all sites and reinstate effective quality assurance systems.
- Staff told us diagnostic imaging department leadership was in parts new, it felt stable and was positive and proactive. Staff told us that they knew what was expected of staff and the department and that every effort was being made to recruit and train more staff.
- Departmental managers were supportive in developing the service and practice, and the trust as a whole valued its staff. Staff felt that they could approach most managers with concerns and feel listened to. We observed good, positive and friendly interactions between staff and managers.
- Staff told us they saw the divisional management team regularly.
- Managers told us that IR(ME)R incidents were looked upon as an opportunity to learn. We saw notes in regular staff meeting minutes which stated that staff had completed reflection exercises and learning points were disseminated in team meetings.

Culture within the service

- Most staff we spoke with told us they felt respected and valued. Overall, staff we spoke with enjoyed their roles and were proud of the service that they provided. Staff

we spoke with told us there was good team work and that teams were supportive. Morale varied in the Oncology outpatient department, mainly due to staffing shortages in the service.
- Some staff we spoke with told us they had attended national conferences relevant to their practice and they shared information gathered with the team.

Diagnostic imaging:

- Staff were encouraged to report incidents and complaints and felt that these would be investigated fairly.
- Managers told us that they felt well-supported by the organisation.
- Staff were passionate about their patients and felt that they did a good job. Staff we spoke to in all the diagnostic imaging departments said that they felt part of a team and empowered to do the job.
- Diagnostic imaging staff told us there was a good working relationship between all levels of staff. We saw that there was a positive, friendly but professional working relationship between consultants, nurses, radiographers and support staff.
- Diagnostic imaging staff told us that they felt there was a culture of staff development and support for each other. Staff were open to ideas, willing to change and were able to question practice within their individual modalities.
- Department managers told us that there were formal team meetings as well as informal meetings and team leaders walked around departments every day to speak to staff.

Public engagement

- There was limited public engagement in outpatients. The main outpatient department had a performance board on display in the waiting area. This outlined some of the performance information related to the department such as nurses on duty and waiting times. This allowed patients to see some of the performance indicators for the department.
- The services used a patient survey called 'two minutes of your time' to receive feedback about the services.

Diagnostic imaging:

- Information was displayed on message boards to engage the public in messages about the service and to seek feedback. We saw a "You said: We did" section showing examples of comments that had been made by patients and how the department had addressed them.

Staff engagement

- A daily staff huddle was carried out daily in the outpatient department. This allowed staff to discuss any issues related to outpatients they may have or receive and share important information. Staff told us these were good for regular updates about the service and receive information from other parts of the trust.

Diagnostic imaging:

- Staff told us diagnostic imaging managers shared new information and news with staff through team meetings and information was attached to meeting minutes
- Staff told us they met informally with team leaders each morning. We saw evidence of notes from meetings and other communications, and information for staff on noticeboards.
- Policies and procedures were available to staff via the trust intranet and lead radiographers helped staff to access information.
- Departmental staff liaised with teams and specialists from other hospitals within the trust and neighbouring trusts to keep updated with new practices and developments to ensure that services offered were in line with current practice and effective.

Innovation, improvement and sustainability

- A daily huddle had been introduced into the main outpatient department which allowed staff to share information and share general issues in main outpatients. This was held around a communication board where information and notices regarding changes and information disseminated by the trust could be highlighted.
- The fracture clinic had introduced a virtual fracture clinic which carried out telephone appointments with patients.

Outstanding practice and areas for improvement

Outstanding practice

- National Patient safety awards finalist for better outcomes in orthopaedics.
- The trust had the only surgeon between Leeds and Glasgow doing a meniscal augment in the knee.
- Honorary Professorship University of Cumbria received by a consultant for work on applying digital technologies in Health Care for elderly population in rural setting, a part of CACHET.
- Multinational multicentre prospective study in the use of intramedullary nail in varus malalignment of the knee. The trust had the largest international experience of this technology for this application.
- CIC was one of only 18 Hospitals in England and Wales referred to in the first NELA audit for contributing examples of best practice in care of patients undergoing emergency laparotomy.
- The real strength of MDT working across stroke, neurorehabilitation and older person's services;
- The 'expert patient programme' and 'shared care initiative' to promote patient empowerment and involvement in care;
- The variety of data capture measures to monitor 'real-time' patient experience and collate patient feedback;
- The innovative and progressive Frailty Unit projects;
- The growth, expansion and development of the MPU service; and,
- The implementation of dance related activities for vulnerable patient groups to stimulate social interaction, patient involvement, family partnerships and exercise.

