North Cumbria University Hospitals NHS Trust

Quality Report

Newtown Road
Carlisle
Cumbria
CA2 7HY
Tel: 01228 523444
Website: www.ncuh.nhs.uk

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

Ratings

Overall rating for this trust	Requires improvement
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Requires improvement
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

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

We carried out this comprehensive inspection because North Cumbria University Hospitals NHS Trust had been placed in a high risk band 1 in CQC's Intelligent Monitoring System. The trust was also one of 11 trusts placed into special measures in July 2013 after Sir Bruce Keogh's review into hospitals with higher than average mortality rates. At that time, there were concerns around inadequate governance and pace and focus of change to improve overall safety and experience of patients; slow and inadequate responses to serious incidents and a culture that did not support openness, transparency and learning; staffing shortfalls and other workforce issues across staff groups that may have been compromising patient safety. In addition the review found a lack of support for staff and effective, honest communication from middle and senior management level; failure in governance to ensure adequate maintenance of the estate and equipment, and significant weaknesses in infection control practices.

Immediately before the Keogh review, and since that time, the trust has been led by an interim (recently permanent) Chief Executive and a largely interim management team. Support has been provided by both the Trust Development Authority and Northumbria Healthcare Foundation Trust as a 'buddy' organisation. Northumbria trust has seconded staff to strengthen the management team and provide additional capacity to secure improvements to services.

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

Overall, this trust was found to require improvement, although we rated it good in terms of having caring staff.

Our key findings were as follows:

- We recognised that the trust had worked hard and had made some progress since entering special measures in July 2013. Importantly, mortality rates were now within expected limits. However, the trust had 52 required actions as part of its Keogh Mortality Review action plan and, as of March 2014, all but four had been delivered. The remaining four actions had revised dates for delivery during 2014, as approved by the trust board.
- The range and nature of the improvements required within a complex and geographically challenging environment had added to the complexity of the challenges facing the trust.
- Despite the progress made in mortality rates and improved governance, there remained many issues of serious concern. The trust was experiencing major difficulties in recruiting doctors – particularly consultants. The shortfall in consultant cover was posing a considerable challenge to the trust with regards to maintaining safe and timely standards of care and treatment. Nurse staffing had improved overall, but still remained a challenge in terms of staffing all wards and departments appropriately and consistently.
- There were other significant challenges that were taking some time to resolve as they require cultural and behavioural changes by the trust's workforce. Staff at all levels gave a very mixed picture regarding the culture within the trust. Some were positive about the new senior team and felt the Chief Executive was visible and accessible. However, many staff who spoke with us stated that raising concerns was not always viewed positively and we heard many examples of staff feeling unable to speak openly or be involved in proposed changes. The lack of effective, honest communication from middle and senior management level remained an issue. Staff reported being fearful of raising issues with managers and a number of staff were visibly upset when raising their concerns with us and were concerned that their names would be made known to managers in relation to concerns raised. It was clear that some executive messages were becoming distorted before reaching the ward and departmental staff, leaving staff with mixed messages and unclear direction.

Summary of findings

- Changes had already been made to the care pathways for patients with high risk trauma and orthopaedic or complex surgical needs. This had resulted in more patients being transferred and/or cared for at the Cumberland Infirmary in Carlisle. However, this had left an imbalance and some discontent among staff about the effective use of resources in relation to routine elective work between the two acute hospitals.
- Care and treatment was not always robustly supported by evidence-based policies and procedures. The trust could not give assurance that all care and treatment was in line with NICE guidelines as monitoring systems were incomplete and inconsistently applied.
- Patient flow was poorly managed, resulting in poor experiences for patients. This was evident in delays at A&E where some patients had extended stays in the department and on occasions overnight. There were delays in discharge from critical care beds to the wards as beds were unavailable. We noted a number of incidents when patients were transferred between wards late at night. Some beds were not being used because of the lack of staff to provide care. This was an added dimension to the difficulties regarding patient flow and access to appropriate care settings.
- Despite actions taken to improve responses to serious incidents and promote a culture that supported openness, transparency and learning, the trust had reported 10 never events since November 2012. Never events are very serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place. The recurring themes emerging from the never events indicate that the actions taken and the sharing of lessons learned were not systematically embedded or applied across the trust.
- Infection control had significantly improved, although there were some concerns regarding the transfer of patients to the mortuary and the laundry facilities in the Special Care Baby Unit at the Cumberland Infirmary. General handwashing and timely general waste disposal could be improved.
- Clinical audit was not fully supported, although the trust was trying to improve this situation across all services.Clinical audit is important in monitoring, managing and improving care and treatment for patients.
- Outpatient services were failing to meet the six and 18-week targets for referral to treatment. Concerns about the effectiveness of clinics related directly to medical staffing issues and the supply of medical records, which was having a detrimental effect on the efficiency of the service.
- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect. Staff interacted positively with patients and /or their relatives and demonstrated caring attitudes. They were very supportive to both patients and those close to them and offered emotional support to provide comfort and reassurance.

