North Cumbria Integrated Care NHS Foundation Trust

Inspection report

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Our reports

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the trust wide leadership in the related Evidence appendix.

The Evidence appendix appears under the Reports tab on our website here: www.cqc.org.uk/provider/RNN/reports.

Background to the trust

Organisational history

North Cumbria Integrated Care NHS Foundation Trust (NCIC) was created in October 2019 following an acquisition of North Cumbria University Hospitals NHS Trust (NCUH) by Cumbria Partnership Foundation Trust (CPFT). During the acquisition the mental health and learning disability services were transferred out to another NHS trust.

The trust provides a range of acute hospital services based at the Cumberland Infirmary in Carlisle (CIC) and the West Cumberland Hospital (WCH) in Whitehaven. It also provides a midwifery-led maternity service at Penrith Community Hospital and community services covering the Cumbria region (adult and children's community services in north Cumbria and some which are whole county based). The trust has 536 inpatient beds across the acute hospital sites and 133 beds across six community hospitals. The trust employs over 5,400 members of staff.

The main commissioner is North Cumbria Clinical Commissioning Group (CCG), which commissions around 85% of its services, with NHS England commissioning a further 13%. The trust serves a population of approximately 320,000 in the west, north and east of Cumbria, in the districts of Allerdale, Carlisle, Copeland, Eden Valley and South lakes and Furness for some community services. It also provides services to parts of Northumberland and Dumfries & Galloway. The community is spread over a large geographical area, with 51% of residents living in rural settings. Over 65’s make up a

Summary of findings

larger proportion of the population than the national average. The health of people in Cumbria is mixed, with five indicators scoring better and nine indicators worse than the England average; 12 indicators are not significantly different from the England average. Deprivation is similar to the England average and about 11,700 children (14.5%) live in poverty. Life expectancy for men is lower than the England average and life expectancy for women is similar to the England average.

NCUH was one of 14 selected for Sir Bruce Keogh's 2012 review of quality of care and treatment provided by those NHS Trusts and NHS Foundation Trusts that were persistent outliers on mortality indicators (known as The Keogh Review). Following the review, in July 2013, NCUH was placed into special measures and was taken out of special measures in March 2017.

Overall summary

What this trust does

The trust provides acute inpatient, outpatient community healthcare services to people living in and around the local area. There are two main hospital locations, Cumberland Infirmary in Carlisle (CIC) and the West Cumberland Hospital (WCH) in Whitehaven and six community hospitals, the trust also provides a midwifery led birthing centre in the Penrith Community Hospital.

- Urgent and emergency care
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology
- Children and young people
- End of life care
- Outpatients and diagnostics

North Cumbria Integrated Care NHS Foundation trust also provides a full range of community services across North Cumbria and some in South Cumbria. Services include:

- Community health services for children and young people
- Community services for adults and long-term conditions
- Community end of life care
- Community dental services
- Community sexual health services
- Community inpatient health services

Key questions and ratings

We inspect and regulate healthcare service providers in England.

Summary of findings

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? For this focused inspection we looked at elements of the safe and responsive domains in the core services and the provider well-led domain.

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

This is the first time we have inspected North Cumbria Integrated Care NHS Foundation Trust, since it became a legal entity in October 2019.

We conducted this responsive focused inspection in response to emerging concerns of risk to patient and staff safety. The inspection was undertaken using specified key lines of enquiry in the safe and responsive domains in emergency and urgent care, medicine, end of life care and community adults' services. We invited all staff to share their feedback directly to CQC though a staff survey. We conducted onsite visits of CIC on 26 -27 August 2020 and both main acute hospital sites on 02 September 2020 we also undertook interviews with core service leads. We undertook a virtual well led inspection between 8 to 15 September 2020. Before this inspection, we received information from a variety of sources, including whistle-blowers and independent reports in relation to patient safety, infection prevention and control, and safeguarding patients.

What we found

Overall trust

Our rating of the trust remains the same as the previous inspection because:

This was a responsive focused inspection based on escalating risk, therefore we inspected specific elements of the safe and responsive domains. We did not inspect all of the key lines of enquiry as our concerns were related to specific risks. For the trust wide well led we inspected against all of the key lines of enquiry but did not rate at this time.

This means that the previous ratings for our 2019 CPFT inspection remain.

Are services safe?

We did not inspect enough of this domain to rate.

Are services effective?

We did not inspect this domain on this occasion.

Are services caring?

We did not inspect this domain on this occasion.

Are services responsive?

We did not inspect enough of this domain to rate.

Summary of findings

Are services well-led?

We did not inspect this domain on this occasion.

Ratings tables

This was a focused responsive inspection we were not able to provide a rating on this occasion. The ratings on our website relate to previous inspections.

Areas for improvement

We found areas for improvement including several breaches of legal requirements that the trust must put right.

For more information, see the Areas for improvement section of this report.

Action we have taken

We issued under Section 31 of the Health and Social Care Act 2008 a letter of intent, on the 28 August 2020, which specifically related to the emergency department (ED).

We undertook further enforcement and issued another letter of intent and a warning notice, on the 16 September 2020, under Section 29A of the Health and Social Care Act 2008. This identified specific areas that the trust must improve and set a date for compliance as 30 November 2020. The trust initiated immediate steps to improve this included working with stakeholders, developing an action plan with clear timescales for improvement and a review of systems and policies. For more information on action we have taken, see the sections on Areas for improvement

What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our engagement with the trust and our inspection process. Following our inspection and enforcement action, the trust have been and will continue to provide fortnightly assurance against their improvement plan.

Areas for improvement

We found areas for improvement in this service.

Action the trust MUST take to improve:

Action the trust MUST take is necessary to comply with its legal obligation.

Trust wide;

- The trust must ensure strategies are translated into measurable and deliverable plans for the care groups, and plans are monitored and reviewed appropriately and care groups held to account regarding their performance. (Regulation 17)
- The trust must ensure it reviews and improves its governance systems at a service and trust wide level to ensure they effectively assess, monitor and improve care and treatment. (Regulation 17)
- The trust must ensure leaders and the board are supported to develop the skills and abilities to lead effectively. (Regulation 17)

Summary of findings

- The trust must ensure it continues to make progress against the trust risk register and board members and members of staff understand the process of escalating risks to the board through the board assurance framework. (Regulation 12)
- The trust must implement an effective systems to identify and assess any potential safeguarding issues and the management of vulnerable children and adults. (Regulation 13)
- The trust must ensure a robust programme of structured safeguarding of high quality supervision is implemented for all staff who require it. (Regulation 13)
- The trust must ensure the quality of appraisals improves and they take place consistently for all staff. (Regulation 18)
- The trust must put initiatives in place to promote equality and diversity and ensure workforce inequalities are appropriately identified and addressed. (Regulation 18)
- The trust must ensure compliance with duty of candour is in line with national standards and local policies. (Regulation 20)
- The trust must ensure a robust mortality review process is implemented in line with National standards, to ensure appropriate and timely reporting to the coroner. (Regulation 17)
- The trust must ensure all death certificates are held centrally. (Regulation 17)
- The trust must implement effective training and processes to all staff in the recognition, reporting and investigation of incidents. Investigations must be carried out and reported in a timely manner. In addition, the quality of 72hr reports must document immediate actions taken to prevent recurrence. (Regulation 17)
- The trust must ensure board are fully appraised of all staffing challenges across the trust (acute and community). (Regulation 12)
- The trust must ensure that there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance. (Regulation 18).
- The trust must ensure that mandatory training compliance, including resuscitation and Mental Capacity Act and Deprivation of Liberty Safeguards training, meets the trust target. (Regulation 12).
- The trust must ensure information management systems are equipped to support the necessary improvements required to monitor patient flow and improve patient safety (Regulation 17)

In Urgent and Emergency Care services;

Cumberland Infirmary

- The service must have a robust formalised or documented plan in place for managing patients arriving by ambulance including risk assessing patients quickly when they arrive to make sure patients are identified quickly and receive their treatment within nationally accepted clinical guidelines. (Regulation 12)
- The service must have robust mechanisms in place, audited and with full compliance to ensure deteriorating patients are identified quickly and appropriate actions taken. (Regulation 12)
- The service must have a robust system in place to ensure only appropriate patients are moved into additional escalation areas so that patients are cared according to their health needs. (Regulation 12)
- The service must ensure there are sufficient qualified, skilled and trained staff deployed in the department to meet the needs of patients and ensure patients are kept safe and staff the rapid assessment and treatment zone. (Regulation 18)

Summary of findings

- The service must have in place appropriately qualified, skilled and trained staff in the department to ensure Royal College of Emergency Medicine standards are met. (Regulation 18)
- The service must have a robust system in place to manage and mitigate risks, including IPC when opening additional escalation areas. (Regulation 12)
- The service must improve the quality and accuracy of record keeping ensuring clinical records are contemporaneous, detailed, signed and clearly show the care and treatment patients receive and when they have received it. (Regulation 17)
- The service must introduce safeguarding children processes, procedures and practices that adequately support the identification and protection of children and young people who may be at risk of harm. (Regulation 13)
- The service must ensure incidents are reported and investigated quickly, learning from incidents is shared with all staff and immediate and longer term actions are clearly documented as being acted upon. (Regulation 12)
- The service must ensure all staff are working within their competencies and qualifications, and not carrying out tasks related to medicines which they are not qualified to do. (Regulation 18)
- The service must ensure all patients receive medicines in a timely manner in line with prescription instructions. (Regulation 12)
- The service must ensure all patients transferred from another site have a dedicated bed at the receiving site to ensure appropriate care and treatment is received in a timely manner. (Regulation 12)
- The service must ensure patient flow through the department is effective and patients are transferred in a timely manner to their receiving ward or department. (Regulation 12)

West Cumberland Hospital

- The service must take prompt action to address a number of significant concerns identified during the inspection in relation to safeguarding identification and reporting. (Regulation 13)
- The service must ensure there are sufficient numbers of suitably qualified, skilled and experienced doctors and nurses to meet the needs of patients in the Emergency Department, especially in relation to paediatric care. (Regulation 18)
- The service must ensure all staff complete the required level of mandatory training especially in relation to resuscitation training. (Regulation 18)
- The service must have robust mechanisms in place, audited and with full compliance to ensure deteriorating patients are identified quickly and appropriate actions taken. (Regulation 12)
- The service must improve the quality and accuracy of record keeping ensuring clinical records are contemporaneous, detailed and clearly show the care and treatment patients receive and when they have received it. (Regulation 18)

In Medical care services;

Cumberland Infirmary

- The service must ensure comprehensive, accurate patient records are maintained and stored securely, in accordance with trust policy and GDPR legislation. (Regulation 12)
- The service must ensure patient risk assessments are completed and updated so that staff can identify and quickly act upon patients at risk of deterioration. (Regulation 12)

Summary of findings

- The service must ensure there is effective management of patient flow into and out of the medical department, to provide prompt care and reduce patient safety risks associated with delayed transfers of care. (Regulation 12)
- The service must ensure staff follow best practice when prescribing, giving, recording and storing medicines. (Regulation 12)
- The service must ensure effective senior management oversight of infection control, relating to bed spacing, staff adhering to social distancing measures and consistent cleaning practices. (Regulation 12)
- The service must ensure health care staff receive appropriate training to enable them to provide one to one enhanced supervision and understand the differing forms of restraint. (Regulation 13)
- The service must ensure appropriate immediate action is taken following incidents, to make improvements, share learning and reduce the possibility of the same incident occurring again. (Regulation 17)
- The service must ensure they provide enough nursing staff with the right qualifications, skills, training and experience to keep patients on HASU safe from avoidable harm and to provide the right care and treatment. (Regulation 17)

West Cumberland Hospital

- The service must ensure that staff complete mandatory training to comply with the targets for completion set by the trust. (Regulation 18)
- The service must ensure that there are sufficient numbers of suitably qualified, competent, skilled and experienced registered nursing and medical staff to ensure safe care of patients. (Regulation 18)
- The service must ensure that staff maintain securely an accurate, complete and contemporaneous record in respect of patients to include the nursing records and medication charts (Regulation 17)
- The service must ensure that the medicine service is responsive in terms of access and flow. (Regulation 12)

In end of life services;

Cumberland Infirmary

- The service must ensure comprehensive, accurate patient records are maintained and stored securely, in accordance with trust policy and GDPR legislation. (Regulation 12)
- The service must ensure there is effective management of patient flow out of the department and provide a robust triage system to identify which patients take priority for discharge to their chosen place of death. (Regulation 12)

West Cumberland Hospital

- The service must ensure comprehensive, accurate patient records are maintained and stored securely, in accordance with trust policy and GDPR legislation. (Regulation 12)
- The trust must ensure there is effective management of patient flow out of the department and provide a robust triage system to identify which patients take priority for discharge to their chosen place of death. (Regulation 12)

In community adult services;

- The service must complete a staffing review to understand the acuity and dependency of the caseloads. (Regulation 18)

Action the trust SHOULD take to improve:

Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Summary of findings

Trust wide;

- The trust should identify different ways in working with community services to increase the out of hospital offer in relation to admission avoidance.
- The trust should ensure their leaders are visible to all staff to enable them to understand first hand the challenges face.
- The trust should consider a review of the freedom to speak up guardian process and develop strategies to encourage staff to use it.

In Urgent and Emergency Care services;

Cumberland Infirmary

- The service should continue to recruit RSCNs to ensure children seen by the department are treated by suitably skilled and qualified staff.
- The service should make sure all staff are confident to report incidents and understand their responsibilities in relation to incident reporting in a timely way.
- The service should ensure all staff fully understand the OPEL system and have received appropriate training to ensure it is used effectively.

West Cumberland Hospital

- The service should continue to recruit RSCNs to ensure children seen by the department are treated by suitably skilled and qualified staff.

In Medical care services;

Cumberland Infirmary

- The service should ensure work continues to provide appropriate training for agency staff, to enable them to undertake blood transfusions and administer intravenous injectable medicines.
- The service should ensure staff complete planned training in prevention and management of violent aggression (PMVA), to deescalate aggressive situations.

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

We inspected but did not rate well led, however, we found:

- The trust had an inexperienced leadership team, who did not always have the necessary skills and abilities to lead effectively. There was little attention regarding succession planning and the development of managers at all levels including executive.

Summary of findings

- Leaders were not always fully sighted with what was happening on the front line, and they could not identify or describe the risks and issues described by staff. Staff told us they did not know who their leaders were and they were inaccessible. There were few examples of leaders making a demonstrable impact on the quality or sustainability of services.
- The system strategy was not underpinned by detailed, realistic objectives and plans for high-quality and sustainable delivery and did not reflect challenges specifically faced by the trust. In addition, there was no effective approach to monitoring, reviewing or providing evidence of progress against delivery of the strategy or plans. The strategy had not been translated into meaningful and measurable plans at all levels of the service.
- The leadership team understood the importance of a positive culture within the trust, however, staff satisfaction was mixed. Staff did not always feel actively engaged or empowered. Management and clinicians did not always work cohesively.
- When something went wrong, people were not always told and did not always receive an apology. There was little attention to staff development and there were low appraisal rates. Appraisals took place inconsistently and were not of high quality. Equality and diversity were not consistently promoted and the causes of workforce inequality were not always identified or adequately addressed.
- The trust's governance arrangements and their purpose were unclear. There was a lack of clarity about who had authority to make decisions and how individuals were held to account. There was no process to review key items such as the strategy, values, objectives, plans or the governance framework.
- Staff and their managers were not clear on their roles or accountabilities. There was a lack of systematic performance management of individual staff, or appropriate use of incentives or sanctions.
- Risks, issues and poor performance were not always dealt with appropriately or quickly enough. The risk management approach was applied inconsistently and were not linked effectively into planning processes.
- The approach to service delivery and improvement was reactive and focused on short-term issues. Clinical and internal audit processes were inconsistent in their implementation and impact. The sustainable delivery of quality care is put at risk by the financial challenge.
- The information that was used to monitor performance or to make decisions was inaccurate, and unreliable or not relevant. Finance and quality management were not integrated to support decision making.
- There was insufficient and limited challenge of performance by leaders and staff. There were significant failings in systems and processes for the management and sharing of data.
- There was minimal engagement with people who use services, staff, the public. There was a limited approach to sharing and obtaining the views of staff. There was insufficient attention to appropriately engage with those with particular protected equality characteristics. Feedback was not always reported or acted upon in a timely way.
- Improvements were not always sustained. The organisation did not react sufficiently to risks identified through internal processes, but often relied on external parties to identify key risks before they start to be addressed. Where changes were made, the impact on the quality and sustainability of care was not fully understood in advance. Systems lacked maturity and senior leaders recognised this.

Key to tables					
Ratings	**Not rated**	**Inadequate**	**Requires improvement**	**Good**	**Outstanding**
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

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

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Acute health services

Background to acute health services

North Cumbria Integrated Care NHS Foundation Trust provides acute inpatient and outpatient services to people living in and around the local area.

There are two main hospital locations, Cumberland Infirmary in Carlisle and the West Cumberland Hospital in Whitehaven. The trust also provides a midwifery led birth centre in the Penrith Community Hospital.

The trust provides;

- Urgent and emergency care
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology
- Children and young people
- End of life care
- Outpatients and diagnostics

Summary of acute services

This is the first time we have inspected North Cumbria Integrated Care NHS Foundation Trust, since it was formed.