Areas for improvement

Action the hospital MUST take to improve

In urgent and emergency services

- Meet the target to see and treat 95% of emergency patients within four hours of arrival linked to meeting the locally agreed trajectory to see and treat emergency patients within the standard agreed with regulators and commissioners.
- Ensure medical and nursing staff use the computer system fully as intended so that patient real time events are recorded accurately and this is demonstrated through audit.
- Take further steps to resolve the flow of patients into and out of the hospital.

In Medicine

- Ensure systems and processes are established and operated effectively to assess, monitor and improve the quality and safety of the services provided, and, evaluate and improve practice to meet this requirement. Specifically, review the escalation process involving 'floor working' to ensure the quality and safety of services are maintained;
- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed across all divisional wards. Specifically, registered nurses to ensure safe staffing levels are maintained, especially in areas of increased patient acuity, such as NIV care and thrombolysis.

In Surgery

- Must ensure the peri-operative improvement plan is thoroughly embedded and that all debrief sessions are undertaken as part of the WHO checklist to reduce the risk of Never Events.
- Improve compliance against 18 week referral to treatment standards for admitted patients for oral surgery, trauma & orthopaedics, urology and ophthalmology.
- Improve rate of short notice cancellations for non-clinical reasons specifically for ENT, orthopaedic and general surgery.
- Must ensure patients whose operations are cancelled are treated within the 28 days.

In Maternity and Gynaecology

- Review staffing levels, out-of-hours consultant paediatric cover, and surgical cover to ensure they

Outstanding practice and areas for improvement

meet the Royal College of Obstetricians and Gynaecologists (RCOG) guidelines (including 'safe childbirth: minimum standards for the organisation and delivery of care in labour')
- Ensure that systems are in place so that governance arrangements, risk management and quality measures are effective.

In Services for Children and Young People

- The trust must ensure children and young people services meet all Royal College of Paediatrics and Child Health (RCPCH) - Facing the Future: Standards for Acute General Paediatric Services (2015 as amended).
- The trust must ensure nurse staffing levels on SCBU adhere to establishment and meet recognised national standards.

In End of Life Care

- Ensure that DNACPR forms are fully completed in terms of best interest assessments in line with the Mental Capacity Act.

In Outpatients and Diagnostic Imaging

- Address the number of cancelled clinics in outpatient services.
- Ensure referral to treat (RTT) indicators are met across outpatient services.

Action the hospital SHOULD take to improve

- Ensure that levels of staff training continue to improve in the hospital so that the hospital meets the trust target by 31st March 2017.

In urgent and emergency services

- Increase the complement of medical consultant staff as identified in the accident and emergency service review
- Achieve quantified improvements in response to the trauma audit and research network (TARN) audit and the NICE clinical guideline self-harm audit (CG16), and demonstrate progress achieved through audit.
- Take steps to ensure patient confidentiality can be maintained in the accident and emergency reception area.
- Extend the scope and consistency of staff engagement