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

Importantly, the trust must:

- Ensure there is a culture that supports openness, transparency and learning through effective, honest communication from middle and senior management level, robust responses to serious incidents and open engagement with all staff regarding future plans.
- Ensure that board assurance is supported by robust sources of information and is presented informatively.
- Address staffing shortfalls, in particular the numerous consultant vacancies. Nurse staffing levels must also be appropriate in all areas, without substantive staff feeling obligated to work excessive additional shifts.
- Follow national guidelines of having an anaesthetist available at all times for obstetrics at the West Cumberland Hospital, and a second theatre for obstetrics and gynaecology use.
- Address the impact of the changes to routine elective work between the two acute hospitals appropriately.
- Ensure that policies and procedures to support safe practice are robust and that they include a major incident plan for surgery.
- Show evidence of compliance with relevant NICE guidance and that clinical audit is consistently used to assess practice and support improvement.
- Ensure clinical risk management provides robust systems to monitor, mitigate and learn from incidents to support service improvement and patient safety.

Summary of findings

- Improve waiting times in A&E and the patient flow to ensure patient transfers are not unnecessarily delayed, patients are not moved at inappropriate times of the day or night or inappropriately accommodated in A&E overnight.
- Support outpatients to effectively meet national targets, and ensure patient records are available to support patient consultations.
- Provide clinical supervision to all staff.
- Address all estates and equipment deficits.

In addition the trust should:

- Ensure there is an epidural service at the Cumberland Infirmary.
- Ensure specialist triage nurses in A&E are available for all children presenting.
- Improve infection control in the mortuary and the Special Care Baby Unit at the Cumberland Infirmary, and improve general handwashing and timely general waste disposal.
- Continue to improve responses and reviews of complaints.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to North Cumbria University Hospitals NHS Trust

The Trust was created in 2001 following the merger of Carlisle Hospitals NHS Trust and West Cumberland NHS Trust. It is based primarily over two acute medical sites: Cumberland Infirmary at Carlisle and the West Cumberland Hospital at Whitehaven. In February 2011, the trust board concluded that the best option to secure high quality and safe services for the people of North Cumbria was to merge with another NHS trust. In January 2012, Northumbria Healthcare NHS Foundation Trust was named as the preferred bidder. Currently, the trust is in a period of appropriate detailed negotiations surrounding the acquisition with Northumbria, local health commissioners and NHS North of England (the strategic health authority). The trust's main commissioners are Cumbria CCG.

The trust was selected for the Keogh review as a result of its Hospital Standardised Mortality Rate (HSMR) results for 2011 and 2012 (the HSMR is a calculation used to monitor death rates in a trust). In both years, its HSMR was statistically above the expected level. It was during this time that the trust board decided to be acquired because it determined that this was the best way forward to secure long term sustainability and improve quality. The trust is not a foundation trust.

The trust serves a population of 340,000 people, and in 2012-13 was in a financial deficit of £15.3m. This is a rural community spread over a large geographical area. Deprivation levels vary from relatively low to high. Ethnic diversityis low. However, homelessness and youth drinking is significantly more common in North Cumbria than in the rest of England. Over 65s make up a larger proportion of the population than the national average.

The Cumberland Infirmary, Carlisle provides a 24-hour A&E service with Trauma Unit status, a consultant-led maternity service and special care baby unit, a wide range of clinical services, including delivering complex vascular and general specialist services, and outpatient clinics. It has 412 inpatient beds and serves the local people around Carlisle and in North Cumbria.

West Cumberland Hospital is a general hospital providing 24-hour A&E, a consultant-led maternity unit and special care baby unit, a range of specialist clinical services and an outpatients service. It has 217 inpatient beds and serves the local people around rural Whitehaven and West Cumbria. The West Cumberland Hospital building no longer meets modern needs and a £97 million phase 1 redevelopment of the hospital is currently underway.

The trust also runs a small birthing centre from Penrith Community Hospital to support delivery closer to home.

The inspection team inspected the following core services:

- Accident and Emergency
- Medical care (including older people's care)
- Surgery
- Intensive / Critical care
- Maternity and Family Planning
- Children and young people's care
- End of life care
- Outpatients

Our inspection team

Our inspection team was led by:

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

Head of Hospital Inspections: Ann Ford, Care Quality Commission

The team included an Inspection Manager, 10 CQC inspectors and a variety of specialists including a Surgical Operational Manager of Acute Trust Clinical Services; Director of Improvement, Quality and Nursing; Clinical governance expert; Consultant Physician and Gastroenterologist; Consultant Obstetrician & Gynaecologist; Consultant Paediatrician & Honorary Senior Lecturer - Neonates/general paediatrics; Executive Director of Nursing with experience in Community Services, Service Transformation, Clinical Governance,

Summary of findings

Risk Management, Prevention & Control of Infection, Emergency Planning, Safeguarding of Children; Surgical Nurse; Paediatric Emergency Nurse Consultant; Head of Midwifery and Supervisor of Midwives; Lead Nurse for Critical Care and previous Head of Nursing Development and Quality; Student Nurse and two experts by experience.

How we carried out this inspection

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

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

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

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

We carried out an announced inspection visit on 30 April to 2 May 2014. We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, junior doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

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

We carried out an unannounced inspection on 12 May 2014 between 8.30am and 4pm to look at the levels and type of staff available, and how they cared for patients.

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 both the Cumberland Infirmary, Carlisle, the West Cumberland Hospital in Whitehaven and the Penrith Birthing Centre.

What people who use the trust's services say

Before the inspection we received large quantities of information from our website, by phone and email from local people and staff. People told us they were concerned about privacy and dignity, a lack of portering staff, the skills, experience and numbers of nursing staff, infection control issues and concerns about the care of people living with dementia.