We conducted this responsive focused inspection in response to escalating concerns of risk to patient and staff safety. The inspection was undertaken using specific elements of key lines of enquiring of the safe and responsive domains in emergency and urgent care, medicine and end of life services.

Please see the inspection findings for the acute services below.

West Cumberland Hospital

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Key facts and figures

West Cumberland Hospital (WCH) is part of the North Cumbria Integrated Care NHS Foundation Trust (NCIC), which was created in October 2019 following an acquisition of North Cumbria University Hospitals NHS Trust (NCUH) by Cumbria Partnership Foundation Trust (CPFT). During the acquisition the mental health and learning disability services were transferred out to another NHS trust.

It underwent phase one of a £90 million redevelopment, with the new building opening in October 2015. Phase two of the redevelopment is underway. It 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 outpatient clinics.

The consultant-led emergency department at West Cumberland Hospital, Whitehaven is open 24 hours a day, seven days a week to provide an accident and emergency service for children and adults. The hospital was not a designated trauma unit but accepts trauma patients for stabilisation only prior to transfer to the Cumberland Infirmary. The paediatric area included a separate waiting room. A spacious resuscitation area contained three bays, one of which was also equipped for paediatric patients. The department also housed a relatives' room, and an ambulatory care area with two beds and seating. Emergency care was situated adjacent to the radiology department.

The medical care service at the trust provided care and treatment at the West Cumberland Hospital (WCH) situated in Whitehaven. The medical care service was managed by a single management team covering both sites under the urgent and emergency care group.

The West Cumberland Hospital (WCH) provided elective surgical services for general surgery, head and neck, ENT, orthopaedics, gynaecology and ophthalmology. There was one large ward, an operating suite, a day-case unit, and recovery area. Patients requiring emergency surgical intervention were transferred to the Cumberland Infirmary.

West Cumberland Hospital (WCH) in Whitehaven provided care and treatment for maternity gynaecology patients in the West Cumbria area. The maternity services comprised outpatient clinics, a day ward, a ward for post-natal and antenatal care 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.

Services for children and young people at WCH included a children's ward and there was a special care baby unit (SCBU). The children's outpatient department was situated within the main outpatient department.

The Specialist Palliative Care Team (SPCT) service at NCIC cover both hospital sites.

The outpatient departments held clinics for various specialities throughout the trust across the different hospital sites. Diagnostic imaging was available at Cumberland Infirmary and WCH. Clinics were held in the main outpatient area and

Summary of findings

departments such as Ophthalmology. WCH had been in the newly built outpatient department. Diagnostic imaging at WCH provided plain film x-rays, ultrasound, CT, MRI, and interventional treatments. The acute clinical work including fluoroscopy was concentrated at the two main sites; Cumberland Infirmary and West Cumberland Hospital that offered a range of diagnostic imaging, image intensifiers in theatres, and interventional procedures.

Summary of services at West Cumberland Hospital

The urgent and emergency care services had enough staff to care for patients and keep them safe however they had insufficient paediatric staff. In the medicine core service, we were not assured there was enough staff to care for patients. Staff managed safety incidents well and lessons learned from them. They managed medicines well.

In the urgent and emergency care and medicine services there was limited training in key skills and staff did not always know how to protect patients from abuse and manage safety well. The service controlled infection risk most of the time. Risks to patients were not always assessed or acted upon. Across all core services inspected staff did not keep detailed records of patients' care and treatment, records were not clear, up-to-date, or easily available to all staff providing care.

People could not access the urgent and emergency care and medicine service when they needed them and often had long waits for treatment. Patients could not access the specialist palliative care service when they needed it. Waiting times from referral to transfer to preferred place of care and death were not always in line with good practice.

Urgent and emergency services

Key facts and figures

West Cumberland Hospital (WCH) emergency department is a consultant led service that operates 24 hours a day 7 days a week to manage critically ill patients including children. Approximately 40,000 patients attend the department each year, 10,000 of which are children.

The WCH ED accepts trauma cases for stabilisation only, before transferring these to either Cumberland Infirmary Carlisle (CIC) or a tertiary centre. At WCH there are also a selected number of conditions that follow a high risk transfer pathway from WCH to CIC. These include;

- Gastro-intestinal bleed.
- Respiratory patients assessed as high risk (i.e. those with an initial diagnosis of pneumothorax or potential empyema.
- Cardiac Non-ST elevation myocardial infarction/acute coronary syndromes/endocarditis, or bradycardia requiring urgent cardiac pacing).
- Emergency surgical pathways including; General surgery, orthopaedics, ear nose and throat, ophthalmology, Urology and vascular.

There is a 29 bedded emergency assessment units unit at WCH for medicine and surgical admissions. The unit is supported by acute care physicians. The emergency assessment unit and ambulatory care unit were inspected under our Medical Care Core Service Framework.

We carried out unannounced focused inspections of the emergency department at West Cumberland Hospital on 02 September 2020. The inspections took place in response to concerning information we had received in relation to patient care. We had previously inspected the department in February 2020 and we visited the department on 02 September to find out whether any improvements had been made since the previous inspection.

During our inspection we spoke to members of staff and reviewed 15 sets of patient records.

This is the first time we have inspected North Cumbria Integrated Care NHS Foundation Trust, since it was formed.

We conducted this responsive focused inspection in response to escalating concerns of risk to patient and staff safety. The inspection was undertaken using specific elements of key lines of enquiry of the safe and responsive domains in emergency and urgent care, medicine, end of life care and community adults services.

Summary of this service

The service had enough general staff to care for patients and keep them safe, but had insufficient specialist paediatric staff. Not all staff had completed training in key skills and were not able to demonstrate that they understood how to protect patients safe from abuse. Staff did not always manage patient safety effectively. The service controlled infection risk well. Staff did not always assess risks to patients nor act on risks. Staff failed to keep adequate care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Urgent and emergency services

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff, but we were not assured that all staff had completed the required training.

On review of the training compliance data we saw that there were 20 mandatory training modules, eight modules had not been completed to the trust's compliance target. These modules included safeguarding children (levels two and three) with compliance of 80% and 50% respectively. Compliance for both adult and paediatric resuscitation training was 56% for adult immediate life support (ILS) and 69% for paediatrics ILS. Compliance for advanced life support (ALS) was 46% for adult ALS and 43% for paediatric ALS.

During inspection we did see that the department had employed a senior nurse in a clinical educator role and that their role included addressing low mandatory training compliance. However, they had not been in post long enough to fully embed all changes, but some improvements had been reported.

Safeguarding

Staff did not always have the training on how to recognise and report abuse. This meant the service did not always protect patient from harm or abuse.

The trust's safeguarding children processes, procedures and practices did not adequately support the identification and protection of children and young people who may be at risk of harm.

Overall safeguarding training compliance did not meet the trust target of 85% for both nursing and medical staff. Safeguarding children level three training compliance was 55% and safeguarding adults level two training was 68%. There was no record of any staff completing safeguarding adults level three.

There was a lack of robust information sharing processes within the trust. For example, there was no formal paediatric liaison procedure in place within the ED. We found there was an over reliance on staff professional curiosity to inform other relevant services such as health visitors, strengthening families and social care of children's attendance at the trust. The system was fragile with no clear thresholds or oversight of information being shared between professionals.

Children and young people were not always receiving support at the earliest opportunity. We found evidence of babies and children under five who attended the ED after avoidable accidents in the home were not routinely being referred to their health visitor.

There were limited prompts / space in the adult emergency department card to record the names and dates of birth of any children in the family of the patient. In records we reviewed there was limited or no recording of practitioner exploration of children and family circumstances.

There was no evidence within emergency department of practitioners being proactive in identifying potential child sexual exploitation (CSE) and in conversation with practitioners, staff told us there was no routine approach to screening for signs of exploitation.

In all 15 records examined within the ED, we saw no mention of any questions being asked in relation to domestic abuse, CSE or involvement in 'county lines' (where illegal drugs are transported from one area to another), even when behaviours might indicate that these could factor in a child's life.

Staff we spoke with told us they did not receive training specific to domestic abuse and the importance of asking adult attenders of any such risk to them and child witnesses. There was also a lack of identification of the hidden child and the wider approach to think family. Staff also told us they have not received training in how to ask those sometimes difficult questions of people in their care.

Intelligence sent to CQC suggested porters were being used to monitor patients one-to-one when patients were restless and wouldn't stay in bed for their own safety. We addressed this with the trust in May 2020 and were assured this would no longer happen. Our staff survey asked staff across the trust if, after May 2020, they had witnessed security guards or porters giving one-to-one care to patients. Of the 177 responses to this question, 38 (21%) related to ED across the trust and of these 38, five (13%) related specifically to West Cumberland Hospital emergency department.

Therefore, we had concerns about how some vulnerable people such as those living with dementia were supported within the department. This was because the people delivering one-to-one care had not received the correct training to be able to manage such patients appropriately. There was a risk that patients could experience suboptimal care or come to harm due to this lack of training.

The trust had developed a standard operating procedure (SOP) for the provision of enhanced care which detailed the process for the management of such events as one to one supervision of a patient. The SOP was currently in a draft version only but had been presented to the Nursing Midwifery & AHP Group in September 2020 and was yet to made available to staff.

We saw that the department had a system in place to identify ongoing safeguarding issues with a colour coded sticker system that was applied to the patient notes on arrival in the department. This was not a robust system but we were told that participation in a national improvement project was ongoing.

All children presenting to the department would have a safeguarding triage completed on arrival.

Staff had access to safeguarding advice and support from both from the trust intranet, and the trust's central safeguarding team.

Any patient considered at risk of female genital mutilation (FGM) or child sexual exploitation was referred to the safeguarding team and other appropriate agencies for follow-up working with local system partners and established reporting mechanisms. Staff we spoke with told us that a new FGM policy was in place and they were able to recount of a specific incident where FGM was suspected and all appropriate pathways were followed.

If a patient was assessed as being at risk of suicide or self-harm acute staff sought guidance from the crisis team that was available within the department or through a telephone referral system in the out of hours period.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Handwash facilities, alcohol hand gel and personal, protective equipment (PPE) were available in each area. We found appropriate waste segregation and disposal systems in place and biohazard spill kits.

We saw posters displayed around the department about infection prevention, COVID-19 and handwashing. Hand washing facilities and antibacterial gel dispensers were available at the entrance and throughout the department.

Infection prevention and control training for this site showed that compliance was 90% for all department staff which exceeded the trust target.

All staff had undergone fit testing, donning and doffing (the safe application and removal of personal protective equipment) PPE training at the start of the COVID-19 pandemic to ensure they were competent putting on and taking off PPE safely and correctly. Staff were allocated buddies to check individual donning and doffing techniques. New staff were given 1-1 sessions with their allocated buddy. Not all staff passed fit tests, however, were provided with alternative masks in which they passed the fit test. The staff who did not pass any fit test did not work in the hot zone for their own and patient safety.

We found the department to be visibly clean. There were cleaning schedules in place and daily cleaning records showed these were adhered to. Cleaning records were up to date and demonstrated that all areas were cleaned regularly. We saw that all high touch areas were cleaned at least twice a day.

Staff were attempting to socially distance but due the restrictions caused by the building layout this wasn't always possible. Risk assessments had been completed and been acted on, for example the amount of people permitted in each room such as when taking breaks.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Staff we spoke with said there were sufficient stocks of disposable equipment. We checked disposable equipment throughout the department and saw that all were in date.

All resuscitation and sepsis trolleys within the department were checked daily and we found the records showed that all contents to be correct and in date. We saw the daily check system was recorded correctly and without omission.

The COVID-19 treatment area was clearly marked. There was adequate PPE, bins for disposal and a designated area for donning and doffing of protective equipment.

We saw social distancing was encouraged by staff and restrictions within the waiting room prevented people from sitting together. At the time of inspection, no visitors were permitted in the department.

Assessing and responding to patient risk

Staff did not always accurately record actions taken in the management of the deteriorating patient. Not all staff had the required level of training to appropriately assess and respond to increased patient risk. We were not assured that additional measures were taken as necessary.

There was a clear streaming and triage process in place with all patients receiving an initial clinical assessment by a healthcare practitioner within 15 minutes of arrival. We saw examples of streaming being undertaken and the use of a nationally recognised streaming tool being used to support the process.

We reviewed performance data which demonstrated that greater than 80% of patients were seen within 15 minutes of arrival. The trust reported nine black breaches from 1 March to 15 September 2020. A black breach is when a handover from ambulance staff to hospital staff exceeds a 60 minute wait.

However, we were not assured that the risk of patients presenting with COVID-19 symptoms were being effectively screened and identified which had the potential to increase infection rates amongst staff and patients. We had seen previously that there was a procedure in place to screen patients on arrival, but we did not observe any additional screening being undertaken and no evidence in the records we reviewed that it was consistently being followed.

Staff shared key information to keep patients safe when handing over their care to others. We observed staff using a standard process when patient details were being handed over.

Shift changes and handovers included all necessary key information to keep patients safe. We observed patient handovers with all relevant information being shared. We observed handovers at the beginning of shifts and between changes in staffing. The handovers were detailed with all pertinent information being shared. The staff were observed to use Situation, Background, Assessment, Recommendation (SBAR).

We saw evidence of appropriate screening tools for sepsis throughout the department, these also included specific paediatric, maternal, obstetric and neonatal tools. All staff were able to tell us about their use and we observed this in practice. We saw there was an escalation policy in place for patients with presumed or confirmed sepsis who required immediate review.

We had concerns regarding the completion of both national and paediatric early warning systems following our inspection in February 2020 and concerns regarding this area remained when we reviewed the level of progress made. Regular observations were completed by staff but when we reviewed audits completed for completion of the national early warning system (NEWS) and the paediatric early warning system (PEWS), we saw that compliance with NEWS completion was 71% and PEWS completion was 93%.

We saw an example of a patient who had triggered escalation through NEWS had a sticker attached to their medical report which identified the actions taken by staff.

We were told that any patients who required transfer due to increased need, were discussed with the medical team at the receiving hospital prior to transfer. We had concerns that the patient may be transferred without a bed available which necessitated waiting in ED and therefore increasing the wait time from decision to admit. There was a clear transfer policy between hospitals. We requested audit data for all interhospital transfers from the emergency department, but the trust had not recorded this information.

We were told there was always a member of staff on duty with an advanced life support training qualification, however we saw a compliance rate of 69% against the trust level for completion of 85%.

We had concerns regarding the completion of specific risk assessments following our inspection in February 2020 and concerns regarding this area remained when we reviewed progress to achieve the required level of compliance. We reviewed audit results related to the identification of sepsis and administration of antibiotics. Whilst the results showed an improving picture from May 2020 it was still below the trust target for compliance.

The department had recognised that delays in patients leaving the department could compromise patient safety. In response the department used the principles of the Bristol safety checklist to provide a framework for patients who were in the department for more than four hours. We saw examples of the documentation within the emergency department patient notes and we also reviewed audit data which showed 100% compliance in August 2020.

Staff we spoke with understood their responsibilities in regard to consent, the Mental Capacity Act (MCA) and deprivation of liberty safeguards. However, on review of mandatory training we saw that no training compliance had been recorded, therefore, we were not assured that all staff had received training.

Staff had access to the mental health liaison team. Staff knew where the team were based and how to make urgent referrals. Staff told us that they got timely response to referrals.

Nurse staffing.

The service had enough general nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Senior staff knew how many staff they needed to keep patients safe and used Baseline Emergency Staffing Tool (BEST) to inform staffing requirements. Staffing was planned to meet hourly, daily and seasonal variations in demand.

During inspection we were told by senior management that the department was fully staffed with no registered nurse vacancies.

We saw agency nurses on shift but there was not an excessive reliance on non-permanent nursing staff within the department. All non-permanent staff members received a full induction on their first shift.

Urgent and emergency services

We had concerns regarding paediatric nurse staffing following our inspection in February 2020 and concerns regarding this area remained when we looked at nurse staffing levels. We saw that the actual staffing level for adult registered nurses met the planned staffing level in all examples we reviewed. However, the Royal College of Emergency Medicine (RCEM) standard for registered sick children's nurse (RSCN) is two nurses per shift. The department was not meeting this standard but had arrangements with the paediatric unit to provide one RSCN per shift. We reviewed nurse staffing rotas and saw that from the 27 August to 20 September there was no RSCN on duty overnight.

We observed handovers at the beginning of shifts and between changes in staffing. The handovers were detailed with all pertinent information being shared. The staff were observed to use Situation, Background, Assessment, Recommendation (SBAR).

Medical staffing.

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

Following our inspection in February 2020 we were aware that the department did not adhere to the Royal College of Emergency Medicine (RCEM) guidance that a ST4 level doctor was required overnight to fulfil the senior decision maker role. During this inspection we were aware that the department still had no ST4 level doctor on site overnight, we were told that this was mitigated by using GP staff with extended skills equivalent to the required ST4 level to provide cover overnight in the senior decision maker role.

Senior staff had completed a new workforce medical staffing review which had identified areas in which needed an increase in staff levels which we were told was currently being implemented.

All medical staff we spoke with felt there were sufficient numbers of doctors to safely staff the department.

All locum staff received an induction on their first shift in the department.

We observed handovers at the beginning of shifts and between changes in staffing. The handovers were detailed and robust with all pertinent information being shared. The staff were observed to use Situation, Background, Assessment, Recommendation (SBAR).