In Medicine

- Continue to progress patient harm reduction initiatives;
- Revisit the 'floor working' initiative, particularly across Elm wards;
- Revisit thrombolysis cubicle bed utilisation to reduce potential unnecessary, inappropriate or inconvenient bed moves;
- Ensure IPC compliance improvement and consistency in standards, in particular regarding catheter and cannula care;
- Ensure best practice guidelines for medicines related documentation is reinforced to all prescribers;
- Ensure oxygen prescribing is recorded and signed for accordingly;
- Ensure medicines management training compliance improves in line with trust target;
- Ensure NEWS trigger levels are adhered to (or document deviation/individual baseline triggers in the clinical records);
- Ensure care and treatment of service users is appropriate, meets their needs and reflects their preferences. Specifically, ensure the endoscopy pathway design meets service user preferences and care or treatment needs
- Ensure fluid and food chart documentation is accurate to reflect nutritional and hydration status;
- Ensure staff are given time to complete all necessary mandatory training modules and an accurate record kept;
- Ensure all equipment checks are completed in line with local guidance;
- Continue to proactively recruit nursing and medical staff, considering alternate ways to attract, such as utilising social media;
- Ensure measures are put in place to support units where pending staffing departures will temporarily increase vulnerability;
- Ensure food satisfaction standards are maintained and where relevant improved;
- Develop an action plan to detail objectives to improve and progress diabetes care across the division;
- Evidence improvements in patient outcomes for respiratory patients around time to senior review and oxygen prescribing;
- Ensure all staff can access development opportunities in line with organisational/staff appraisal objectives protecting/negotiating study time where required;

Outstanding practice and areas for improvement

- Ensure appraisal rate data recorded at trust level coincides with figures at divisional/ward level;
- Revisit the patient journey, booking and listing procedures at the endoscopy suite at CIC;
- Continue to minimise patient moves after 10pm;
- Continue to work with community colleagues to develop strategies to minimise DTOC and unnecessary lengthy hospital stays for patients MFFD;
- Reinforce the benefits of dementia initiatives to ensure consistency of practice;
- Ensure the risk register is current and reflects actual risks with corresponding accurate risk rating; Ensure all actions and reviews of risk ratings are documented;
- Ensure progress continues against QIP, realign completion dates and account for deadline breaches;
- Revisit medical rota management processes for junior doctors;
- Revisit modes of communications with staff to ensure efficiency whilst avoiding duplication;
- Ensure staff involved in change management projects are fully informed of the aims and objectives of the proposal and these are implemented and concluded in appropriate timeframes; and,
- Ensure divisional leads and trust leaders promote their visibility when visiting wards and clinical areas.

In Surgery

- Ensure robust recruitment and retention policies continue to improve staff and skill shortages.
- Continue to embed the perioperative quality improvement plan.
- Improve debrief in theatres post-surgery.
- Improve the proportion of patients having hip fracture surgery on the day or day after admission.
- Improve the rate of patients receiving a VTE re-assessment within 24 hours of admission.
- Ensure all mandatory training is completed by March 2017.
- Reduce the management of medical patients on surgical wards.
- Ensure bullying allegations in theatres are addressed.

In Critical Care

- Take action to improve pharmacy staffing in line with GPICS (2015).
- The clinical educator should provide a full time role in the CIC unit in order to meet GPICS (2015) standards for a unit of this size.
- The role of the clinical coordinator should be protected as per GPICS (2015) standards. Currently this is not the case as nursing staff are frequently moved to cover ward staffing shortfalls with a disregard for the value of the supernumerary coordinator role in the critical care unit.
- Staff should not be moved to cover ward shortages if this compromises safe nurse to patient ratios of care in the critical care unit, Senior staff at trust and unit level should offer continued support and monitor this issue closely to reduce the need for the frequency of unplanned staff movement to reduce risk of compromising patient safety and to improve morale amongst nursing staff in the unit.

In Maternity and Gynaecology

- Ensure that processes are in place for midwives to receive safeguarding supervision in line with national recommendations.
- Continue to improve mandatory training rates to ensure that trust targets are met by the end of March 2017.
- Ensure there are processes in place to make record-keeping, medicine management, and checking of equipment consistent across all areas.
- Review the culture in obstetrics to ensure there is cohesive working across hospital sites and improved clinical engagement.