We spoke to over 80 people at our listening events. At the listening event in Whitehaven, concerns were raised about the need for older people to be transferred to Carlisle for trauma such as a fractured neck of femur. We were also told that patients quite often have to be transferred during their care to free up beds rather than for their clinical need. One patient told us that because of a lack of medical staff when she was admitted through A&E to West Cumberland Hospital, she had to wait six hours on the ward for pain relief. There were similar concerns at Carlisle; people also raised concerns about long waits in A&E and poor care experiences. This was a particular concern on some medical wards. Patients' relatives remained concerned about poor communication and a poor attitude of some staff in relation to sharing information and including them in the care of their family members.

Summary of findings

Between September 2013 and January 2014, a questionnaire was sent to 850 recent inpatients at the trust as part of the CQC Adult Inpatient Survey 2013. Responses were received from 414 patients at North Cumbria University Hospitals NHS Trust. Overall the trust was rated about the same as most other trusts that took part in the survey.

In December 2013, the trust performed below the national average in the inpatient Family and Friends Test. The trust has a significantly higher response for A&E data than for Inpatient services. The January 2014 inpatient survey included 31 wards at North Cumbria University Hospitals NHS Trust. Response rates within wards varied between 0% and 56.3%. Thirteen wards scored less than the trust average of 66. Beech B scored the least of all wards, the next two lowest scoring wards were Aspen Gynae and Larch C/D.

The trust had 294 reviews on the NHS Choices website from patients between July and December 2013. It scored 4 out of 5 stars overall. The highest ratings were for cleanliness, excellent care, respectful and dedicated staff, and good aftercare. The lowest ratings were for overcrowding, discharge arrangements and waiting times.

Patient-Led Assessment of the Care Environment (PLACE) is a self-assessment undertaken by teams of NHS and independent healthcare staff and also the public and patients. They focus on the environment. In 2013, the trust scored between 79.9% and 85.3%.

CQC's Survey of Women's Experiences of Birth, 2013 showed that the trust was performing about the same as other trusts on all questions on care, treatment and information during labour, birth and care after birth.

The Cancer Patient Experience Survey (CPES) is designed to monitor national progress on cancer care. In the 2012/13 survey the trust performed better than other trusts in three of the 69 questions but worse than other trusts in 21 of the other questions.

Facts and data about this trust

The Cumberland Infirmary, Carlisle provides a 24-hour A&E service with Trauma Unit status, a consultant-led maternity service and special care baby unit, a wide range of clinical services, including delivering complex vascular and general specialist services, and outpatient clinics. It has 412 inpatient beds and serves the local people around Carlisle and North Cumbria.

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

The West Cumberland Hospital structure no longer meets modern needs and there is currently a £97 million phase 1 redevelopment of the hospital underway.

The Penrith Birthing Centre had 23 births in 2013 and had recently undergone a midwifery review across the service.

We inspected the North Cumbria University Hospitals NHS Trust as part of the comprehensive inspection programme between 30 April and 12 May 2014. This inspection follows previous inspections including the Keogh and CQC inspections in 2013.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? Overall we rated the safety of services in the trust as 'requires improvement'. For specific information please refer to the reports for Cumberland Infirmary, Carlisle; West Cumberland Infirmary and Penrith Community Hospital. At the time of the Keogh review, there were concerns around staffing shortfalls and other workforce issues across staff groups that may have compromised patient safety; significant weaknesses in infection control practices and inadequate responses to serious incidents; and a culture that did not support openness, transparency and learning. There were also concerns relating to mortality rates in the Keogh review. The trust had undertaken a significant amount of work to gain a greater understanding of its mortality data. A review had been undertaken during 2012/13 and the trust now reviewed mortality each week as part of its Safety Panel at a corporate level, reviewed all deaths at service level and discussed mortality and clinical outcome data within its Business Unit Governance reports. The trust is now within expected ranges for both HSMR and SHMI measures At this inspection, one of the main areas of concern was staffing shortfalls, in particular the many consultant vacancies that were being supported by using locum doctors. A number of consultants spoke to us about patient safety concerns as a result of the failure to recruit consultants to services. The trust was not currently meeting national guidelines of having an anaesthetist available at all times for obstetrics at West Cumberland Hospital and there was no second theatre for obstetrics and gynaecology. Nurse staffing levels were calculated using a formal acuity tool. While we could see that some improvements have been made in nursing staffing levels, nursing staff were still describing the need to work double shifts and feeling under pressure to do this in order to maintain safer staffing levels. The limit of specialist triage nurses in A&E meant children were not always seen by the most appropriate nurse. The staffing levels within the medical records office required review as concerns were raised regarding the inadequate supply of notes to clinics, which was having a detrimental effect.	**Requires improvement** 

Summary of findings

Infection control had significantly improved, but some concerns remained regarding the mortuary and the management of laundry facilities in the Special Care Baby Unit at the Cumberland Infirmary. General handwashing and timely general waste disposal could also be improved.

Despite actions taken to improve responses to serious incidents and promote a culture that supported openness, transparency and learning, the trust had reported 10 never events since November 2012. Never events are very serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place. The recurring themes emerging from the never events indicate that the actions taken and the sharing of lessons learned were not systematically embedded or applied across the trust.

Other concerns identified at this inspection included patients being inappropriately accommodated in A&E overnight at the Cumberland Infirmary, for which the department was not designed, and this was not supported by a standard operating procedure. Policies and procedures to support safe practice were not robust. They were difficult to identify on the trust's intranet site as old versions were still live and this led to confusion. There was also a lack of review in line with major clinical pathway changes and many were out of date or did not reflect national standards.