Records.

Following our inspection in February 2020 we had concerns over the quality of medical records throughout the trust. Medical records were reviewed across all inspected core services.

Patient electronic and paper records were of a poor standard. Records were not chronological. Electronic information did not accurately reflect the time patients received care and treatment such as time of triage and the time seen by a doctor.

We observed poor documentation practices in paper records we reviewed. There were incomplete records and assessments and there was a lack of standardised documentation across clinical areas. The standard of filing was poor; there were many loose pages and test results. Some volumes of notes were not in a standard medical notes folder, they were held together with elastic bands.

Medicines.

The service used systems and processes to safely prescribe, administer and record medicines.

Staff followed systems and processes when safely prescribing, administering and recording medicines. We reviewed one patient's prescription. The medicines were checked by a second nurse and administered safely.

Staff reviewed patient's medicines and provided specific advice about patients' medicines. We were informed that the clinical pharmacist assigned to the acute medical unit (AMU) supported ED in busy daytime periods. Doctors accessed patients' summary care records (with consent). EMIS (formerly known as Egton Medical Information Systems) provided a summary medical record which included information such as current prescribed medication.

Staff stored and managed all medicines and prescribing documents in line with the trust policy. Medicines (including controlled drugs) were stored correctly. However, in a recent incident a patient had broken into the medicine fridge in the resuscitation room and stolen a lorazepam injection. This occurred because one of the doors into the resuscitation room could not be secured.

Staff followed the trust's policy for monitoring the temperature of the medicines fridge and took appropriate action when the temperature was outside the required range.

Staff followed current national practice to check patients had the correct medicines. Patients' medicines were reconciled in the department by medical staff. Medication reconciliation is the process of creating the most accurate list possible of all medications a patient is taking and comparing that list against the prescribed medication in department with the goal of providing correct medications

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff we spoke with were aware of how to report incidents and could give examples of the type of things they would report, this included 'near misses'. All staff were aware of the duty of candour and they understood the importance of being open and honest when delivering care.

Lessons were learnt following the investigation of incidents and learning was shared with staff via emails, shift handovers and safety huddles. Several staff told us they had received direct verbal feedback.

We observed documentation in staff rest areas regarding incident reporting, feedback and lessons learnt. All staff told us incident reporting was encouraged.

From reviewing clinical governance minutes and reports we saw evidence of incidents being monitored and discussed.

Is the service effective?

We did not inspect this domain on this occasion.

Is the service caring?

We did not inspect this domain on this occasion.

Is the service responsive?

We did not inspect this domain on this occasion.

Urgent and emergency services

Is the service well-led?

We did not inspect this domain on this occasion.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Medical care (including older people's care)

Key facts and figures

We carried out a focused, responsive inspection at West Cumberland Hospital on 02 September 2020 to review the processes, procedures and practices within the medicine core service. We looked at parts of the safe and responsive domains.

Medical care (including older people's care) was provided across several wards at West Cumberland Hospital, including: a short stay unit (SSU) and same day emergency care unit (SDEC), and covered different specialities, such as general medicine, stroke rehabilitation, cardiology, respiratory, and elderly care and old age.

We observed care and treatment and specific documentation in 20 patient records including consent, mental capacity and deprivation of liberty safeguards documents.

We also interviewed key members of staff, medical staff and the senior management team who were responsible for leadership and oversight of the service. We spoke with 19 members of staff.

In addition, we invited all staff employed by the trust staff to complete an anonymous and confidential check box survey, to gather information about their experiences of working at the trust.

We observed patient care, the environment within wards and safety briefings.

This is the first time we have inspected North Cumbria Integrated Care NHS Foundation Trust, since it was formed.

We conducted this responsive focused inspection in response to escalating concerns of risk to patient and staff safety. The inspection was undertaken using specific elements of key lines of enquiry of the safe and responsive domains in emergency and urgent care, medicine, end of life care and community adults services.

Summary of this service

Compliance with trust targets for mandatory training in key modules by staff was not being met. We were not assured that health care staff caring for patients that showed signs of aggression and confusion and who required one to one supervision, had received appropriate training surrounding the differing forms of restraint, such as use of bed rails. The service did not have enough permanent staff to care for patients and keep them safe and so was heavily reliant on agency staff. We found examples of poor record keeping.

Access and flow was a challenge but the trust had various initiatives in place to try and address this.

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to staff but had not ensured that agency staff were consistently trained to adhere to trust process surrounding specific tasks for example initiating blood transfusions and safe administration of intravenous injectables.

The service had systems and processes in place to ensure that staff could access mandatory training. We saw that the system broke down training into core skill subjects and advanced resuscitation. However, staff we spoke with reported the system for recording staff completion of mandatory training was not wholly reliable. This meant staff based on the ward kept their own records of staff completion of mandatory training.

The trust set a target of 85% for completion of mandatory training, with the exception of information governance which was set at 95%. Data supplied by the trust showed that across most core skill subjects staff were showing as 'amber' and therefore not meeting the target. Staff had until 31 March 2021 to achieve compliance.

Staff we spoke with confirmed they were up to date with their mandatory training. For example, on ward three A and B we were told mandatory training compliance stood at 92%. Ward four was at 87%.

Subject to the comments staff made about reliability of data, mandatory training completion could be monitored centrally with outputs shared with care group managers. Any staff not on track could be flagged to their line manager for individual follow-up.

The trust provided e-learning which supported staff in completing their training.

Mandatory training for agency staff was checked by the agency providing the staff and evidence of completion retained on the agency staff file. Staff told us a new induction pack was being introduced to induct agency staff. Action was being taken to ensure agency staff could access the training they needed. For example, to enable them to undertake blood transfusions.

Some wards benefited from practice educators to support training of agency and other staff. We reviewed the trust's private board papers (July 2020) which evidenced that the trust had successfully recruited a full team of practice education facilitators with the intention of looking at the skills required for both nursing and non-registered staff. This work would then then be collated and uploaded into the electronic staff record (ESR) within the next two months.

Safeguarding

Staff we spoke with understood how to protect patients from abuse. However, we were not assured that health care staff caring for patients that showed signs of aggression and confusion and required one to one enhanced supervision, received appropriate training and understood the differing forms of restraint.

The trust had systems and processes in place to protect children and adults from neglect or abuse. Staff we spoke with had undertaken safeguarding training so that safeguarding was regarded as being everyone's responsibility.

The trust had a lead for safeguarding and they represented the trust at the local safeguarding boards for adults and children.

Trust wide level monitoring took place through the safeguarding team who reported at least annually to the board of directors.

We saw the trust had up to date safeguarding policies for adults and children.

Staff we spoke with understood their responsibilities in identifying and reporting any safeguarding concerns. For example, making a referral if a relative or carer of a patient was suspected of financial abuse.

Staff had access to safeguarding advice and support from link nurses on the ward, from the trust's intranet, and the trust's central safeguarding team.

Any patient considered at risk of female genital mutilation or child sexual exploitation was referred to the safeguarding team and other appropriate agencies for follow-up working with local system partners and established reporting mechanisms.

If a patient was assessed as being at risk of suicide or self-harm acute staff sought guidance from the crisis team that was available 24 hours a day seven days a week.

The trust set a target safeguarding training of 85%. Data supplied by the trust showed this was met for level one safeguarding children training but was at 80% and 55% respectively for levels two and three. For adult safeguarding training, the target was the same, and the completion for levels one and two, respectively, was 84% and 68%. We found that staff were unclear surrounding the differing forms of restraint and what counted as restraint. Staff we spoke with appeared unclear that, for example, bed rails could be a form of restraint, which was confirmed in the trust's bed rail policy. We raised this with senior staff we spoke with. Staff told us training dates for mental capacity act and deprivation of liberty to improve knowledge and practice in this area, was being arranged. Post inspection we were told the trust planned to introduce prevention management of violent aggression (PMVA) training for staff to deescalate aggressive situations. During our inspection we found examples of patients being prescribed risperidone (can be used a form of chemical restraint) without it being on care plans etc (and bed rails up without assessment or being in care plans). We raised this with senior leaders while we were onsite.

Cleanliness, infection control and hygiene

Most of the time the service controlled infection risk well. Staff used equipment to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

We found that the environment was visibly clean, and that systems and processes were in place to control infection and promote hygiene.

Ward two (27 single rooms with en-suite bathrooms) was designated as the COVID-19 ward. However, one of the non-COVID-19 wards was noted to have four bedded bays where the beds were not spaced two metres apart. Yet, on another non-COVID-19 ward, the beds were spaced two metres apart. Many of the other wards either had a selection of en-suite rooms or were all en-suite rooms. This meant services had access to isolation rooms for infectious patients and signs could be placed on the doors to alert people to an infection risk.

Staff breaks were staggered to reduce the risk of transmission of infection. Most staff we saw maintained social distancing and all were seen to be wearing masks. However, in certain areas, whilst staff wore masks, we observed staff not socially distancing.

Visiting on wards was suspended apart from for patients who were at end of life. Staff told us any patient with a positive COVID-19 result would wear a mask and gown as would visitors, where allowed.

To try and manage the spread of COVID-19, patients were swabbed for COVID-19, on a weekly basis and 48 hours prior to discharge to a care home.

We reviewed nationally published nosocomial (hospital acquired) COVID-19 infection data and noted the trust reported had reported two cases in the last five weeks. The wards visited displayed information about infection prevention and handwashing. The infection prevention control team (IPC) did observational compliance of staff washing their hands and provided feedback to the ward manager.

Hand washing facilities and antibacterial gel dispensers were available at the entrance of the wards and on corridors. Domestic staff checked and refilled hand gel dispensers. We saw that all dispensers seen were full.

We observed staff using personal protective equipment (PPE) when required, (in particular, masks) and staff we observed adhered to 'bare arms below the elbow' guidance. Staff were seen using PPE and handwashing before and after patient contact. Staff told us they had been 'fit tested' for their masks and trained in taking off and putting on PPE.

To support staff in maintaining levels of infection control, wards benefited from dedicated domestic services, with high touch areas being cleaned twice a day in accordance with best practice for managing the spread of COVID-19. We saw cleaning records were up to date and complete.

Wards four, ward six and Coronary Care Unit (CCU) reported, for year to date, two cases of clostridium difficile (C. diff), and zero cases of Methicillin Resistant Staphylococcus Aureus (MRSA).

All wards visited had a link nurse for infection control.

Environment and equipment

Overall the design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.

We found the ward environments used keypad door locks to secure access to the ward, and wards were clutter free, wheelchair accessible, and with enough equipment for staff to carry out their role. We saw clear signage of which areas were COVID-19 positive (called 'red zones') and COVID-19 negative (called 'green zones'). Where the ward layout permitted, patients were in single rooms and so socially distanced.

Staff told us they received daily coronavirus updates, and were supported with a quiet zone, through occupational health and a wellbeing service.

Quality of care boards were seen giving public information about the staff on the ward, visiting times, who was in charge, and other useful information, such as mandatory training compliance and IPC performance.

One of the wards had a bariatric room with replaceable ceiling tracks for hoists.

We found no ceiling mounted drip stands which could provide a ligature point.

Resuscitation trollies were being checked in accordance with trust policies. We found the trollies had been stocked with PPE because of COVID-19.

The trust told us for medical equipment, assurance was derived by use of a maintenance database at the site which allocated a maintenance schedule plus use of stickers showing when the equipment was due its maintenance check. Performance was tracked using key performance indicators. All equipment we saw was in date for maintenance checks.

Waste was separated and disposed of in appropriate colour coded bins.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient or take action to remove or minimise risks. But staff identified and quickly acted upon patients at risk of deterioration.

A strategic tactical group oversaw all implementation of COVID-19 guidance which was cascaded down to ward level staff through established governance structures.

Staff had access to an electronic early warning score to assess the health and wellbeing of patients and staff were using this. This tool supported staff to identify if the clinical condition of a patient was changing for the worse and required early intervention or escalation to keep the patient safe. On all wards we visited staff had access to electronic whiteboards situated at or near the nurses' station. This provided staff with headline clinical information about a patient to help them keep the patient safe. Data supplied by the trust showed, for the period January to September 2020, high (90% or above) compliance with recording of NEWS scores.

Ward staff reported use of morning handovers and afternoon safety huddles. We observed a handover on ward six which followed a situation, background, action and result structure for each patient. Matrons were site based and did walkarounds. Staff had access to a critical care outreach team 24 hours a day seven days a week.

Within the medicine service staff had access to a suite of standard assessment forms, for instance, tissue viability or falls. On another ward to address the risk posed by pressure ulcers staff used a clock to remind them when to turn patients.

Across the wards we visited, to address the risk of falls with harm, we saw ward staff adopted a suite of measures such as fall risk assessments, cohorting, and where staffing allowed, deployment of extra staff to stay with a patient who was at a high risk of falls. Trust wide there was a falls improvement plan. Staff reviewed past cases monthly. Wards had falls link nurses.

We saw sepsis guidance was easily available to staff through the trust's intranet. The trust had a sepsis steering group. Staff told us there was a sepsis nurse for the site available on a bleep.

The trust told us it was due to appoint two dementia nurses working cross-site to promote the safety of this patient cohort.

Key staff had received training in advanced life support. For example, on the coronary care unit (CCU), 60% of staff had received training in advanced life support. Staff told us another three staff would be receiving this training in September. Data supplied by the trust showed that across the trust, training compliance for immediate life support for adults and children was at 56% and 69% respectively, against a target of 85%, and advanced resuscitation was at 46% and 43% against a target of 85%.

We found that staff were unclear about restraint and what counted as restraint. As can be seen below (see 'Records') we came across patients with obvious confusion, delirium, or dementia, who had been given medication to control agitation. Also, we found bed rails being used in the presence of staff, but when we asked staff about use of restraint, they did not appear to comprehend that use of bed rails could constitute a form of restraint.

If a patient displayed challenging physical or emotional behaviours, staff were trained in conflict resolution. Staff acknowledged that they required further training, for example, around restraint.

Staff had access to a crisis team 24 hours a day seven days a week, if they were concerned about the mental health of a patient.

Nurse staffing

Although managers regularly reviewed and adjusted staffing levels and skill mix, we were not assured the service always had enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Staff told us there were 188 registered nursing vacancies in the emergency and medicine care group. The trust's board was supporting the leadership team with this challenge by utilising the agency framework to block book agency nurses. Block booking means the trust had a secured contract with agreed framework agencies, that provided nursing staff. In the meantime, the trust was looking to make more use of nurse associate roles and over the next five years planned to recruit to 25 of these new roles. By the end of December 2020, a full nursing review was due to be completed. Until more staff arrived, agency staff were block booked to that date. Owing to the COVID-19 pandemic, all recruitment of overseas staff had to cease.

The leadership team for medicine at the site were clear that nursing staffing could be challenging. This was echoed by staff we spoke with. For instance, one staff member reported being on their own for six hours with 15 patients. Whilst this was escalated, on the day in question, there were no staff available to offer support.

Most of the wards we visited reported vacancies in registered nursing staffing. For example, Ward three A and B had four-point-six whole time equivalent vacancies. However, because the trust had block booked agency staff, we found across most wards we visited, actual staffing met planned staffing.

The pressure on staffing could impact on the trust's ability to comply with recommendations around best practice. For example, on the coronary care unit patients could receive non-invasive ventilation (NIV). The trust's policy for NIV mandated that there should be two nurses for every eight patients. National guidance for NIV recommends one nurse, trained in NIV, for every two patients on NIV, particularly during the first hour of NIV commencing. Data supplied by the

trust showed that, for a 10 day period in July to August 2020, most days there was only one patient receiving NIV. On the 26 August 2020, the data showed there were two patients receiving NIV. However, staffing data showed that on that day the actual registered nurse staffing was down by one registered nurse. Staff told us that because the coronary care unit was adjacent to the critical care unit, they could call on staff from the critical care outreach team to assist with care of patients in receipt of NIV. This was confirmed by the trust's policy on NIV. However, it was not possible to track how often staff from the critical care outreach team attended the coronary care unit to support patients on NIV because this data was not in the staffing figures supplied by the trust. Bearing in mind the registered nurse staffing rostered also had to look after patients on the coronary care unit as well, we were not confident that the trust was able to staff its ward adequately to comply with national best practice around staffing of patients on NIV.

To support staff in planning staffing levels based on patient needs, bed meetings took place daily and staff used a nursing care tool, and professional judgment, together with an electronic rostering system to try and ensure staffing remained safe, both during the day and night. A matron of the day was available for any escalation and followed a clear policy of escalation.

Staff reported that the use of agency staff was working well and that they welcomed the support the agency staff provided. However, staff did report that being moved around wards to cover gaps in staffing was not welcome, because staff were often unfamiliar with the ward they had been moved onto.

Medical staffing

Overall the service had sufficient medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank, locum and agency staff a full induction.

All specialities we visited had medicine consultant cover to at least 10pm Monday to Friday with on call 24 hours for weekends and out of hours. Consultants worked across both acute sites but should not be on call for both sites at the same time.

For example, a stroke consultant visited the stroke ward three times a week and during the week a consultant in general medicine visited the general medicine ward daily.