In Services for Children and Young People

- Ensure that staff adhere to and update the cleaning schedule and cleaning log in the children's outpatient department as appropriate.
- Ensure that medical staff sign all signature sheets and print their names and designations against all entries on all patient notes.
- Ensure that all staff have completed the required mandatory training and that systems accurately reflect this data.
- Ensure the patient database system in A&E has the capacity to flag children and young people who have multiple attendances at A&E, children looked after, and children subject to a child protection plan.
- Ensure the new paediatric anaesthetist lead (when appointed) receives an appropriate amount of

Outstanding practice and areas for improvement

professional leave time to develop a specialist skill base for this highly specialised role. This should include robust training and support, including time spent at specialist centres for paediatric surgery

In End of Life Care

- Arrange formal contract meetings with members of the Cumbria Healthcare Alliance to monitor that the service being commissioned and provided is of an appropriate standard in terms of quality and meeting patient need.
- Ensure that it is aware of the number of referrals to the SPCT within their hospitals.
- Ensure that it is aware of how many patients are supported to die in their preferred location and there is regular audit of the CDP to demonstrate this.
- Produce an action plan to address areas in national audits where performance was lower than the England average with key responsibilities and timelines for completion.

In Outpatients and Diagnostic Imaging

- Continue to ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed in order to meet the needs of the patients.
- Ensure that staff have up to date safeguarding training.
- Should ensure staffing levels are sufficient in all outpatient services.
- Consider ways to increase mandatory training compliance.
- Consider ways of implementing clinical supervision for outpatient staff.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The provider has not ensured the provision of appropriate care and treatment that meets people's needs. Regulation 9(2).** **Reg. 9 (3b) - The care and treatment of service users must be appropriate, meet their needs, and reflect their preferences. Without limiting paragraph one designing care or treatment with a view to achieving service users' preferences and ensuring their needs are met;** **How the regulation was not being met:** • The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the A&E. The trust breached the standard continuously between September 2015 and August 2016. • Between September 2015 and August 2016 performance against this metric showed a decline from September 2015 to January 2016. There was a general improvement from January 2016 to July 2016 however this declined again in August 2016. In August 2016, the percentage of patients, admitted, transferred or discharged within four hours was 90.1 % compared with an England average of 91.0%. • The locally agreed trajectory for the 4-hour target as agreed with commissioners and regulators was not being met. • Four surgical specialities are not meeting the 18 week referral to treatment standards for admitted patients (oral surgery, trauma & orthopaedics, urology and ophthalmology).

This section is primarily information for the provider

Requirement notices

- Short notice cancellations for non-clinical reasons are high specifically for ENT, orthopaedic and general surgery.
- High percentage of patients not receiving their procedure within 28 days of the initial cancellation.
- There were a number of cancelled clinics in outpatient services.
- DNACPR forms were not fully completed in terms of best interest assessments in line with the Mental Capacity Act.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Reg. 18 (1) There must be sufficient numbers of suitably qualified, competent, skilled and experienced staff on duty.** **How the regulation was not being met:** • Nurse staffing levels within children and young people services were not adhering to establishment and meet recognised national standards. • Children and young people services did not meet all Royal College of Paediatrics and Child Health (RCPCH) - Facing the Future: Standards for Acute General Paediatric Services (2015 as amended). **Specifically, the unit did not meet:** • Standard 1 – A consultant paediatrician is present and readily available in the hospital during times of peak activity, seven days a week; • Standard 3 – Every child who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician within 14 hours of admission, with more immediate review as required according to illness severity or if a member of staff is concerned; • Standard 4 – At least two medical handovers every 24 hours are led by a consultant paediatrician.

This section is primarily information for the provider

Requirement notices

- Out-of-hours consultant paediatric cover and surgical cover did not meet the Royal College of Obstetricians and Gynaecologists (RCOG) guidelines (including 'safe childbirth: minimum standards for the organisation and delivery of care in labour').
- There were insufficient numbers of suitably qualified, competent, skilled and experienced persons a deployed across medical wards. Especially in areas of increased patient acuity, such as NIV care and thrombolysis.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Reg. 17 (2a, f) Ensure systems and processes are established and operated effectively to assess, monitor and improve the quality and safety of the services provided. Evaluate and improve practice to meet this requirement.** **How the regulation was not being met:** • There were gaps in how outcomes and actions from audit of clinical practice were used to monitor quality in maternity services. • Escalation process, specifically 'floor working' initiatives across medical wards were not effective.