The supply of medical records to clinics was affecting safety.In six months, 16 sets of notes were reported either damaged, unavailable or lost, but staff reported that this was happening much more frequently.

Adequate maintenance of the estate and equipment had improved, but issues remained with the mortuary and availability of equipment that was in working order.

The NHS Staff Survey 2013 showed that six of the 28 indictaors in relation to training; experience of physical violence; incident reporting; pressure to attend work when feeling unwell and discrimination at work were better than expected.

Are services at this trust effective?

Requires improvement

Overall we rated the effectiveness of services in the trust as 'requires improvement'. For specific information please refer to the reports for Cumberland Infirmary, Carlisle; West Cumberland Infirmary and Penrith Community Hospital.

Compliance with NICE guidance could not be assured. The Safety & Quality Committee received reports without detail as to what guidance was either non-compliant or partially compliant and the

Summary of findings

level of potential risks this may present to a service or the organisation as a whole. As of the Q3 report, only 39 of 410 pieces of guidance applicable to the organisation had been audited with compliance confirmed. Compliance had been stated without any independent assurance or audits by clinicians in a further 136 pieces of guidance. A response on whether guidance was definitely applicable and the current status was awaited for 184 of the 410, and 49 pieces of guidance were confirmed as not compliant. We discussed this with the Acting Director of Governance who explained that some of these areas were now being discussed at Quality Panels focusing on clinical outcomes, audit and clinical guidelines. Evidence of these panels was requested but not provided.

Clinical audit was not fully supported although the trust was trying to improve. Evidence of this was seen with the increased participation in national audits, which will help the trust benchmark clinical outcomes against other providers. Data showed that at Quarter 3 the percentage of audits being completed in line with the agreed timescales ranged from 0% for Corporate Services (0/2 audits had been completed) to 75% in Medicine (43/57 audits completed). Eighteen audits had been abandoned, largely in the Medicine and Surgery business units, by the end of quarter 3. We were told that work is being undertaken to prioritise the audit plans, including national audits and audits as a result of serious incidents. Monitoring of audit progress was not robust, lacking detail on actions outstanding for each audit, who should be completing these, by when and the level of risk to the service/organisation. No evidence of sharing learning from clinical audits at ward and department level was provided during the course of the inspection.

Outpatients services were not meeting the six and 18 week targets for referral to treatment. Concerns about the effectiveness of clinics related directly to medical staffing issues (use of locum cover for consultant vacancies) and issues with the timely supply of medical records that were fit for purpose.

Are services at this trust caring?

Good

Overall we rated the caring aspects of services in the trust as 'good'. For specific information please refer to the reports for Cumberland Infirmary, Carlisle; West Cumberland Infirmary and Penrith Community Hospital.

Throughout our inspection we witnessed patients being treated with compassion, dignity and respect. Staff interacted positively with patients and /or their relatives and demonstrated caring attitudes. They were very supportive to both patients and those close to them and offered emotional support to provide comfort and reassurance.

Summary of findings

Patients and relatives said they felt involved in their care and they received good emotional support from staff. They were positive about staff attitudes and had confidence in the staff's ability to look after them well. It was clear that staff were very committed and caring and worked to achieve the best outcomes for patients.

Are services at this trust responsive?

Requires improvement

Overall we rated the safety of services in the trust as 'requires improvement'. For specific information please refer to the reports for Cumberland Infirmary, Carlisle; West Cumberland Infirmary and Penrith Community Hospital.

NHS trusts in England are required to admit, transfer or discharge 95% of patients within four hours of their arrival in the A&E department. The trust has struggled to meet this target – its lowest performance was in January 2014 at 85.2%.

Across the trust there were concerns about patient flow through the hospital. This was having an adverse effect on A&E admissions, patients not being admitted to the most appropriate ward for their condition and some patients being moved during the night to accommodate new admissions.

Since June 2013, trauma operative work, high risk general surgery and colorectal cancer work has all transferred to the Cumberland Infirmary in Carlisle. This has led to routine elective work being regularly cancelled at Carlisle. The transfer of routine work to the West Cumberland Hospital had not been as systematic as anticipated due to patients preferring to wait to have their procedure/operation at Carlisle. This had affected referral to treatment times (RTT) that were not being met for admitted patients, particularly in orthopaedics. The trust had a detailed action plan that included measures such as: additional number of procedures per month to achieve 90%; fully utilising capacity at West Cumberland Hospital and recruiting extra consultants, but there is a clear difficulty recruiting consultants in the North Cumbria area, which was hindering the plan.

There were no clearly defined pathways of care in place for the care, treatment or support of patients once a diagnosis of dementia had been made on the medical wards we visited. Another area of concern was the lack of an epidural service at the Cumberland Infirmary, which meant limited options for pain relief for women in labour.

The digital imaging service was meeting the two-week target for urgent patients. The digital imaging service was breaching the six-

week target for more routine patients, particularly with regard to MRI scans. A small percentage of patients were waiting more than 10 weeks. Patients were prioritised according to clinical urgency. There was a plan in place to bring all waits down to within six weeks.