On CCU consultant cover was provided daily Monday to Friday by three different cardiologists. However, if the nominated consultant was providing consultant of the week cover at the trust's other hospital, they would not be available to attend the site. This meant on some days there was no cardiologist physically present on site on CCU. Following our inspection, the trust informed us the visiting consultant would review the patients in CCU. In the absence of this, if a cardiologist was unable to visit, a telephone board round would be performed with the consultant of the week from Cumberland Infirmary.

For respiratory medicine, there was a consultant that visited the site daily.

Anaesthetists were available on site 24 hours a day seven days a week, who could provide support to non-invasive ventilation patients on CCU if required.

On ward 6 there was one consultant in SSU and one in SDEC.

Staff told us the medicine service still had gaps in medical staffing because of national shortages in certain specialities. For example, in care of the elderly, there were shortages in geriatrician consultants. The trust was trialling the use of advanced care practitioners to bridge the gaps in the medical rota. We were told the trust was working with a local medical school to improve medical staffing at the West Cumberland Hospital.

To address the gaps, use of agency was a last resort, and staff told us whilst there was use of locums, for most vacant posts, they looked to fill on a substantive like for like basis.

Pathways were in place to identify and transfer patients to the trust's other hospital. Staff we spoke with gave differing accounts about how the transfer system worked. For example, in an emergency, we were told the staff would dial 999 for an emergency ambulance. However, the trust's policy we saw suggested staff should in fact contact the trust's other hospital to make sure a bed was available before sending the patient. Based on what staff told us, we were not confident that this policy was being followed.

All the services we visited had a daily consultant review and multi-disciplinary team meetings (MDTs).

Records

We found gaps in records we reviewed of patients' care and treatment. What was recorded was not always clear or always up to date. Staff found records easily available and agency staff were able to access electronic patient records, where they were in use.

We reviewed twenty sets of records (including medicine charts). We found them to be generally legible, and generally with no gaps. However, we also found poor practice.

The trust used mainly paper records to record patient care, but some risk assessments were in electronic form. Staff told us that everyone was trained on the use of electronic risk assessments and staff aware which risk assessments were electronic and which were paper. Staff told us this was covered in training of new staff.

COVID-19 paper based risk assessments were completed in most records we saw on the wards.

In terms of poor practice, across a range of notes, we found the notes difficult to navigate, with loose sheets.

Further, the 'stop date' and 'initials for discontinued medication' was seen to be a wavy line and so illegible.

Other records had issues with legibility, or key information missing. For example, on some records we could not determine whether the patient had been seen by a consultant within 14 hours of admission because the times had not been completed.

Food record charts indicated a careful description was needed (such as, slices/ teaspoons/ cups and so on) however entries seen said "Tea" "Yoghurt" "soup" and at times were illegible. As such we found it difficult to understand how staff could track the volume of food and hydration a patient had ingested, where this was relevant.

In eight sets of records we reviewed to look at venous thrombo-embolism (VTE), we found two out of the eight records had not had the VTE assessment completed.

In another set of notes, no confusion risk assessment was in place and no deprivation of liberty applied for or capacity assessment done, where indicated. When we pointed this out to staff we were told the consultant would do the necessary assessments.

On another record we saw that a patient had been prescribed a medicine to control agitation. But the notes did not record a diagnosis of a mental health disorder and there was no detailed care plan for de-escalation strategies.

Patient records were held in trollies which whilst not locked were kept closed at or near the nurses' station.

Medicines

The service did not always follow best practice when prescribing, giving, recording and storing medicines. Most of the time patients did receive the right medication at the right dose at the right time.

We checked the storage of medicines, fluids and gases on the wards we visited. With some minor exceptions, (for instance, on ward three, where we saw unlocked wooden cupboards to store medication) we found that medicines, fluids and gases were stored securely in appropriately locked rooms or fridges. Checks were in place and stocks seen were in date.

Medical care (including older people's care)

Wards we visited did benefit from a visit by a clinical pharmacist each day and during core hours take home medications were being clinically checked and dispensed and patient medication reconciled. Although the pharmacist highlighted gaps on prescription charts, on charts we saw, it was noted the gaps had not been followed-up.

Whilst records we reviewed showed that medicines were given in a timely way, there was evidence that, with one exception, patients allergy status on the prescription chart was not signed and weights of patients were not being recorded. For example, one patient required a dose reduction if they weighed below 50 kilograms yet there was no written evidence to show they had been weighed since their admission. A copy of the discharge letter was sent to the GP of the patient. Out of five sets of records reviewed, only two sets of notes had a discharge letter, and in four of the records the stopping of medication page had not been completed, and in one set of notes there was no medicines information found.

The trust used electronic prescribing for discharge only and this was covered Monday to Saturday.

At this inspection, on all the wards we visited, we found controlled drugs (with one exception, noted above) were locked away in a metal cupboard in a locked room. We carried out a random check of controlled drugs and found all records of controlled drugs that staff kept were complete with no gaps and stock seen was in date.

Fridges used to store drugs requiring refrigeration were locked and logs for checking whether the fridge temperature had gone out of range had a couple of gaps for the month of August but were otherwise complete.

Incidents

Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team.

The medical director held weekly patient safety meetings. Staff told us currently there were 12 serious incident reviews in progress. Staff told us incidents were reviewed at ward-based speciality meetings, followed by directorate meetings and above that at care group meetings.

We saw the trust had a system in place to review incidents involving sepsis by the sepsis steering group.

All staff we spoke with could describe the process of incident reporting and understood their responsibilities to report safety incidents including near misses.

Staff we spoke with said feedback from incidents was shared mainly at handover because staffing pressures and COVID-19 pressures meant that team meetings were not taking place, or at least, not on every ward we visited.

Is the service effective?

We did not inspect this domain on this occasion.

Is the service caring?

We did not inspect this domain on this occasion.

Medical care (including older people's care)

Is the service responsive?

Access and flow

Patients were able to access the service when they needed it but because of bed capacity issues, admission could be delayed. However, patients received the right care promptly once admitted.

The service had systems and processes in place to monitor access and flow and to ensure that they were responsive to the needs of patients.

At a site level, flow within the service was a daily challenge and posed risks to patients. For instance, trust documents we reviewed indicated there were occasions when beds had been available in community hospitals, but their transfer was not progressed from the acute ward. On one of these occasions, the empty bed was held in a community hospital for four days. This impacted on patient flow through the hospital and meant patients may be exposed to risks such as infections, by remaining in an acute bed.

An urgent and emergency care programme was looking at flow issues to try and resolve them. Data supplied by the trust showed the days delayed per month by site for April 2020 to August 2020, for West Cumberland acute, was respectively, 181, 409, 543, 525, and 387. Trust board papers we reviewed confirmed the number of patients with a delayed transfer of care had been consistently high throughout 2019/2020 at the trust. In addition, the national discharge to assess model to facilitate discharges for patients awaiting further assessment (non-medical care), was not in place, although work had begun to establish this.

Staff we spoke with confirmed the trust was sighted on issues around access and flow and the site had several initiatives to tackle the challenges posed by access and flow through the service.

For instance, to avoid admission that was unnecessary the service had a ward six, which staff said was split into a SSU and a SDEC unit. Patients from the site's emergency department were placed here to decide whether to admit the patient pending results of diagnostic tests.

Further, we saw that active recruitment was ongoing with a view to opening a ward five in or around October 2020. This initiative was designed to relieve pressure on ward six and improve flow from that ward into the hospital.

Staff told us there were plans to recruit an enhanced care team to bring more focus on resolving patients with long lengths of stay or those with complex discharge issues. Staff received daily emails about long length of stay patients to flag this group so they remained visible to staff who could act.

Staff we spoke with confirmed that the site had done capacity and demand modelling of the service to see if access and flow could be improved. For example, changes made to the order in which diagnostic tests were done and appointments arranged within the cardiology service had led to improvements in turnaround times. In addition, staff told us about physical changes to the estate which were planned to improve access and flow.

At a ward level we found there were also staff in post to support appropriate movement through the service. Each ward we visited had a discharge navigator who worked with the bed managers so that the bed managers looked after the admission side of things whereas the discharge navigator looked after the discharge side of things.

The trust also had an integrated discharge team that staff could access for advice and support around discharge.

Staff we spoke with told us that the greatest threat to discharge was the unavailability of care packages in the community because of the rural nature of the local setting.

Staff told us they could access data on referral to treatment times and diagnostic performance to support them in managing flow issues.

Medical care (including older people's care)

Is the service well-led?

We did not inspect this domain on this occasion.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

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End of life care

Key facts and figures

The specialist palliative care team operates across the whole trust and is made up of a very small team covering a large geographical region. The team consists of clinical nurse specialists, consultants, speciality doctors, a specialist occupational therapist, and a lead nurse for bereavement services.

One of the consultants had been on long term sick leave for some time, and their post had not been backfilled. This had put some pressure on the ability of the team to respond to patient need.

Referrals are received from GPs, acute wards, district nurses, social care and local charities or directly from people themselves.

The service works closely with local hospices and hospice at home services across the county. The specialist palliative care team operates Monday to Friday from 9am to 5pm. There is an out of hours helpline staffed by qualified nurses and a doctor at the hospice in Carlisle.

We carried out a focused inspection at Cumberland Infirmary 02 September 2020 to review the processes, procedures and practices within the end of life core service. We looked at parts of the safe and responsive domains. We did not rate services because this was a focused, short notice inspection in response to specific areas of concern.

We looked at access and flow specific documentation in 10 patient records including, do not attempt cardiopulmonary resuscitation (DNACPR) documents, and reviewed data requested from the trust. We also interviewed key members of staff, medical staff and the senior management team who were responsible for leadership and oversight of the service. We spoke with nine members of staff and two patients.

This is the first time we have inspected North Cumbria Integrated Care NHS Foundation Trust, since it was formed.

We conducted this responsive focused inspection in response to escalating concerns of risk to patient and staff safety. The inspection was undertaken using specific elements of key lines of enquiry of the safe and responsive domains in emergency and urgent care, medicine, end of life care and community adults services.

Summary of this service

Staff did not keep detailed records of patients' care and treatment. Records were not clear, up-to date, or easily available to all staff providing care. Records were not stored securely.

Patients could not access the specialist palliative care service when they needed it. Waiting times from referral to transfer to preferred place of care and death were not always in line with good practice.

Is the service safe?

Records

Staff did not keep detailed records of patients' care and treatment. Records were not clear, up-to-date, or easily available to all staff providing care. Records were not stored securely.

We were not assured of the quality of records produced and used by the service.

The service used a combination of electronic and paper documents to record care and treatment of patients. This meant it was difficult to follow the timeline of a patient's care and treatment easily or accurately. Records were of poor quality, difficult to follow and did not always have sufficient information to ensure patients were cared for and treated safely.

End of life care

The purpose of a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision is to provide immediate guidance to healthcare professionals on the best action to take (or not to take) should a person suffer cardiac arrest or die suddenly. The Resuscitation Council (UK) provides advice and guidance around this including model forms for use.

It was agreed by the trust resuscitation committee that DNACPR Version 17a of the form would be used across the trust in order to standardise the process throughout the organisation. DNACPR Version 17a forms audits were reviewed on a regular basis. The most recent audit was completed in March 2020. The March 2020 audit data showed improving outcomes overall with some remaining areas of improvement required in relation to recording of a patients GPs, recording of key people involved in decision making processes, and the recording of responsible clinician details on the forms. Figures generally improved over each quarter of the year.

We were informed that there had been some confusion during the initial implementation of the DNACPR Version 17a form, as some clinicians had thought it was a care plan.

The trust followed "Care after Death" standard operating procedures (SOP). 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. However, the document did not have a commencement date, revision date, author, or ratification date.

Some staff stated that there was no requirement for ward staff to complete care of the dying documentation and they were of the understanding that the data was not audited. Other members of staff confirmed that completion of the documentation depended on the ward as to whether the care of the dying paperwork would be completed or not.

Documentation for advanced care planning had been introduced, however we saw limited used of this document in practice and staff told us it's use was variable from ward to ward. No audit of this document took place. This meant there was no monitoring of outcomes from the advanced care planning tool.

Is the service effective?

We did not inspect this domain on this occasion.

Is the service caring?

We did not inspect this domain on this occasion.

Is the service responsive?

Access and flow

Patients could not access the specialist palliative care service when they needed it. Waiting times from referral to transfer to preferred place of care and death were not always in line with good practice.

The service was not available over seven days, it was Monday to Friday only. Out of hours telephone support was available at weekends and evenings, provided by a hospice some distance from the hospital. However, West Cumberland Hospital had provided 9am to 5pm access to face to face specialist palliative care seven days per week for seven weeks between the period 23 March 2020 and 15 May 2020 to meet the demands of increased referrals. The team said they were keen to work towards a service that covered seven days in line with national guidance for access to specialist palliative care services. A business case was in development to support an increase in provision with supporting activity to demonstrate impact on provision and patient care.

End of life care

Between January and August 2020, 740 patients died at the trust with an open referral to SPCT. Information provided by the trust showed that the percentage of patients who died at their preferred place of death was 51.6% (382 patients). Some patients did not die in their preferred place of death due to sudden deterioration, inability to meet clinical needs at home, or because the patient was unable to express a preference. However, we found that some patients did not die in their preferred place of care as their discharge from hospital was not facilitated in a timely way.

There was no robust triage system in place to identify which patient took priority, however fast track discharges were flagged as priority. A new referral system had been implemented using Integrated Clinical Environment software (ICE) for receipt of electronic referrals. We were advised that referrals were triaged as they were received, however, response times were not monitored or audited. The current policy stated that a 1 to 3 day response time was required, but staff told us "they were usually picked up the same day". This was not monitored or measured. This meant there was limited assurance that patient referrals to the palliative care team were acted upon in a timely way.

There were no link nurses on the ward for end of life care patients. However, we were advised that ward staff could refer to specialist palliative nurses using the ICE system, by telephone or ad hoc conversations with specialist nurses when they were on the ward.

An end of life command centre had been implemented to support the increasing pressure on the acute and community system during COVID-19. Primarily, this was around mapping changes in demand alongside staffing capacity, logging syringe driver availability and supporting the logistics, providing advice and guidance for frontline staff around the end of life COVID-19 pathway.

The command centre focused on proactive information gathering and appropriate dissemination around trends and supporting the redeployment of resources. It also provided support for frontline community staff dealing with urgent end of life queries such as medication management.

The command centre had ten clinical and four administrative redeployed staff who identified a specific amount of time they were able to dedicate to the centre. A rota was drafted, and staff had received initial training. The centre was live from Friday 24 April 2020 operating slightly reduced hours with the potential to step up to 8am to 8pm working, if required.

The specialist palliative care team developed a syringe driver decision making tool to ensure that the most appropriate patients were allocated from the limited stock of syringe drivers on a priority basis. On one occasion in recent weeks, two integrated care communities were in the position of needing to borrow syringe drivers from a neighbouring integrated care community. This demonstrated that levels of such equipment had quickly become critically low.

We found that during COVID-19 the SPCT had created and embraced the 'attend anywhere' virtual clinics. Staff found that the virtual clinic enabled clinicians to see patients from each end of the local area (patch) in one day, with consultant attendance if necessary, and that greater triage had increased productivity overall, releasing time for responsiveness to urgent situations.

It was also felt by the SPCT and recorded in minutes of their team meeting that joint consultation with palliative care consultant could be organised via 'attend anywhere' clinic or teleconference in a reactive, timely fashion and problems dealt with much quicker. In addition, better relationships had been formed with GPs and district nurses with frequent phone contact leading to increased collaborative working.

Documentation we received, highlighted that the pharmacy department and SPCT services developed a number of 'just in case packs' which included a small supply of pre-emptive medications, a pre-printed community prescription and a small supply of needles and syringes. These were held in safe places within West Cumberland Hospital, Cumberland Infirmary and the community. This ensured timely access to symptom management for palliative patients enabling them to stay at home, be sent home from the emergency department for end of life care or be discharged urgently home from hospital. All the above were implemented in response to COVID-19.

End of life care

Is the service well-led?

We did not inspect this domain on this occasion.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Cumberland Infirmary

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Key facts and figures

North Cumbria Integrated Care NHS Foundation Trust (NCIC) was created in October 2019 following an acquisition of North Cumbria University Hospitals NHS Trust (NCUH) by Cumbria Partnership Foundation Trust (CPFT). During the acquisition the mental health and learning disability services were transferred out to another NHS trust.

It is a provider of acute hospital services based at the Cumberland Infirmary in Carlisle (CIC) and the West Cumberland Hospital (WCH) in Whitehaven. It also provides a midwifery-led maternity service at Penrith Community Hospital. The trust has 536 inpatient beds across the acute hospital sites and 133 beds across six community hospitals. The trust employs over 5,400 members of staff.

Cumberland Infirmary provides urgent and emergency care, medical care (including older people's care), surgery, critical care, maternity and gynaecology, children and young people, end of life care and outpatients and diagnostics.

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. A separately equipped cubicle was available for ophthalmic treatment. 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 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.

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.

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.

Services for children and young people at CIC included a children's ward and 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).

The Specialist Palliative Care Team (SPCT) service at NCIC cover both hospital sites.

Summary of findings

Diagnostic imaging was available at CIC and West Cumberland Hospital. Clinics were held in the main outpatient area 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 Community 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. The trust has a medicine department at Cumberland Infirmary.