The trust appears to have had some challenges in responding to complaints effectively. In May 2013, over 100 complaints had been in the system without a response for some time. The backlog was reduced to one by October 2013. For 2013/14, closure of complaints had fluctuated, in January 2014 only 41% were closed, February 34%, and March was significantly improved at 90%. In addition, four complainants referred their cases to the Parliamentary and Health Service Ombudsman (PHSO) during 2013/14, all of which were partially upheld.

The Head of Patient Safety informed us that one complaint took 609 days to respond to; this complaint was initially received in 2010 and the length of time for the response was extended as the new Chief Executive, re-opened the complaint to demonstrate the new approach. Complaints were now acknowledged within three working days and the trust consistently met this timeframe. However, the trust had not yet sustained the 25 working day response time that it agreed with complainants and often had to contact complainants to agree delayed timeframes.

A significant proportion of complainants reopened complaints with the trust. In January, seven of 29 complaints had been reopened and in February three of 37, at the time of writing the March 2014 trust Board paper. Complainants could also experience further delays when their complaint was reopened. The trust allocated an investigator external to the department to answer the initial complaint, to conduct the investigation and respond to the complainant. We were shown an example where the trust received the initial complaint in October 2013, yet the reopened complaint would not be completed until July 2014 (a six-month timescale was anticipated). In addition to this, the trust had four complainants who referred their cases to the PHSO during 2013/14, all of which were partially upheld.

The trust recognised that improvements could be made to the quality of responses to complaints and had introduced an Independent Assurance Complaints Panel. This had met once. In addition to this panel, all complaints assessed to have caused serious harm were presented at the weekly Safety Panel. This panel would consider whether the complaint should also be reported as a serious incident as well as looking at themes and monitoring actions. Actions from the remainder of complaints or themes from complaints were not yet formally managed or monitored. Evidence

Summary of findings

of learning from complaints was quite limited. The two business unit quarterly reports provided did not demonstrate learning from complaints, but did look at the data. For example, the 'Actions/ Outcomes' column in the PALS update had comments such as "52 given complaints information by PALS, 32 resolved by ward/dept, 26 resolved by PALS". This could mean that opportunities for learning were missed. The monthly Board report also focused on numbers and a summary of the serious complaints.

A report presented to the November 2013 Safety & Quality Committee identified the need for staff training in handling patient concerns and complaints. It recommended that this training was made manadatory using an e-learning platform and face-to-face workshops for identified complaint leads. This training had started, with 60 staff attending training in May 2013. Complaints training is now mandatory for all staff. The investigation of complaints was largely undertaken by the area/service in which the incident occurred. External investigations occured if a complainant was dissatisfied with the trust's response and their complaint was reopened (eight cases to date) and also if an initial complaint was serious (three cases to date).

Are services at this trust well-led?

Requires improvement

The trust's leadership was rated as 'requires improvement'. Many of the executive team were new in post in the last 12 months and they have acknowledged that the trust is on a journey of significant improvement.

At the time of the Keogh review, there were concerns around inadequate governance and pace and focus of change to improve overall safety and experience of patients.

The governance processes were in place and the Board Assurance Framework V9, March 2014, detailed risk and aligned them to strategic priorities. The board owned this document and the board agenda was focused on the risks within the Framework. The Acting Director of Governance was confident that the Accountable Officers (Directors who owned the risks) would be able to articulate the risks, the planned actions and target risk ratings. This was not the case when tested with the Medical Director and Director of HR.

We also saw evidence of the trust board being informed of issues and risks through the 'Corporate Reputation Risk Register'. This process was not described in the trust's policies but had been introduced as a way of sharing good practice and was managed by the communications team. This document was a useful summary of serious incidents and other potential risks or issues for the board.

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Trusts who wish to become foundation trusts must achieve a score of 3.5 or less against the Monitor Quality Governance framework to proceed with an application. North Cumbria University Hospitals NHS Trust had commissioned an external assessment against the framework. This assessment gave a score of 9.5 from September 2013 and the trust was provided with an action plan, but this action plan had not been updated since that time. However, evidence of some of the actions being completed, such as the review of the Risk Assessment Policy and Board Assurance Framework, could be demonstrated. The trust had plans to be reassessed in June 2014 and was expecting to score around 5.5 to 6, but no formal self-assessment had been undertaken.

Board assurance was supported through 'Ward Assurance Reports'. These included data on staffing levels, harm-free care and a range of clinical indicators. The understanding of the data at ward level varied across the trust and it was unclear in the reports whether the clinical indicators were taken from the snapshot audits of five sets of casenotes per month or a more robust data set. It was acknowledged that some of the data/information requirements were quite 'clunky' and that the trust was working on ways to streamline this.

To support improvements in governance, additional risk management training was being provided to help the services manage their risk registers appropriately and to provide challenge on risk ratings and the management of risks through the Safety and Quality Committee.

At the time of the Keogh review there were concerns relating to the lack of support for staff and effective, honest communication from middle and senior management level.

This remained an issue. Staff reported being fearful of raising issues with managers and a number of staff were visibly upset when talking to us. We were told that most staff who attended our focus groups or planned interviews on the West Cumberland site were then 'grilled' by their matrons to let 'gold command' know what they had said. Some staff at the West Cumberland site also told us that they had been advised not to raise any patient safety issues as "the CQC would close the hospital down within 48 hours of the inspection."

Support for staff continued to raise concern as clinical supervision was not embedded and some staff had not received an appraisal. Patient safety walkrounds had been revised and were concentrating on themes identified through serious incidents. This was to provide assurance to the board that known patient safety issues were being addressed and improvements to practice sustained.