Summary of services at Cumberland Infirmary

The urgent and emergency care and medicine core services did not always have enough staff to care for patients and keep them safe. There was limited training in key skills and staff did not always know how to protect patients from abuse and manage safety well. Infection prevention and control risks were not always managed well. Risks to patients were not always assessed or acted upon. Staff did not always manage safety incidents well and learned lessons from them were not always acted upon or shared. The medicine core service did not manage medicines well. Across all core services inspected staff did not keep detailed records of patients' care and treatment, records were not clear, up-to-date, or easily available to all staff providing care. Records were not always stored securely.

People could not always access the urgent and emergency care and medicine service when they needed them and often had long waits for treatment. Patients could not access the specialist palliative care service when they needed it. Waiting times from referral to transfer to preferred place of care and death were not always in line with good practice.

Urgent and emergency services

Key facts and figures

The Cumberland Infirmary emergency department is a consultant led service that operates 24 hours a day seven days a week to manage critically ill patients including children. Approximately 70,000 patients attend the department each year, 18,000 of which are children.

We carried out unannounced focused inspections of the emergency department at Cumberland Infirmary on the 26 and 27 August and 02 September 2020. The inspections took place in response to concerning information we had received in relation to patient care. The inspection on 02 September was in response to the inspection that took place on 26 and 27 August 2020 when we issued the trust with a Section 31 letter of intent which outlined the serious concerns we had identified. We visited the department on 02 September to find out whether any changes had been made since our August visits.

During these inspections we inspected using our focused inspection methodology.

During our inspection we spoke to members of staff and reviewed 15 sets of patient records.

This is the first time we have inspected North Cumbria Integrated Care NHS Foundation Trust, since it was formed.

We conducted this responsive focused inspection in response to escalating concerns of risk to patient and staff safety. The inspection was undertaken using specific elements of key lines of enquiry of the safe and responsive domains in emergency and urgent care, medicine, end of life care and community adults services.

Summary of this service

The service did not have enough staff to care for patients and keep them safe. Staff had limited training in key skills and did not always know how to protect patients from abuse and manage safety well. The service did not always control infection risk well. Staff did not always assess risks to patients, act on them or keep good care records. Medicines were not always managed well. The service did not always manage safety incidents well and learned lessons from them were not always acted upon or shared.

People could not access the services when they needed them and often had long waits for treatment.

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff however training rates did not meet the trust compliance standard and not all staff had completed it.

We saw evidence of staff compliance levels up to the 31 July 2020. Mandatory training was identified through organisational essential learning and core learning. Mandatory training included immediate life support, paediatric immediate life support, safeguarding, moving and handling, conflict resolution and information governance. The clinical educator confirmed 88% compliance in this area against a trust standard of 85%.

Staff told us new starters were enrolled within the preceptorship scheme which lasted a year. In addition, these staff were supernumerary for their first three weeks in post. We were told that should the nurse require additional supernumerary time this would be determined on an individual basis.

The clinical educator had a system in place to identify staff compliance levels and who was due to complete their yearly mandatory training sessions.

Mandatory training time was protected and was identified on the staff rota for individual staff. On occasion, staff said they would attend the mandatory training session on their day off. In this instance, staff would be given their time back. In addition, mandatory training had to be completed by staff before they received their yearly increment.

The clinical educator said all band six/seven staff were required to have completed adult life support (ALS) and advanced paediatric life support training. However, they recognised that advanced paediatric life support (APLS) trained nurses did not cover every shift. We looked at the training records for September 2020 and found nine of 20 band six/seven staff had not undergone ALS and 11 of 20 had not undergone APLS training. Six European Paediatric Life support (EPLS) trained adult nurses in the emergency department.

Immediate life support training was completed by band five staff. The clinical educator said all band five staff had completed paediatric immediate life support (PILS) training, apart from one new starter and one staff member on long term sick. We checked this information against the records sent to us and found there were a total of three staff who had not completed PILS, one of whom was on long term sick.

Staff completed Mental Capacity Act and Capacity and Deprivation of Liberty Safeguard online training annually and this was included as part of the essential skills training.

The clinical educator said all trained staff had completed sepsis training. They were supported by the trust wide sepsis team to train staff in sepsis management. The clinical educator supported individual staff members with sepsis training and management skills and evidence sent to us showed all staff had completed this training.

All trained staff received yearly deteriorating patient training and all staff had completed this at the time of our inspection.

Safeguarding

Staff did not always have the training on how to recognise and report abuse. This meant the service did not always protect patient from harm or abuse.

At our inspection in February 2020, we identified some concerns regarding the trust's safeguarding processes and procedures. At this inspection, these concerns remained. The trust's safeguarding children processes, procedures and practices did not adequately support the identification and protection of children and young people who may be at risk of harm.

Face to face training stopped during COVID-19. At the time of the inspection, safeguarding training was delivered online. Safeguarding training levels in the department were below the 95% target set by the trust. Level two training for safeguarding children was 85%, level three for safeguarding children was 65% and level two adult safeguarding was at 66%.

There was lack of robust information sharing processes within the trust. For example, there was no formal paediatric liaison procedure in place within the ED or the paediatric ward. We found there was an over reliance on staff professional curiosity to inform other relevant services such as health visitors, strengthening families and social care of children's attendance at the trust. The system was fragile with no clear thresholds or oversight of information being shared between professionals.

There were limited prompts / space in the adult emergency department card to record the names and dates of birth of any children in the family of the patient. In records we reviewed there was limited or no recording of practitioner exploration of children and family circumstances.

There was no evidence within emergency department / paediatric wards of practitioners being proactive in identifying potential child sexual exploitation (CSE) and in conversation with practitioners, staff told us there was no routine approach to screening for signs of exploitation.

In all 15 records examined within the ED, we saw no mention of any questions being asked in relation to domestic abuse, CSE or involvement in County Lines (where illegal drugs are transported from one area to another), even when behaviours might indicate that these could factor in a child's life.

Staff we spoke with told us they did not receive training specific to domestic abuse and the importance of asking adult attenders of any such risk to them and child witnesses. There was also a lack of identification of the hidden child and the wider approach to think family. Staff also told us they had not received training in how to ask those sometimes difficult questions of people in their care.

The trust did not have robust safeguarding systems and processes in place to monitor the safety of vulnerable patients or ensure policies were robust for staff to follow to keep people safe.

The service used a nationally recognised electronic child protection information sharing system within the department. Any information received into the department was checked at the point of arrival and shared by way of a flagging system on the electronic record and by documenting on the triage paperwork with clinicians.

The emergency department had identified a departmental safeguarding lead. In addition, adult and children's leads were identified. The hospital safeguarding hub could be contacted by staff if there was a concern. Staff could also complete an incident form via the incident reporting system. At night, staff approached the site coordinator for safeguarding advice.

However, results from a staff survey carried out by CQC as part of our inspection process showed 26% of staff did not know how to make a safeguarding referral. At Carlisle this figure rose to 30% and 42% of staff from the Carlisle site did not know who the safeguarding lead for their area was.

Safeguarding supervision took place in groups with peer support, we found records were chosen on an 'ad-hoc' basis to discuss actions taken and potential improvements that could be made. There was no oversight of the quality of these supervision sessions, therefore the trust could not be assured that safeguarding supervision was effective. Safeguarding supervision did not always support practitioners to improve their safeguarding practice.

The department had a sudden unexpected death in childhood (SUDIC) file and box. These were used when an unexpected death occurred and had very strict rules in place about how and when they must be used. Staff we spoke with said they had not experienced the need to use the SUDIC procedure.

Intelligence sent to CQC suggested security guards and porters were being used to monitor patients one-to-one when patients were restless and wouldn't stay in bed for their own safety. We addressed this with the trust in February 2020 and were assured this would no longer happen. Our staff survey asked staff across the trust if, after May 2020, they had witnessed security guards or porters giving one-to-one care to patients. At Carlisle Infirmary, 36% of staff said they had witnessed security guards or porters giving one-to-one care. Of the 177 responses to this question, 38 related to ED across the trust and of these 38, 33 related specifically to Carlisle Infirmary ED.

Therefore, we had concerns about how some vulnerable people such as those living with dementia were supported within the department. This was because the people delivering one-to-one care had not received the correct training to be able to manage such patients appropriately. There was a risk that patients could experience suboptimal care or come to harm due to this lack of training.

Patients were offered chaperones. This was usually a clinical staff member and was recorded in the patient's records by the medical team.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not use equipment and control measures to protect patients, themselves and others from infection. They did not always keep equipment visibly clean.

On inspection we found staff were not documenting/completing COVID-19 risk assessments or managing the risk appropriately. This was discussed with the matron and identified within the patient records inspected.

When we visited the department, we found it to be visibly clean. The department was divided into two sides, for hot (potentially COVID-19 positive) and cold (COVID-19 negative) patients. The division between the two sides was clearly marked and there were physical barriers in place to mark the specific areas.

However, we noted COVID-19 positive patients had to pass through the 'cold' area to access the wards if they were being admitted. We also saw that staff were unable to keep one metre apart whilst working at the medical or nurse station as the computer monitors were close together and there were not sufficient terminals for staff to use. We identified the lack of terminals available to staff at our last inspection in February 2020.

During our inspection all staff wore appropriate Personal Protective Equipment (PPE) when they were with patients and all patients were provided with a mask to wear whilst in the department. There was hand gel for both patients and staff to use. There was sufficient PPE in the department to ensure staff and patients were safe. Staff were observed disposing of PPE and other waste appropriately.

All staff had undergone fit testing, donning and doffing (the safe application and removal of personal protective equipment) PPE training at the start of the COVID-19 pandemic to ensure they were competent putting on and taking off PPE safely and correctly. Staff were allocated buddies to check individual donning and doffing techniques. New staff were given 1-1 sessions with their allocated buddy. Not all staff passed fit tests, however, were provided with alternative masks in which they passed the fit test. The staff who did not pass any fit test did not work in the hot zone for their own and patient safety.

Waste bins were identified for clinical waste use and the waste bins we observed were used correctly and not full.

During our inspection, we observed the department being cleaned by a designated cleaner.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not keep people safe.

We received intelligence that the trust was using the large atrium to the hospital to hold patients when the ED was full. The atrium is a large open area within the hospital. There are several floors that look down onto a large central open area. Departments such as ED and outpatients also lead off the atrium and it is a busy thoroughfare used by patients and staff alike to move around the hospital.

We had concerns that this was not an appropriate environment for patients to be waiting on hospital trollies and beds. Although the trust told us screens were in place at ground floor level, we remained concerned about the privacy and dignity of patients waiting in the area because they could be seen by people on the upper floors.

We also had concerns about how the trust ensured patients were subject to infection prevention controls in such an open area exposed to people accessing the rest of the hospital.

Additionally, we were concerned about how patients were monitored and by whom. We were concerned there was a risk that a deteriorating patient could be missed whilst located in the atrium.

Staff told us they had raised concerns about patients being cared for in escalation areas such as the atrium. These were patients who were arriving by ambulances (not patients already in the department who had been clinically reviewed and/or with lower acuity levels. Staff felt these patients were more appropriate to be cared for in the escalation area). We were told the paramedics still had responsibility for the patients in this area and the ambulance service provided a health care assistant to support this.

When we arrived on inspection in August 2020, the IPC team had advised staff to start using the corridor in ED for ambulance patients but there was no risk assessment in place. This had not been in consultation with ED staff or the matron, it would not have adhered to social distancing and would have meant COVID-19 positive patients walking past COVID-19 negative patients.

There was usually a designated children's area within the waiting room however, this had been closed as a result of COVID-19 because it was not big enough to allow social distancing to take place safely. Staff told us resources had been identified to increase the children's area size and facilities and plans had been drawn up for this change. When we asked, staff were not aware of the date this work was to commence.

During our inspection we saw there was no isolation area for children. At the time of the inspection, children were treated on the children's ward. We had some concerns because we were told the children's ward needed the area currently used by the ED team, vacated at the end of October 2020, due to expected winter pressures. Staff were unclear what would happen after this. It was unclear where paediatric patients would be located.

There was no resuscitation trolley containing emergency equipment and defibrillator within the paediatric area. This was a repeated concern which was originally identified during our inspection in February 2020.

The resuscitation trolley containing emergency equipment and a defibrillator were located within the general resuscitation area where one bay had been allocated for children. However, when not in use this bay also accommodated adult patients. We noted this bay had a paediatric specific resuscitation trolley whose drawers were colour coded as a quick visual aid for staff. The colour-coded drawers provided a clear reference in emergency situations – defining colour as the universal language of safety throughout the entire spectrum of acute paediatric care.

We checked the resuscitation trolleys in the department to ensure they were regularly checked and fully equipped to support staff in responding to a deteriorating patient. We found the trolley in the rapid assessment and treatment area had only undergone one weekly check and one daily check throughout August 2020. The trolley in the corridor had also only undergone one daily check and one weekly check throughout August 2020. Resuscitation checks were not being carried out in line with the department policy. There was a risk to patients that resuscitation trolleys could be missing essential equipment or have medication that was out of date which had the potential to harm patients.

There were separate entrances for walk-in patients with a seated waiting area. Reception was used by both walk in patients and ambulance crews booking patients into the department.

There was a separately equipped ophthalmology treatment room and a designated mental health room within the department.

We checked equipment in the department such as blood pressure machines to make sure it was safe and ready for use and did not identify any concerns.

Assessing and responding to patient risk

Staff did not complete risk assessments for each patient. This meant staff could not identify or quickly act upon patients at risk of deterioration.

We had concerns about the length of time patients in ambulances waited before being registered in the department. National standards state patients should be handed over from ambulance staff to hospital staff within 15 minutes. We spoke with ambulance crews who told us patients often had long waits in ambulances before being handed over. This

meant patients had not been assessed by a nurse or doctor, nor had any initial tests ordered or carried out and did not have a treatment plan in place. There was a risk that a seriously ill patient could experience delays to time sensitive treatments such as for stroke, bowel obstruction and sepsis. We found evidence of this during our inspection. Delays also meant ambulance crews had to stay with patients and could not go back out on the road to attend to other ambulance calls.

Guidance from CQC issued to NHS trusts in November 2017 made it clear that any patient physically on the hospital site should be regarded as under the care of the emergency department and patients should be booked in without delay and not wait in ambulances. Additionally, initial clinical assessment should be carried out without delay and give the department confidence about whether each patient has a serious problem. We did not have confidence that this was the case at Cumberland Infirmary.

We looked at ambulance attendances and turnaround times. This is the length of time it takes for an ambulance to handover a patient and be ready to go back on to the road. For the time period 20 July 2020 to 21 August 2020:

- There were 1,624 ambulance attendances, of these 171 had a turnaround time of over 60 minutes which equates to over 11% of total attendances.
- The longest ambulance turnaround was 246 minutes on the 13 August 2020.
- On review of the data we found that 63 patients had called an ambulance with a presenting complaint of stroke or Cerebrovascular attack (CVA). The average ambulance handover time for these patients was 34 minutes and the longest wait time was 84 minutes.
- We found that 10 patients had called an ambulance with a presenting complaint of chest pain. The average ambulance handover time for these patients was 31 minutes and the longest wait time was 45 minutes.
- During the Improvement Board meeting on 26 August 2020 the trust told us there was a senior decision maker (consultant) who assessed the ambulance queue and patients were seen in the order of who was most sick rather than order of arrival. However, during our inspection, staff told us there was no robust system in place to ensure this happened and this was done on an “ad hoc” basis. We were told band seven nursing staff would go out and “look at the patient” and a doctor would do this if they “had time”. In addition, there was no documented evidence that these checks had been completed.

We found the following examples.

- On 21 July 2020 for a person who had called an ambulance with a serious medical condition, there was an ambulance turnaround time of 47 minutes. There was also a note on the data provided which stated, “Complex clinical handover”.
- On 16 August 2020 for a patient who had called an ambulance with a serious medical condition, there was an ambulance turnaround time of 45 minutes. There was also a note on the data provided which stated, “No hospital beds available”.
- On 17 August 2020 a patient who had called an ambulance with a serious medical condition, there was an ambulance turnaround time of 72 minutes. There was also a note on the data provided which stated, “No clinical assessment capacity in department”.

During our inspection of ED in February 2020 we were concerned regarding the time taken to triage of patients. We asked the trust to improve the initial assessment provision. During our first inspection on 26 August we found the department did not have a standard operating procedure (SOP) for triage. This was in place when we returned on 02 September 2020, we saw there was an SOP in place. This had been published in August 2020 and was due for review in August 2021.

The SOP reflected the England standard; all patients should undergo triage within 15 minutes of arrival at the department whether on foot, or by ambulance. The policy also informed staff if the 15 minute triage time was not being met, this should be escalated to the nurse in charge so they could take appropriate action. Staff we spoke with told us they did escalate triage times; however; the department often did not have enough staff to have a second nurse carrying out triage due to staffing pressures. This meant patients often waited more than 15 minutes for an initial assessment once they had booked into the department.

We looked at initial assessment times between 20 July 2020 and 21 August 2020 and found:

1. A. 756 (46%) patients had an initial assessment wait over 15 minutes.
   B. Of those 756 patients, 149 (9%) had an initial assessment waiting time of over 60 minutes.
   C. A further 32 patients (2%) had an initial assessment waiting time over 120 minutes.
   D. The longest recorded time for an initial assessment was 578 minutes, on 14 August 2020.
   E. Of patients arriving by ambulance, 142 waited more than 60 minutes for initial assessment.
   F. 2363 patients arrived by other means and of these 37 waited more than 60 minutes for initial assessment.
   G. 57% of non-ambulance patients were seen within 15 minutes.
   H. The average patient wait for initial assessment for all patients regardless of how they arrived at the department was 17 minutes.

This data shows the trust had not put implemented actions to improve the triage times, which were identified in our February 2020 inspection.

We reviewed the data regarding initial assessment for the time period 20 July 2020 to 21 August 2020 which showed: -

- There were 29 patients categorized as category 1. Of these patients, 20 (69%) were seen in less than 15 minutes, four (14%) were seen within 15-30 minutes and five (17%) were seen within 30-60 minutes.
- There were 920 patients categorized as category 2. Of these patients, 533 (58%) were seen in less than 15 minutes, 247 patients (27%) were seen within 15-30 minutes, 100 patients (11%) were seen within 30-60 minutes and 40 patients (4%) were seen in over 60 minutes.

Additionally, over the same time period, we found:

1. A. Time to see a doctor for all patients regardless of how they arrived at the department ranged from one minute to 14 hours.
   B. 189 patients were in the department for more than 12 hours. Of these, 152 patients went on to be admitted.
   C. On 26 July 2020, 25 (28%) patients were seen within 60 minutes which meant 72% of patients were seen over 60 minutes.

- During our inspection, staff told us that throughout August 2020 they felt this had been a deteriorating position.

Through our review of the information and our onsite inspection we were not assured the trust had a robust system in place to manage the risk of harm to patients presenting to the emergency department by ambulance. This could cause delays in time-critical treatments for these patients; therefore, this meant patients may or will be exposed to the risk of harm.

The department also used a streaming nurse who signposted patients to the correct service for their needs, such as to the minor injuries department. The streaming nurse could see the waiting room and was therefore able to see if any patients visibly deteriorated whilst waiting to be triaged or to see a doctor.

Reception staff had access to guidance including specific medical conditions and symptoms, plus advice for when they should immediately contact clinical staff to see a patient who presented to the department.

Staff had access to specific screening tools to assess children. These directed staff to ask very specific questions to build a picture of the situation surrounding a child's illness or injury and take into consideration potential safeguarding situations such as exploitation, abuse or other vulnerabilities. One of the tools was built into the electronic record and therefore staff had to complete it as part of their triage process.

The department had a deteriorating patient policy called NEWS2 (National Early Warning Score) which included sepsis management. The policy was dated May 14, 2020.

The department had training in place to support staff to identify a deteriorating patient using National Early Warning Scores (NEWS2). Of the 35 members of staff working in the department, four were on long term sick, four were new starters, 24 had undergone training since January 2018 and three had not undergone training since at least 2017. When we looked at patient notes we saw that NEWS2 was not always completed in a timely manner. Therefore, we were not assured staff in the department could always identify a deteriorating patient as quickly as they should. We found similar concerns during our inspection in February 2020. This meant the trust have not taken the appropriate action as directed to improve the recognition of the deteriorating patient.

There was a single point of access line to mental health services. Psychiatric liaison visited the emergency department daily. Out of hours, staff said they had experienced problems accessing psychiatric support. Staff said that this concern was identified on the emergency department risk register. We had concerns because this meant patients with poor mental health waited a long time before being assessed and receiving specialist mental health support.

Nurse staffing

The service did not have enough nursing staff or support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm or to provide the right care and treatment.

We had concerns about the level of nurse staffing in the department. This had originally been brought to our attention when we inspected the department in February 2020. We raised our concerns with the trust at this time. Further concerns were subsequently raised to use by whistle blowers and concerned members of the public. When we returned in August 2020 the department still had significant staffing problems with little sign of an improved situation. We highlighted our concerns after the initial visit of this inspection in August 2020 and issued a Section 31 letter of intent under the Health and Social Care Act 2008 asking the department to carry out a staffing assessment using a recognised staffing tool and send the report to us along with their action plan. We received the report and action plan from the trust as requested.

At the time of the inspection, the staffing establishment was funded for:

- band seven – 5.4 wte (whole time equivalent),
- band six – 7.6 wte,
- band five – 18 wte,
- band four nursing associate – one wte,
- band three health care assistant (HCA), 2.6 wte
- band two HCA – 3.6.

Staff, including the matron told us the funded establishment was insufficient for the departmental workload.

Urgent and emergency services

We spoke with the matron for Cumberland Infirmary at Carlisle (CIC) who told us they were working with the matron at West Cumberland Hospital to assess staffing levels. They had used the BEST (Baseline Emergency Staffing Tool) assessment as the basis of improving staffing levels in the department.

The results of the staffing assessment tool based on the number and acuity of patients attending the department, showed there was a significant shortage of nursing staff deployed on shifts and that the planned staffing levels the trust had in place were not sufficient to ensure staff were able to meet the needs of patients in their care. Results of the assessment showed the department needed to increase staffing numbers by approximately 50% to ensure patients were safe and received their care and treatment appropriately.

This meant we were not assured patients were receiving the care they needed in a timely manner. For example, medical records showed patient pain scores and national early warning scores were not completed in line with frequency rules in a timely manner.

The matrons told us their plan was not to follow the BEST recommendations exactly but to use it as the basis to increase staffing at band five and six level rather than band seven as the assessment suggested. In the short term, whilst the recruitment process was underway, the department had added further agency staffing hours to the rota to ensure more staff presence in the department.

Evidence sent by the trust showed 28% of shifts were covered by agency and bank staff in June 2020, 46% in July 2020 and 65% in August 2020. This raised concerns about consistency of care, competencies and training of staff and there was an increased risk to patients that they may not receive care and treatment in line with departmental policies and procedures.

We found the low staff numbers also impacted on the department's ability to run a rapid assessment and treatment model of operation in the department as there were insufficient medical and nursing staff to support the operational model. We identified this as an issue at our first visit of this inspection in August 2020 and asked the trust to tell us how they would rectify this. The trust told us staffing would be increased and the model would be in place with immediate effect. When we returned to carry out our responsive inspection on 02 September, we found the operating model was not in use. Staff told us this was because there were insufficient staff to run the model.

There was also a lack of registered sick children's nurses (RSCNs) within the department which meant that children were not always triaged or looked after by a nurse with specialist training in caring for children. This was a continuing concern following our inspection in February 2020. However, we did not find evidence of harm in relation to this. The department had recently recruited two RSCNs and were advertising for an additional two at the time of the inspection. One of the three RSCNs employed had completed Advanced Paediatric Life Support (APLS) training.

Reported incidents showed examples of compromised patient care such as delays in patients receiving fluids and medication. Staff we spoke with told us they did their very best for patients but due to staffing levels and high numbers of patients in the department, sometimes patients were waiting a long time for treatment.

The department used an electronic rostering system to allocate staff duties; however, key skills such as advanced adult and paediatric life support were not always considered at the point of allocation. This was of particular concern when allocating staff to areas such as triage and the resuscitation area, this was a continuing concern following the February 2020 inspection. Staff told us (in line with national guidance) there should be an ALS trained nurse on per shift however, from the information we looked at, this was not always the case. Training figures showed only six staff had undergone ALS training and four had undergone APLS training.

We looked at staffing rotas for the department showing staffing levels after our initial unannounced inspection on 26 August 2020. Rotas showed staffing levels had been increased and actual staffing levels were higher than planned staffing levels for weeks commencing 24 August and 31 August 2020. Rotas showed the department aimed to have more than the baseline planned levels for weeks commencing 7 September and 14 September 2020 although at the time of writing this report, these dates had not passed and we were unable to verify whether this was the case.

We continued to have concerns about the sustainability of the trust's plan to address staffing in the department in the short term. Staff told us some shifts comprised of up to 50% bank and agency cover.

Bank and agency staff received an induction to the department, had access to policies and procedures on the trust intranet and were able to generate incident report forms. We saw evidence of the induction process. Department leadership told us bank and agency staff were not used in the triage area.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm or to provide the right care and treatment.

The department achieved the Royal College of Emergency Medicine (RCEM) standard of having consultant cover on site for at least 16 hours each day. However, according to the ED operating policy, the remainder of hours were covered by an on call rota and an ST3 (specialist trainee year three) doctor. This was a qualified doctor who had three years of specialty training in emergency medicine. This was not in line with the Royal College of Emergency Medicine workforce recommendations, that overnight the department should be staffed by a minimum of ST4 (specialist trainee year four) with advanced life support training. This was a concern because the minimum standard set is designed to protect patients and practitioners. Those who had not yet achieved the correct level of training may not always have sufficient experience or advanced skills and knowledge such as advanced paediatric life support to ensure patients are safe. We identified this concern at our inspection in February 2020 and it remained a concern at our recent inspections in August 2020 and September 2020.

We spoke with the medical management team about medical staffing and they told us that due to their allocation of trainee staff they were not in a position to always have an ST4 or above working overnight. They did however explain to us that there was mitigation in place, consultants were either resident on call (stayed overnight on sight) or were within a 30 minute drive of the hospital. They also explained that staff such as advanced clinical practitioners, GPs with specialist experience and other trainees were used in the department to support the overnight cover.

The department had one paediatric emergency consultant who treated both adults and children.

The management team told us a staffing review had recently been undertaken and discussions were ongoing in order to make the best use of the staff already employed in the department, arrange staffing rotas to cover peak times of activity and ensure patients received timely care by the person best placed to meet their needs. The department in Cumberland Infirmary were also keen to work more closely with West Cumberland Hospital to share skills, training and supervision for trainees.

At the time of our inspection, medical staffing cover was supported by locum use. Data sent by the trust showed 32% of consultant shifts, 6.5% of senior decision maker shifts and 2.6% of junior doctor shifts were covered by locum doctors. From 21 June 2020 to 21 September 2020, 8.4% of all doctor shifts were covered by locum staff.

Records

Staff did not keep detailed records of patients' care and treatment. Records were not clear or up-to-date.

We were not assured of the quality of records produced and used by the department.

The department used a combination of electronic and paper documents to record care and treatment of patients. This meant it was difficult to follow the timeline of a patient's care and treatment easily or accurately. There was a risk that patients may receive inappropriate care or treatment because of this or fail to receive treatment in a timely manner.

When we looked at incident data from the trust, we found examples of when patients had not received their medication in a timely manner. We found further evidence of this when we looked at medicine records during this inspection.

We looked in detail at the clinical records of six patients whilst we were inspecting the department. Analysis of the records showed two sets of records were fully completed with the relevant risk assessments and enough detail to communicate across departments giving a full picture of care and treatment. The remaining records had inaccuracies and poor dating and timing. Records were of poor quality, difficult to follow and did not always have sufficient information to ensure patients were cared for and treated safely.

We also carried out some assessment and analysis of the quality of electronic records used by the department prior to the inspection. The analysis showed inaccuracies, some patients apparently saw the doctor several hours before being triaged or saw the doctor days after leaving the department. Of the records analysed, 16% showed the patient was seen by the doctor after leaving the department. We had little confidence of the accuracy of the records because of this.

One staff member told us there had been occasions when some paediatric patients' notes had gone missing but they were unable to provide any further details.

Patient personal information was not on display and we observed monitor screens were not on view to the public.

Patient records were stored securely when not in use by staff.

Medicines

The service did not use systems and processes to safely prescribe, administer, record and store medicines.

Medicine administration records were not fully completed. Some medicines were prescribed via multiple routes, patient weights were not recorded and handwriting was difficult to read, this meant it was not possible to check that medicines were appropriately prescribed and administered. This was a risk to patients.

We looked at the notes of three patients who had already been discharged from the department. We found no date of admission or weights recorded. The weight of a patient could impact on dosages. We also found some records difficult to follow with gaps on the medication charts and records of patients receiving prescription medicines before even being seen by a prescribing physician. We therefore had concerns about the accuracy of the medication records used in the department.

We found examples of delays patients experienced waiting for medicines. We saw the records of one patient who was prescribed antibiotics at 10.50pm however the infusion was not actually started until 8am the following day. We spoke with the consultant on duty who agreed that this should have been started 'last night'. A second patient had been prescribed intravenous paracetamol due to a temperature however there was no evidence in the records that this had been administered.

We looked at the records of two patients in the department at the time of inspection who had been diagnosed with sepsis. Neither patient had received their antibiotics within the 'golden hour' of arrival. The "golden hour of sepsis" stresses the relationship between timely initiation of antibiotic treatment and outcome, each hour delay in treatment reduces sepsis survival.

One patient waited 70 minutes the other waited 91 minutes for antibiotics to be started.

We observed a health care assistant (HCA) draw up a clear solution in a syringe and place it in a bowl with single use equipment. The solution was not checked by the consultant of the day who was present at the time. The plastic ampule was disposed of by the health care assistant. We raised this practice with the consultant who said the HCA could do this.

We then spoke with the nurse in charge who said that any syringes should be prefilled, the HCA should not have drawn up the fluid and confirmed that a trained staff member should have checked the solution. The nurse in charge said they had run out of prefilled syringes on the Monday the day before inspection. We reviewed the trust medicines management policy which did not confirm this as usual practice. We had concerns that staff were working outside of their competencies and that hospital policies were not being followed. This meant there was a risk to patients of medication errors.

Staff in the resuscitation area told us night staff were responsible for checking medicines fridges.

We looked at fridge check records. These showed nine checks for August 2020 were missed. One check had been missed in July 2020 and there were two gaps in June 2020 checks. If fridge temperatures were out of range, the policy was for pharmacy and estates to be contacted and a log of variances on the back of the chart completed. However, we could find no evidence of action taken by staff when fridges were out of accepted and safe range. The nurse in charge told us this should have been noted on the record. Therefore, we were not confident that action had been taken.

Staff told us they were unaware of any learning from medicine incidents and raised the lack of frequency of medicine alerts being circulated to staff. We had concerns about this because medicine alerts are issued to ensure patients do not come to harm from medicines that may be faulty or dangerous.

We had concerns about the support ED received from the pharmacy team. This was because interviews with the pharmacy team revealed they were not staffed sufficiently to go to ED. A support pharmacist had been employed however was not replaced whilst the person was on long term absence from the trust. Thus, ED was left without sufficient pharmacy support.

We randomly checked medicines cupboards in the clean utility room and the resuscitation area and noted all cupboards were locked. FP10 prescription pads were stored securely and locked away in the resuscitation bay.

We checked the storage and records relating to controlled drugs and had no concerns. They were checked daily and stored securely.

We noted oxygen cylinders were secured to the wall in line with trust guidance.

The ambient temperature within the medicines room was below 25 degrees. This met with the trust policy.

Incidents

The service did not manage patient safety incidents well. Staff did not always recognise and report incidents and near misses or report them appropriately. Managers investigated incidents but lessons learned were not always shared with the whole team in a timely way. When things went wrong, staff apologised and gave patients honest information and suitable support.

We saw that over a two month period between July 2020 and August 2020, there had been 148 incidents reported within the department. Of these, 65 were reported as no harm, 79 as low harm, three as moderate harm and one as death. The main themes of these incidents were implementation of care and ongoing review, patient accidents (slips, trips and falls), pressure area damage and delays in treatment and care. From the information we had, it was unclear of the actions taken by the trust in response.

We examined further data about serious incidents reported between January 2020 and August 2020. There were seven serious incidents for CIC ED, six of which had been classified as unexpected/potentially avoidable death or injury requiring treatment to prevent death or serious harm. We had serious concerns about these incidents.

We looked at the 72 hour reports completed by the trust for the serious incidents. The 72 hour reports detailed the immediate actions that should be taken to ensure the risk of an incident reoccurring is reduced. We found 72 hour reports did not detail action the department had taken to reduce the immediate risk of reoccurrence.

Urgent and emergency services

During our inspection in February 2020 we identified concerns about staff reporting of incidents such as providing timely care to patients. At this inspection, staff we spoke with continued to tell us they did not always report issues such as difficulty in providing care for patients due to lack of staffing because they were too busy to take the time to report incidents. We also saw two examples of staff stating they had been asked to report an incident on behalf of a colleague.

Results of the staff survey we carried out as part of this inspection showed across the trust, around 10% of staff were not clear about how to report an incident. Results also showed 47% of staff at Carlisle Infirmary were not confident incidents were fully investigated and 34% said they did not get any feedback about incidents they had reported.

We had concerns about whether the trust as a whole, shared lessons learned and updated policies and standard operating procedures as a result to minimise the risk to patients and ensure incidents did not reoccur.

We had particular concerns about the interhospital transfer policy between West Cumberland Hospital and CIC as there was no emphasis on the receiving consultant ensuring there was a bed for a patient before accepting the patient and the patient being sent. This had resulted in some patients arriving at CIC and having to wait in an ambulance or ED for long periods of time until a bed was found for them. It had happened on more than one occasion and led to the patients coming to serious harm.

Staff and managers understood duty of candour and knew how to apply it appropriately.

Is the service effective?

We did not inspect this domain on this occasion.

Is the service caring?

We did not inspect this domain on this occasion.

Is the service responsive?

Access and flow

People could not access the service when they needed it to receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards .

During the first part of our inspection (26 and 27 August 2020) staff, including the senior management team of the department, told us there was no formalised or documented plan on how to manage excess demand into the emergency department from patients arriving in ambulances.