Summary of findings

Following our announced inspection to the trust, we were contacted by an anonymous member of staff who informed us that the trust had removed beds from the medical wards to present an impression of better staffing levels on the wards.

We revisited the wards at the Cumberland Infirmary Carlisle unannounced on 12 May and found that additional beds had been placed in one of the medical wards without providing any additional staffing.

Vision and strategy for this trust

- At the time of the Keogh review there were concerns around inadequate governance, and pace and focus of change to improve overall safety and experience of patients; slow and inadequate responses to serious incidents and a culture which did not support openness, transparency and learning; staffing shortfalls and other workforce issues across staff groups which may be compromising patient safety; lack of support for staff and effective, honest communication from middle and senior management level; failure in governance to ensure adequate maintenance of the estate and equipment and significant weaknesses in infection control practices.
- Throughout the hospital sites, posters describing the trust's quality priorities were highly visible. However, staff told us that these appeared around two weeks before the inspection.
- A number of comments were made by staff at drop-in sessions about middle managers. One comment was "We have had about eight chief executives; they can't all have been bad eggs." We were told that middle managers were often moved from one area to another instead of new people being appointed. The inspection teams in the core services reported that leadership at ward level appeared to be working well, but that staff did not know who their managers were or the executive team.
- Staff and patients told us that they were uncertain of what future service provision would look like at the trust. Department staff who we spoke with told us with that initially they were engaged with this, but that there hadn't been an opportunity recently. This was particularly the case with regards to the new build at West Cumberland Hospital, where both staff and patients attending the listening event told us that nobody knew what the new hospital was going to be used for other than an A&E.

Governance, risk management and quality measurement

- The trust has a Risk Assessment Policy (V2.0 21/02/14) and a Board Risk & Assurance Framework 2014/15 V4.0 to describe

how risks are identified, assessed, managed and escalated. The documents provide a comprehensive overview for staff on how risk assessments should be undertaken and how they are approved for inclusion on the risk register. Evidence of this happening was seen in practice in most service areas. Details of how risks are managed at a corporate level were described in the Framework document, and again, evidence of implementation was provided.

- The risk register for all risks greater than or equal to 15 were reviewed. Some of the risks staff told us about were reflected on the risk register, such as staff appraisals, use of medical locums and staffing levels. The risk descriptions were not always clear in terms of condition, cause and consequence, and there also appeared to be an inconsistency in risk ratings, with a significant proportion of risks having the same inherent and current risk rating despite controls being in place and limited gaps in controls identified. We discussed this with Clinical Business Unit Directors who explained that a significant amount of work had been undertaken to ensure the risk register captured the right risks, but there was still work to do on the understanding of ratings. The business units were supported by a Governance Facilitator who managed the administration of the register. The trust only started to use inherent risk ratings in the past six months, so not all had fully considered the controls in place at the time the risk was identified. The Acting Director of Governance confirmed this and told us that 12 months ago the trust would have been unable to produce the risk registers that we requested as they were not held centrally and were all managed differently. They went on to explain that additional risk management training was being provided to help the services manage their risk registers appropriately and that challenge was being provided on risk ratings and the management of risks through the Risk and Assurance Committee. It was acknowledged that the trust had further improvements to make in this area.
- We reviewed the Board Assurance Framework, V9, March 2014. The risks were detailed and aligned to strategic priorities under the heading of 'Risk Cause' and Risk Effect'. The Acting Director of Governance told us that the Board owned this document and the Board agenda was focused on the risks within the Framework. The Acting Director of Governance was confident that the Accountable Officers (Directors who owned the risks) would be able to talk to the risks, the planned actions and target risk ratings. This was not the case when tested with the Medical Director and Director of HR. The Medical Director could not explain how the trust would reduce the severity of risk 1.3

from a 5 to a 3, in addition to the likelihood reduction from a 3 to a 2. We discussed risk 2.10 with the Director of HR who confirmed that the target risk rating was a typing error (aimed to be 2 x 4, compared to 3 x 3 therefore increasing severity rating) and that the action plan of 'Robust monitoring process in place with Medical Director' did not sufficiently describe the actions required to manage this risk.

- The trust Board had a Safety and Quality Committee and a Risk and Assurance Committee to monitor safety, quality, risk and assurance within the organisation. The Safety & Quality Committee received reports from the weekly Safety Panels, Clinical Business Units and a number of groups, such as Medical Devices, Infection Prevention Committee and Safeguarding. The Risk & Assurance Committee received reports from the Health & Safety Committee, Emergency Preparedness and the Clinical Business Units/Corporate Functions. Reports such as the quarterly business unit governance reports, safety panel monthly reports and the quarterly clinical audit and effectiveness report were received by the Safety & Quality Committee for challenge and to escalate any potential risks or issues to the trust Board. We saw evidence of the trust Board being informed of issues and risks through the 'Corporate Reputation Risk Register'. This process was not described in the trust's policies but we were informed by the Acting Director of Governance that this was introduced as sharing good practice from Northumbria and was managed by the communications team. This document appeared to be a useful summary of serious incidents and other potential risks or issues for the Board.
- The trust had undertaken a significant amount of work to gain a greater understanding of its mortality data. A review of 1,000 deaths was undertaken during 2012/13 to inform improvement work around mortality. The trust now reviewed mortality data each week as part of its Safety Panel at a corporate level, reviews all deaths at service level and discusses mortality and clinical outcome date within its Business Unit Governance reports. The Safety Panel provided a monthly report to the Safety & Quality Committee and the Business Units provide quarter governance reports to the same committee. The Trust was now within expected ranges for both HSMR and SHMI measures.
- The majority of staff were aware of what to report as an incident and how to do this. Staff told us that they did not receive feedback once an incident has been reported. The latest NRLS data (published 30/04/14 covering the April to October 2013 period) reported the trust's patient safety incident reporting

ratio as 6.22 per 100 admissions, against an average for medium acute trusts of 7.47. The trust has seen a significant increase in reporting serious incidents from 44 in 2012/13 to 90 in 2013/14 (trust data). This demonstrated an improved reporting culture but it was not yet as expected in comparison with other trusts.