There was no robust system in place to ensure only appropriate patients were moved into additional escalation areas so patients were cared according to their health needs.

When we returned on 02 September 2020, the emergency department had an escalation plan and used OPEL one to four (Operational Pressure Escalation Levels). Green was rated as one and black was rated as four. The escalation plan was displayed in the emergency department/medical unit/ surgical assessment unit and admissions for the consultant in charge to see.

The department was included in the trust escalation, patient flow and full capacity protocol. This listed actions such as ensuring patients were referred to sub-specialties immediately following decision to admit and ensuring the site coordinator was aware of any three to four hour trolley waits.

During our inspection we found patients struggled to access the services then needed due to demand and lack of bed space within the hospital. Patients did not always have access to services in a timely way. This had been an issue we identified during our inspection in February 2020.

Data showing length of time patients waited in the department showed the department was failing to meet the national four hour target despite attendances at ED dropping due to the COVID-19 pandemic. The standard, set by the Department of Health for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department and that all patients have seen a doctor (or equivalent) within 60 minutes of arrival.

During the period between our two inspections, 26 August 2020 and 02 September 2020 the trust had bed occupancy of between 91% and 98%. High bed occupancy impacts on the ability of patients to be moved from the ED on to specialty wards and leads to patients waiting in ED for longer.

Evidence provided by the trust showed patients continued to regularly wait more than 12 hours in the department for a bed on a ward. We also found this during our inspection in February 2020. During this inspection we found evidence of patients waiting an excessively long time for beds on the wards. For example, one patient in the department had waited 14 hours without a treatment plan in place. There was a continuing picture of patients experiencing long waits in the department whilst waiting for beds on wards or treatment plans.

Incidents reported by the trust provided evidence that flow through the department into the rest of the hospital sometimes had a serious impact on the wellbeing and safety of patients. For example, we found evidence of unwell patients being transferred from the West Cumberland Hospital to CIC who waited in ambulances outside ED because there were no free beds in the hospital to accommodate them. Some of the patients had suffered serious consequences as a result of the lack of bed for them. Trust leaders told us that acute admission patients went to the emergency department instead of the acute medical unit because of backlogs. This meant there was an increased flow of patients through the department.

We additionally found evidence of other patients who had suffered avoidable harm whilst in the department. For example, we found evidence of a patient wrongly diagnosed who waited 36 hours for a correct diagnosis, a patient with a missed long bone fracture and a patient who did not receive the correct medication and suffered a deterioration in their condition.

We spoke with the senior management team about support the department received from other specialties such as critical care, medicine and surgery. They told us specialty teams were supportive and came to the department regularly and in a timely manner to see patients.

The department used the emergency department dashboard to overview activity. Consultants had been trained and had permissions in the new dashboard to monitor the real time position of the department. Once training had been arranged, band seven nursing staff would also have permissions to access this dashboard. The department planned to discuss the new dashboard at the monthly senior meeting attended by band six/seven nurses, registrars and consultants.

Is the service well-led?

We did not inspect this domain on this occasion.

Urgent and emergency services

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Medical care (including older people's care)

Key facts and figures

We carried out a focused, responsive inspection at Cumberland Infirmary 02 September 2020 to review the processes, procedures and practices within the medicine core service.

We observed care and treatment and specific documentation in 14 patient records including consent, mental capacity and deprivation of liberty safeguards documents. We also interviewed key members of staff, medical staff and the senior management team who were responsible for leadership and oversight of the service. We spoke with 19 members of staff.

In addition, we invited all staff employed by the trust staff to complete an anonymous and confidential check box survey, to gather information about their experiences of working at the trust.

We observed patient care, the environment within wards and safety briefings.

On this inspection we visited the medicine service areas in the Elm wards pavilion which included the acute medical unit (AMU) and hyper acute stroke unit (HASU). In addition, we visited same day emergency care (SDEC) and ward Larch C.

This is the first time we have inspected North Cumbria Integrated Care NHS Foundation Trust, since it was formed.

We conducted this responsive focused inspection in response to escalating concerns of risk to patient and staff safety. The inspection was undertaken using specific elements of key lines of enquiry of the safe and responsive domains in medicine services.

Summary of this service

The service did not always have enough staff to care for patients and keep them safe. The service did not control infection risk well. Staff did not consistently assess risks to patients, act on them and keep good care records. They did not manage medicines well. The service did not manage safety incidents well and learn lessons from them.

People could not always access the service when they needed it and some had to wait too long for treatment.

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory Training

The service provided mandatory training in key skills to staff but had not ensured that agency staff were consistently trained to adhere to trust process surrounding specific tasks for example, initiating blood transfusions and safe administration of intravenous injectable medicines.

The trust set an overall mandatory training compliance target of 85% to be achieved by 31 March 2021. Nursing and medical staff compliance as of 31 August 2020, was rated amber. This meant they were on trajectory to meet the target.

Mandatory training for agency staff was checked by the agency providing the staff and evidence of completion retained on the agency staff file.

The trust was currently reviewing the mandatory and specific role training competency model for agency staff to consistently provide safe treatment and care. Staff we spoke with told us a new induction pack was being introduced to induct agency staff. Action was being taken to ensure agency staff could access the training they needed. For example, agency staff were not yet trained to undertake blood transfusions and administration of injectable medicines.

Mandatory training completion could be monitored centrally with outputs shared with care group managers. Any staff not on track could be flagged to their line manager for individual follow-up.

We discussed mandatory training compliance with individual staff members and ward managers. Compliance rates varied from 78% to 86%. Where compliance was low, individual wards had plans in place to address. Staff we spoke with told us they were given protected time to undertake training during work time.

However, during inspection we noted that quality boards on individual wards containing mandatory training data were not consistently updated.

The trust provided e-learning which supported staff in completing their training. In addition, some wards benefited from practice educators to support training of agency and other staff. However, staff we spoke with told us that not all areas had practice educators to provide specific core training.

We reviewed the trust's private board papers (July 2020) which evidenced that the trust had successfully recruited a full team of practice education facilitators with the intention of looking at the skills required for both nursing and non-registered staff. This work would then then be collated and uploaded into the electronic staff record (ESR) within the next two months.

Safeguarding

Staff we spoke with understood how to protect patients from abuse. However, we were not assured that health care staff caring for patients that showed signs of aggression and confusion and required one to one enhanced supervision, received appropriate training and understood the differing forms of restraint.

Nursing staff we spoke with on the wards told us one to one enhanced supervision was provided by nursing staff, following individualised risk assessment of patient safety needs. Although confirmed in May 2020 CQC/trust engagement meeting minutes (recorded by the trust), security guards were not utilised to provide one to one enhanced supervision, 12 check box survey respondents indicated that since May 2020, they had witnessed security guards on medical wards employed in this capacity.

In July 2020 CQC/trust engagement meeting minutes, it was noted that enhanced care team posts were out to advertisement. These minutes also indicated the standard operational procedure (SOP) for enhanced care was going to nursing, midwifery and allied healthcare professionals' group in July 2020. However, information provided by the trust after our inspection confirmed the SOP for enhanced care was still in draft and awaiting ratification prior to launch.

Post inspection we were told the trust planned to introduce prevention management of violent aggression (PMVA) training for staff to de-escalate aggressive situations.

We found that staff were unclear surrounding the differing forms of restraint and what constituted restraint. During inspection we observed patients with obvious confusion, delirium, and dementia, who had been given medication to control agitation. Also, we found bed rails being used, but when we asked staff about restraint, they did not appear to comprehend that the use of bed rails could constitute a form of restraint. We reviewed the trusts safe and effective use of bedrails policy, which confirmed bedrails were not to be used for restraint purposes.

Overall safeguarding training compliance for nursing and medical staff was rated as amber. This meant the trust was on trajectory to meet the target of 85% by 31 March 2021.

The trust had systems and processes in place to protect children and adults from neglect or abuse. Staff we spoke with had undertaken safeguarding training so that safeguarding was regarded as being everyone's responsibility.

The trust had a named lead for safeguarding and they represented the trust at the local safeguarding boards for adults and children.

Trust wide level monitoring took place through the safeguarding team who reported at least annually to the board of directors.

We saw the trust had up to date safeguarding policies for adults and children.

Staff we spoke with understood their responsibilities in identifying and reporting safeguarding concerns. For example, making a referral if a relative or carer of a patient was suspected of financial abuse.

Staff had access to safeguarding advice and support from link nurses on the ward, from the trust's intranet, and the trust's central safeguarding team.

Any patient considered at risk of female genital mutilation or child sexual exploitation was referred to the safeguarding team and other appropriate agencies for follow-up working with local system partners and established reporting mechanisms.

If a patient was assessed as being at risk of suicide or self-harm, staff sought guidance from the crisis team which was available 24 hours a day, seven days a week.

Cleanliness infection control and hygiene

We were not assured that the service-controlled infection risk well. We lacked assurance of senior management oversight of infection control relating to bed spacing, staff adhering to social distancing measures and we observed inconsistent cleaning of specific ward areas.

During our inspection we found several infection prevention and control concerns. For example, ward Larch C did not have an allocated domestic cleaner and there was no evidence of robust cleaning schedules in place. We observed a cleaning rota for August 2020 for bay 24, which had been signed twice over a two-day period to evidence that cleaning had taken place. We escalated this at the time of inspection. The ward was visibly dirty, the clean utility floor was littered with plastic tops from injection vials which had been discarded and not disposed of in accordance with trust policy.

During inspection on Larch C we observed unsuitable storage of pillows on the floor, which impacted on appropriate cleaning to be actioned. We also observed a settee which had torn fabric, unsuitable for a ward area and an infection control risk.

We observed non adherence to national guidance in relation to COVID-19 and social distancing. For example, beds were not appropriately spaced on wards Larch C, and Elm A and B.

Not all wards had a donning / doffing station (the area used for the safe application and removal of personal protective equipment) at the ward entrance to ensure strict adherence to infection control guidance and policy. A donning and doffing station is a specified area where staff put on and remove PPE, to reduce the risk of infection.

We escalated our findings with senior management surrounding concerns on Larch C. The senior leadership team immediately instigated steps to address concerns raised at the time of inspection. Domestic support was planned, pillows and the settee were removed from the ward area and a full clean of the ward was instigated.

During inspection we noted that quality boards on individual wards which displayed infection rates and staff hand hygiene compliance were not consistently updated. For example, the board on Larch C was blank and the board on AMU was last updated in April 2020 to evidence clostridium difficile infections. During inspection we noted that the AMU unit had a suspected case of clostridium difficile and this information had not been recorded on the quality board.

During the inspection we asked for evidence that infection prevention and control (IPC) audits, had been undertaken. We reviewed the quarterly infection control committee minutes provided from July 2020 and noted that cleaning audit scores at the Cumberland Infirmary remained a concern. Of particular concern was Elm C ward, which scored 56% for compliance with standard precautions. Standard precautions are the basic infection prevention and control measures necessary to reduce the risk of transmitting infectious agents from both recognised and unrecognised sources of infection. The minutes also noted a plan was in place to address the findings.

We reviewed the most recent trust cleanliness audit data for August 2020. This indicated cleanliness audits were now completed by a contracted provider. However, as part of training and implementation on site, only a sample of audits were completed in August 2020.

The trust had an overarching COVID-19 outbreak control plan in place. Visiting on wards was suspended apart from patients who were at end of life. To try to manage the spread of COVID-19, patients were swabbed for COVID-19 on a weekly basis and 48 hours prior to discharge to a care home.

In June and July 2020, the trust reported nosocomial (hospital acquired) COVID-19 outbreaks on the Willow wards, which lasted 11 weeks. Staff we spoke with told us about the environmental concerns of the Willow wards pavilion and the location of clinical areas; it was a U-shaped pavilion and four areas could link into each other. They also shared concerns regarding some staff non-compliance with PPE (personal protective equipment) and taking breaks together.

These outbreaks were investigated by the trust and the wards underwent a deep clean. In addition, Willow pavilion was audited weekly during August and scored 99-100%.

We reviewed nationally published nosocomial COVID-19 infection data and noted the trust reported had reported two cases in the last five weeks.

The wards visited displayed information about infection prevention and handwashing. The IPC team conducted observational compliance assessments of staff washing their hands and provided feedback to the ward manager.

Hand washing facilities and antibacterial gel dispensers were available at the entrance of the wards and on corridors. Domestic staff checked and refilled hand gel dispensers.

We observed staff using PPE when required, (in particular, masks) and staff we observed adhered to 'bare arms below the elbow' guidance. Staff were seen using personal protective equipment and handwashing before and after patient contact. Staff we spoke with told us they had been 'fit tested' for their masks and trained in taking off and putting on PPE.

Environment and equipment

The design and maintenance of facilities kept people safe and most areas had enough equipment for staff to carry out their role. Staff managed clinical waste well.

We found the ward environments used keypad door locks to secure access, and wards were mostly clutter free, wheelchair accessible, with clear signage which indicated the areas that were COVID-19 positive (called 'red zones') and COVID-19 negative (called 'green zones').

Staff we spoke with told us they received daily coronavirus updates, and were supported with a quiet zone, through occupational health and a wellbeing service.

Most areas we visited had enough equipment for staff to carry out their role.

The exception was Larch C. The ward had opened eight weeks prior to our inspection. Staff we spoke with told us there was a lack of equipment and this was reported by a registered nurse using the incident reporting tool, to senior

management on 25 August 2020. The incident report showed that concerns were raised surrounding, a lack of electronic tablet devices to record patient observations, the ward computer to record patient admissions and discharges had no hardware installed, and the blood pressure monitoring machine did not work. We were informed no immediate action was taken following submission of the incident report.

Staff we spoke with told us the trust estate faced challenges. For example, the heart service operated from a modular laboratory which was old, and the service only had one catheter laboratory, which meant there was a single point of failure if that laboratory went down. We were informed a business case was being considered to address this. Following our inspection, the trust told us there was access to a catheter laboratory in the radiology department and the business case was approved in January 2020.

Resuscitation trollies were checked and recorded in accordance with trust policies. We found the trollies were stocked with PPE because of COVID-19.

Waste was separated and disposed of in appropriate colour coded bins for waste streams.

Sharps waste bins we saw were assembled correctly, labelled, not over filled and stored safely when unattended.

Fire exit signage was seen, and exits were free of obstructions. All fire extinguishers seen were signposted and within date of their next scheduled maintenance check.

The trust told us for medical equipment, assurance was derived by use of a maintenance database at the site which allocated a maintenance schedule. In addition, we saw use of stickers to indicate when equipment was due its maintenance check. Performance was tracked using key performance indicators. All equipment we saw was in date for maintenance checks.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient or take action to remove or minimise risks. We were not assured staff identified and quickly acted upon patients at risk of deterioration.

We had specific concerns about Larch C. This was a ward opened for the previous eight weeks at the time of inspection without a dedicated, named team and no administrative support. There was no clear management structure in place and one substantive nurse was left in charge with agency staff for support. This meant staff did not have the skills to undertake certain tasks, for example, to safely commence and monitor blood transfusions.

There was no safer staffing tool used in this area and the acuity of patients had not been assessed. During inspection it was evident that patient acuity was high and not low risk.

There were no formalised admission criteria for this ward. Staff we spoke with understood this was a temporary ward; however, senior managers told us this was permanent until next review.

We escalated our concerns during inspection and the lead clinician drafted a standard operating procedure (SOP) which stated criteria for admission to Larch C. This was shared with colleagues for comment immediately and was implemented after ratification the following day.

Staff had access to an electronic national early warning score (NEWS2) to assess the health and wellbeing of patients. This tool supported staff to identify if the clinical condition of a patient was deteriorating and required early intervention or escalation to keep the patient safe. National early warning score 2 (NEWS2) scores were recorded but staff did not always repeat observations as indicated. For example, one patient on AMU, had a NEWS2 score of two completed at 4.15pm in the emergency department. However, no further observations were recorded by 10 am the following morning and these should have been repeated after four hours.

Ward staff reported use of morning handovers and afternoon safety huddles. We observed a handover on AMU which was thorough. Matrons were site based and did walkarounds. Staff had access to a critical care outreach team 24 hours a day, seven days a week.

For medical outliers (patients who belong to one medicine speciality but are placed on a different ward because their speciality does not have a bed for them on their ward), Staff could track using the trust's electronic patient record system. Staff we spoke with reported concerns about the number of medical outliers, and how this impacted on patient safety and outcomes because the stroke ward was often used to outlie such patients.

Medical staff on each ward looked after the medical outliers with input from the specialist medical team concerned. There were 17 medical outliers on the day of the inspection.

Nursing staffing

Although managers regularly reviewed and adjusted staffing levels and skill mix, we were not assured the service always had enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Most of the wards we visited reported vacancies in registered nurse staffing. At the time of our inspection, the trust had 188 whole time equivalent staff vacancies.

To support staff in planning staffing levels based on patient needs, bed meetings took place daily and staff used a nursing care tool, and professional judgment, together with an electronic rostering system to try to ensure staffing remained safe, both during the day and night. A matron of the day was available for any escalation and followed a clear policy of escalation.

The service did not monitor nurse staffing levels for patients nursed on the hyper acute stroke unit (HASU) receiving level two care. The service could not assure us that patients were nursed according to British Thoracic Society (BTS) guidelines and the National Institute for Health and Care Excellence (NICE) guidance, which recommend one nurse to two patients. Staffing on the stroke unit was also of concern as this was where patients received thrombolysis, which is a time critical procedure.