- We saw evidence of learning from more recent serious incidents, with shared learning across both hospital sites. The trust had a weekly Safety Panel meeting. The membership included the Medical Director, Executive Director of Nursing and Acting Director of Governance. This panel reviewed serious incidents at various stages and could be part of the decision making process to declare an incident on StEIS. The panel reviewed the serious incidents collectively to identify themes in root causes, contributory factors and allocated leads for actions. The leads were then given a date to return to the panel and provide evidence of completion of actions. Evidence of serious incidents and learning being discussed was also seen at Clinical Business Unit and service level.
- The investigations of serious incidents are largely undertaken by the area or Clinical Business Unit in which the incident occurred. In an attempt to reduce the time taken to investigate and implement immediate actions, the trust no longer has a panel approach to investigating, and allocated a Case Manager and a Case Investigator, both of whom would have complete root cause analysis training. The trust had trained around 100 members of staff to date in root cause analysis techniques. The quality of investigation reports was variable. Some reports, particularly in maternity services, had clear timelines, explored human factors and other contributory factors and used recognised root cause analysis tools. Other reports were brief and did not fully report on the findings of the investigation. This impacts on the ability to implement actions that address the root cause and prevent further incidents of a similar nature.
- The trust had reported 10 never events since November 2012. Never events are very serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place. The recurring themes emerging from the never events indicate that the actions taken and the sharing lessons learned were not systematically embedded or applied across the trust.
- Analysis of incidents overall was limited. We requested evidence of this analysis and actions taken but only received two examples of clinical business unit governance reports. These reports did identify some themes (e.g. pressure ulcers, falls and staffing levels) but did not appear to have robust

actions plans with monitoring. Learning appeared to be better for serious incidents than near misses and other incidents, which may result in opportunities to prevent and learn from serious incidents.

- Staff accessed policies and strategies through the intranet. However, this was quite difficult for staff to navigate and identify which policy they should be using in practice as there were multiple versions of some policies. Old versions of policies and strategies (e.g. Risk Management Strategy, Complaints Policy) were still live on the intranet. There were two versions of a complaints policy.
- When we searched for the Complaints Policy there was also a separate policy for the Maternity Service. The midwives that we spoke to were unaware of this policy. There was an 'Emergency Department Operational Policy' but we found no evidence of review in line with recent clinical pathway changes. The major haemorrhage protocol was not in line with national standards and the policy for the transfer of sick children to tertiary centres was not robust and the ophthalmology surgical policies were all noted to be out of date. The Acting Director of Governance shared a piece of work for policy improvement and acknowledged that this was an area that the trust has identified for action.
- The Acting Director of Governance explained to us that clinical audit was another area where the trust was working to improve. Evidence of this was seen with the increase in participation of national audits. This will help the trust benchmark clinical outcomes against other providers.
- A quarterly report was presented to the Safety & Quality Committee (Clinical Audit and Effectiveness Report). We reviewed the Quarter 3 report, that showed the percentage of audits being completed in line with the agreed timescales within the audit forward plan ranged from 0% for Corporate Services (0/2 audits had been completed) to 75% in Medicine (43/57 audits completed). Eighteen audits had been abandoned, largely in the Medicine and Surgery business units, by the end of quarter 3.
- We were told that work was being undertaken to prioritise the audit plans including national audits and audits as a result of serious incidents. A summary of 'what needs to change' and action to be taken was included in the report. However, this was a narrative overview only and did not provide the committee with an overview of how many actions are outstanding for each audit, who should be completing these, by when and the level

of risk the service/organisation is carrying through not implementing these actions. There was some evidence of sharing learning from clinical audits at ward and department level but this was not consistent across the trust.

Leadership of trust

- There had been significant changes in the trust leadership in the past year. A new trust chair had been appointed and started in March 2014, and a new chief nurse in April 2014. Two new non-executive directors were to be appointed in April 2014. The leadership was forming relationships and developing new ways of working.
- Some services were being delivered with significant consultant vacancies. We were also told about a reduction in middle grades at the West Cumberland Hospital site (six posts have been removed by the Deanery) and plans to remove junior doctor cover (after 10pm) from August 2014. Staff were not able to describe the plans to manage the risks relating to the removal of junior doctor cover and were concerned about the impact this may have on patient safety, care and treatment. Risks were recorded on the risk register in relation to the removal of the middle grade posts and the vacant clinical posts for all medical grades.
- Over 20 members of staff spoke with us at private drop-in sessions. They told us that they did not feel valued. We were told that staff were asked to work double shifts and felt under pressure to do so in some areas. There was a perception that consultants would continue to leave the trust due to services being removed from the West Cumberland site.
- Staff were positive about the leadership at ward level, but there were very mixed views about the quality of leadership from mid and senior managers and the visibility of the board and executive team. Other staff reported that they felt this was the best executive team they had had and that the Chief Executive was visible.

Culture within the trust

- Staff reported being fearful of raising issues with managers and a number of staff were visibly upset when talking to us. We were told that staff attending focus groups or planned interviews on the West Cumberland site were then 'grilled' by their matrons to let 'gold command' know what they had said. We were also told by staff at the West Cumberland site that they had been advised not to raise any patient safety issues as "the CQC would close the hospital down within 48 hours of the inspection."

Summary of findings

- There were similar issues raised at the focus groups in the Cumberland Infirmary. This fear of raising concerns due to staff feeling that there would be reprisals reflected badly on the culture within the trust and meant that staff were not engaged with their senior colleagues in a positive way.
- Clinical supervision was not embedded and not all staff had been given an appraisal. There were limited opportunities for staff to engage with the change agenda and they felt that the recent emergence of the trust's vison and values wheel had been orchestrated for the inspection.

Public and staff engagement

- The trust did not have a Patient and Public Engagement/ Experience Strategy. This was captured through its Communications and Engagement Strategy. The Acting Director of Governance confirmed that the previous Communications and Engagement Strategy (2011-2014) had not achieved its aims in terms of patient and public engagement and that a new strategy had been approved in March 2014 to progress with this work.
- Currently the trust does not have an overview of all the patient groups who support the trust or a strategic approach to capturing the views of patient and the public to develop services. We were told that a piece of work had begun with volunteers to strengthen how the trust maximised the benefits of working with volunteers. The trust appeared to still have had some challenges with managing complaints effectively.
- Staff told us they were not engaged with the decisions regarding the trust's quality priorities and did not understand how the aims were to be achieved. The Director of HR confirmed that staff had not been engaged in a meaningful way to decide the priorities due to time constraints and the need for quality priorities to be in place. However, we were told that staff were engaged through roadshows for the trust values.

Innovation, improvement and sustainability

- We didn't see enough to have the evidence to comment on improvement plans, despite requesting improvement plans on day one. After the inspection we were sent a draft plan for pressure ulcer management, dated April 14 but we are unable to comment on its implementation. We didn't receive the plan for inpatient falls that we requested.

Summary of findings

- There is a mix of different indicators for quality but it is difficult to identify how the priorities are translated into practice, how they are measured and what outcomes the trust is aiming for. This could be because the latest priorities are so new, but it wasn't an area we were able to explore fully.
- We were told that the Histopathology service has funding for seven consultants but currently only had 2.5 in post and one on long term sickness absence. Clinical staff were feeling the pressure of sustaining this service and were worried about patient safety. We were told that this situation had been going on for a number of years.

Overview of ratings

Our ratings for the Cumberland Infirmary, Carlisle are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
A&E	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Good	Requires improvement	Good	Good	Good	Good
Maternity & Family planning	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Children & young people	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients	Inadequate	Not rated	Good	Requires improvement	Good	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for the West Cumberland Hospital, Whitehaven are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
A&E	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Inadequate	Requires improvement	Good	Requires improvement	Good	Requires improvement
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Good	Requires improvement	Good	Good	Good	Good
Maternity & Family planning	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Children & young people	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

Overview of ratings

End of life care	Good	Good	Good	Good	Requires improvement	Good
Outpatients	Inadequate	Not rated	Good	Requires improvement	Good	Requires improvement
Overall	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for The Birthing Centre at Penrith Hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity & Family planning	Good	Good	Good	Good	Good	Good

Our ratings for North Cumbria University Hospitals NHS Trust

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

Notes

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

Outstanding practice and areas for improvement

Areas for improvement

Action the trust MUST take to improve

Importantly, the trust must:

- Address the numerous consultant vacancies.
- Ensure nurse staffing levels are appropriate in all areas, without substantive staff being forced to work excessive additional shifts.
- Promote a culture that supports openness, transparency and learning through effective, honest communication from middle and senior management level, robust responses to serious incidents and open engagement with all staff regarding future plans.
- Ensure that board assurance is supported by robust sources of information and is presented informatively.
- Ensure it meets national guidelines of having an anaesthetist available at all times for obstetrics at West Cumberland Hospital and there is a second theatre for obstetrics and gynaecology use.
- Redress the imbalance with regards to routine elective work between the two acute hospitals.
- Ensure policies and procedures to support safe practice are robust and should include a major incident plan for surgery. There is evidenced compliance with relevant NICE guidance and clinical audit is consistently engaged in and learned from. Clinical risk management provides robust systems to monitor and learn from all incidents and provide safer care.
- Improve patient flow to ensure patient transfers are not unnecessarily delayed, are not moved at inappropriate times of the day or night or inappropriately accommodated in A&E overnight.
- Support outpatients to effectively meet national wait targets and notes are always complete and available for clinics.
- Provide clinical supervision to staff.
- Redress all estates and equipment deficits.

In addition the trust should:

- Ensure there is an epidural service at the Cumberland Infirmary.
- Ensure specialist triage nurses in A&E are available for all children presenting.
- Improve infection control in the mortuary and the Special Care Baby Unit at the Cumberland Infirmary, and general handwashing and timely general waste disposal.
- Continue to improve to complaints responses and reviews.

Please refer to the location reports for details of areas where the trust COULD make improvements.