The trust's hard truths staffing report for July 2020 indicated HASU had an amber (medium risk) rating, which meant the ward had vacancies which impacted when all beds were occupied. The report for September 2020, indicated HASU remained amber; while staffing levels were improving with the use of agency staff, there were still significant vacancies, therefore the ratio of substantive staff to agency could be low.

The acute stroke unit which had ten beds, should have had a planned staffing of five registered nurses (RNs) on each shift for the expected acuity of patients. However, staff we spoke with told us there were usually three RNs on duty during the day and two on night shift. They told us RN gaps were filled with healthcare assistants (HCAs). We reviewed planned and actual staffing data for HASU, for the period 07 September to 06 October 2020. This showed out of 90 shifts, seven (8%) were over staffed, 19 (21%) were fully staffed and 64 (71%) were under staffed.

Other wards identified as amber risk in the hard truths nurse staffing report, were Elm A, B and C. The report identified the trust were unable to source one to one staff at short notice for these wards. However, the trust employed registered mental health nurses to support where possible.

Due to the high staff vacancy rate surrounding nursing staff the trust had received board approval to block book agency staff to fill vacancies until December 2020. Block booking means the trust had a secured contract with agreed framework agencies, that provided nursing staff. We found across most wards actual staffing met planned staffing numbers. Staff we spoke with told us that they had been allocated additional RN's on the day of inspection which was not standard practice.

Staff we spoke with reported the use of agency staff worked well and they welcomed the support agency colleagues provided. Regular agency staff were planned to work in the same directorates and wards in order to support and provide consistency where vacancies were high.

We found there were large numbers of agency staff in use during our inspection. For example, on AMU of the eight RNs on duty for a 32 bedded unit, five (62%) were agency staff. However, agency staff were unable to access some areas of training and could not be signed off for a variety of skills and competencies. This meant they could not undertake some clinical tasks such as initiating blood transfusions and intravenous injectable medicines.

Staff we spoke with told us that future ward configurations remained uncertain, meaning the establishment reviews that were ongoing during inspection for the wards had yet to be completed and reviewed.

The trust had instigated new care group structures, effective from July 2020, to provide improved balance and visibility across sites. Portfolios had been realigned with a triumvirate approach including senior doctors, senior nurses and senior managers. However, we found this was not fully embedded.

In response to national skills shortages, gaps in workforce and the local rural/geographical challenges the trust targeted attraction campaigns, an overhaul of recruitment processes and effective on-boarding, which were all currently being developed.

Medical staffing

Overall the service had sufficient medical staff with the right qualifications, skills, training and experience. Managers regularly reviewed staffing levels and skill mix, and gave bank, locum and agency staff a full induction.

Most specialities we visited had medicine consultant cover Monday to Friday (consultant of the week), with on call 24 hours a day, seven days a week for weekends and out of hours. The trust had a policy for identification of the responsible consultant.

For example, staff told us a stroke consultant visited the stroke ward three times a week and during the week a consultant in general medicine visited the general medicine ward daily.

All the services we visited had a daily consultant review and multi-disciplinary team meetings (MDTs).

Staff we spoke with told us the medicine service still had gaps in medical staffing because of national shortages in certain specialities. For example, in care of the elderly, there were shortages in geriatrician consultants. However, the trust was trialling the use of advanced care practitioners to bridge the gaps in consultant availability. In addition, staff we spoke with told us use of agency medical cover was a last resort, and whilst there was use of locums, most vacant posts were filled on a substantive like for like basis.

A medical recruitment campaign had resulted in the successful appointment of several International Clinical Fellows who arrived during summer and autumn 2019 to help fill longstanding vacancies and support the existing medical workforce.

Records

Staff kept records of patients care and treatment; however, we lacked assurance surrounding the completeness of records and the security of patient records on wards and departments that we inspected.

The trust used mainly paper records to record patient care, but some risk assessments were in electronic form. Staff we spoke with told us that everyone was trained on the use of electronic risk assessments and staff were aware which risk assessments were electronic and which were paper. Staff we spoke with explained use of electronic records was covered in training of new staff.

During inspection we had concerns about information governance and compliance with general data protection regulations (GDPR). For example, we saw seven unlocked patient record trollies outside the outpatients' department in a public area. We escalated this to the management team who immediately dealt with this as an information governance incident. We also observed record trollies in other areas that were closed but unlocked.

We saw unsecured records on tables outside patient rooms on Larch C. During inspection of the same day emergency care (SDEC) unit we observed unsecure patient records; the main reception desk was left unattended with patient records on view and access to the unit's computer was left unlocked without password protection.

We reviewed 14 patient records on Larch C, AMU, SDEC and HASU and found quality of record keeping was poor and important information was missing.

For example, there was inconsistent recording of dates and times of assessments and clinical reviews, which meant we could not always judge if assessments were made in a timely manner. Record folders contained loose leaves and there were examples of misfiling and missing information. This meant we could not identify if mental capacity assessments (MCA) had been made or if deprivation of liberty safeguards (DoLS) were in place or if the paperwork had been mislaid. In some instances, due to what appeared to be errors with dates, it was impossible to establish a chronology of events.

We reviewed the records for a patient on a ward who lived with dementia. Several restrictions were in place to keep them safe and they had been in hospital for four to five days. However, there was no evidence in the records to indicate whether an MCA assessment had taken place or was considered. The standard documents we saw prompted a memory loss question but no further assessment of mental capacity. There was no documentation evident to support the DoLS restrictions. We asked nurses if any DoLS application had been made. They told us there had been, however, they were unable to find the documentation to evidence this and explained it must have gone missing.

There was a record that a discussion about treatment was held with a family member regarding treatment but there were no details of the conversation recorded. We asked the nursing staff to arrange a call with relatives to clarify understanding and what had been discussed so this could be recorded. There was no form of consent or best interest decision making recorded.

Another patient on an end of life pathway did not have their preferred place of death recorded.

Medicines

The service did not always follow best practice when prescribing, giving, recording and storing medicines. Patients did not always receive the right medication at the right dose at the right time.

We had concerns about medicines governance. For example, there was no medicine trolley on Larch C, which meant nurses administered directly from the medicine storage cupboard. This was observed to be overflowing and disorganised. Agency staff also administered prescribed medicines directly from the store cupboard. This meant there was increased risk of medication errors occurring.

We noted in August 2020 daily huddle minutes for AMU that there were multiple master keys missing. This meant we had concerns about security and possible access to restricted areas and medicines by unauthorised persons.

We also found examples of delays in medication prescribing following admission and delays in administration of medicines following prescription. For example, for some patients there were delays in antimicrobial administration.

On HASU, we found a patient had been prescribed and administered slow release medicines through a naso-gastric tube, that were not appropriate for this route of administration.

Medicine administration records we looked at were not fully completed. For example, some medicines were prescribed via multiple routes, patient weights were not recorded, and handwriting was difficult to read. This meant it was not possible to check that medicines were appropriately prescribed and administered.

Clinical pharmacy support to wards was limited by current staffing issues.

Incidents

The process surrounding incident reporting was not robust. We were not assured staff would be able to recognise and report all incidents and near misses. Managers did not always investigate incidents promptly and share lessons learned with the whole team and wider service.

All staff we spoke with could describe the process of incident reporting and understood their responsibilities to report safety incidents including near misses. However, we had concerns that the organisation was slow to report and investigate several serious incidents.

We reviewed minutes of emergency and medical care group weekly governance meetings, where serious incidents and 72 hour reports were discussed. However, we were not assured that appropriate immediate action was taken following incidents, to make improvements, share learning and reduce the possibility of the same incident occurring again.

For example, we reviewed an incident that occurred in November 2019 that was declared as a serious incident. The final report was completed August 2020, eight months later. Another incident we reviewed occurred in February 2020. A serious incident was declared and an investigation was initiated because a complaint was received from the person concerned. The final report was dated July 2020.

A further incident relating to lack of equipment and concerns about staffing was reported in August 2020. Staff had tried to raise concerns with managers however, they felt they were not listened to and escalated their concerns to another manager. They reported it on the electronic reporting system, which generated a staff feedback section for the investigator to complete however, there was no feedback for staff input on the record.

Staff we spoke with told us when they did receive feedback from incidents, it was shared mainly at handover because staffing pressures and COVID-19 pressures meant that team meetings were not taking place, or at least, not on every ward we visited.

We reviewed minutes of ward meetings provided by the trust. These lacked detail and did not provide assurance of immediate actions in response to incidents. For example, minutes from Willow ward staff meeting described a patient fall that was reported as a serious incident. The actions directed staff to refer to the final report located in a 'falls file'. There was no evidence that immediate learning and immediate actions were discussed. In addition, meeting minutes did not describe serious incidents and actions that had occurred elsewhere in the hospital which staff could learn from.

Results of the staff check box survey we sent to all staff as part of the inspection, indicated trust wide, over 90% of respondents knew how to report incidents but 40% were not confident incidents were fully investigated. Only 40% of respondents trust wide indicated they received feedback when they reported an incident.

Is the service effective?

We did not inspect this domain on this occasion.

Is the service caring?

We did not inspect this domain on this occasion.

Medical care (including older people's care)

Is the service responsive?

Access and flow

Patients were not always able to access the service when they needed it. Bed capacity and flow issues, meant admissions, discharges and inter hospital transfers could be delayed. Patients did not always receive the right care promptly once admitted.

The trust had a draft SOP awaiting ratification, which described patient flow procedures in and out of the hospital including admission and discharges. This document also outlined the process for escalation when flow was compromised.

However, we had concerns regarding access and flow, which included high numbers of delayed transfers of care, management of inter-hospital transfers, flow through the hospital, delay in accessing treatment and senior clinical review and oversight of risk.

For example, the trust reported an incident where a patient was admitted to physiotherapy gym in Elm ward, which is not an appropriate ward environment, due to bed capacity issues.

On HASU we found three examples of stranded patients, two had been in the trust since June 2020 and one had been on the ward for over 12 months. One patient was waiting for a system of direct payments to be set up related to their complex needs. This patient had suffered from a number of hospital acquired infections. This contributed to their length of stay and illustrated the need for them to be discharged, to reduce the risk of further healthcare associated problems. The other two patients were waiting for community beds.

There was one patient at the end of their life whose discharge home was delayed, and it was unlikely they would achieve their preferred place of death.

Staff we spoke with said they faced challenges securing care packages in what was a large rural geographical area.

Trust board papers we reviewed confirmed the number of patients with a delayed transfer of care had been consistently high throughout 2019/2020 at the trust. In addition, the national discharge to assess model to facilitate discharges for patients awaiting further assessment (non-medical care), was not in place, although work had begun to establish this.

Trust documents we reviewed indicated there were occasions when beds had been available in community hospitals, but their transfer was not progressed from the acute ward. On one of these occasions, the empty bed was held in a community hospital for four days. This impacted on patient flow through the hospital and meant patients may be exposed to risks such as infections, by remaining in an acute bed.

The hospital's initiatives to try to improve the discharge process included use of bed managers, discharge navigators and discharge coordinators within an integrated discharge team. This was led by a discharge manager appointed in April 2020. Following the inspection, we were informed that the trust had requested an independent review into patient discharge which was supported by system partners with an aim to improve patient flow through the acute and community hospitals.

Several serious incidents relating to timely access to assessment and treatment were also concerning. Our concerns were heightened by the trust's poor performance in the Sentinel Stroke National Audit, January to March 2020. The trust was the worst performer in the region achieving thrombolysis for 30% of stroke patients in under one hour.

We had concerns about the safety and processes regarding inter-hospital transfers. There were several serious incidents where patients had suffered harm with contributing factors such as waiting for transfer from West Cumberland and waiting for a bed after arrival at Cumberland Infirmary.

Medical care (including older people's care)

We were not assured that the current policy and standard operating procedures supported clinical teams to action a safe transfer. It was particularly unclear what course of action should be taken if a bed was unavailable.

Is the service well-led?

We did not inspect this domain on this occasion.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

End of life care

Key facts and figures

The specialist palliative care team operates across the whole trust and is made up of a very small team covering a large geographical region. The team consists of clinical nurse specialists, consultants, speciality doctors, a specialist occupational therapist, and a lead nurse for bereavement services.

One of the consultants had been on long term sick leave for some time, and their post had not been backfilled. This had put some pressure on the ability of the team to respond to patient need.

Referrals are received from GPs, acute wards, district nurses, social care and local charities or directly from people themselves.

The service works closely with local hospices and hospice at home services across the county. The specialist palliative care team operates Monday to Friday from 9am to 5pm. There is an out of hours helpline staffed by qualified nurses and a doctor at the hospice in Carlisle.

We carried out a focused inspection at Cumberland Infirmary 02 September 2020 to review the processes, procedures and practices within the end of life core service.

We looked at access and flow specific documentation in 10 patient records including, do not attempt cardiopulmonary resuscitation (DNACPR) documents, and reviewed data requested from the trust. We also interviewed key members of staff, medical staff and the senior management team who were responsible for leadership and oversight of the service. We spoke with nine members of staff and two patients.

This is the first time we have inspected North Cumbria Integrated Care NHS Foundation Trust, since it was formed.

We conducted this responsive focused inspection in response to escalating concerns of risk to patient and staff safety. The inspection was undertaken using specific elements of key lines of enquiry of the safe and responsive domains in end of life care services.

Summary of this service

Staff did not keep detailed records of patients' care and treatment. Records were not clear, up-to-date, or easily available to all staff providing care. Records were not stored securely.

Patients could not access the specialist palliative care service when they needed it. Waiting times from referral to transfer to preferred place of care and death were not always in line with good practice.

Is the service safe?

Records

Staff did not keep detailed records of patients' care and treatment. Records were not clear, up-to-date, or easily available to all staff providing care. Records were not stored securely.

We were not assured of the quality of records produced and used by the service.

The service used a combination of electronic and paper documents to record care and treatment of patients. This meant it was difficult to follow the timeline of a patient's care and treatment easily or accurately. Records were of poor quality, difficult to follow and did not always have sufficient information to ensure patients were cared for and treated safely.

End of life care

The purpose of a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision is to provide immediate guidance to healthcare professionals on the best action to take (or not to take) should a person suffer cardiac arrest or die suddenly. The Resuscitation Council (UK) provides advice and guidance around this including model forms for use.

It was agreed by the trust resuscitation committee that DNACPR Version 17a of the form would be used across the trust in order to standardise the process throughout the organisation. DNACPR Version 17a forms audits were reviewed on a regular basis. The most recent audit was completed in March 2020. The March 2020 audit data showed improving outcomes overall with some remaining areas of improvement required in relation to recording of a patients GPs, recording of key people involved in decision making processes, and the recording of responsible clinician details on the forms. Figures generally improved over each quarter of the year.

We were informed that there had been some confusion during the initial implementation of the DNACPR Version 17a form, as some clinicians had thought it was a care plan.

The trust followed "Care after Death" standard operating procedures (SOP). 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. However, the document did not have a commencement date, revision date, author, or ratification date.

Some staff stated that there was no requirement for ward staff to complete care of the dying documentation and they were of the understanding that the data was not audited. Other members of staff confirmed that completion of the documentation depended on the ward as to whether the care of the dying paperwork would be completed or not.

Documentation for advanced care planning had been introduced, however we saw limited used of this document in practice and staff told us it's use was variable from ward to ward. No audit of this document took place. This meant there was no monitoring of outcomes from the advanced care planning tool.

During the inspection we flagged a concern from reading a patients record and identifying regarding poor communication following a significant change in a patient care plan without consent, and no involvement of family, despite the patient lacking capacity.

Is the service effective?

We did not inspect this domain on this occasion.

Is the service caring?

We did not inspect this domain on this occasion.

Is the service responsive?

Access and flow

Patients could not access the specialist palliative care service when they needed it. Waiting times from referral to transfer to preferred place of care and death were not always in line with good practice.

End of life care

The service provided at the Cumberland Infirmary was not available over seven days, it was Monday to Friday only. Out of hours telephone support was available at weekends and evenings, provided by a local. The team said they were keen to work towards a service that covered seven days in line with national guidance for access to specialist palliative care services. A business case was in development to support an increase in provision with supporting activity to demonstrate impact on provision and patient care.

Between January and August 2020, 740 patients died at the trust with an open referral to SPCT. Information provided by the trust showed that the percentage of patients who died at their preferred place of death was 51.6% (382 patients). Some patients did not die in their preferred place of death due to sudden deterioration, inability to meet clinical needs at home, or because the patient was unable to express a preference. However, we found that some patients did not die in their preferred place of care as their discharge from hospital was not facilitated in a timely way.

There was no robust triage system in place to identify which patient took priority, however fast track discharges were flagged as priority. A new referral system had been implemented using Integrated Clinical Environment software (ICE) for receipt of electronic referrals. We were advised that referrals were triaged as they were received, however, response times were not monitored or audited. The current policy stated that a 1 to 3 day response time was required, but staff told us “they were usually picked up the same day”. This was not monitored or measured. This meant there was limited assurance that patient referrals to the palliative care team were acted upon in a timely way.

There were no link nurses on the ward for end of life care patients. However, we were advised that ward staff could refer to specialist palliative nurses using the ICE system, by telephone or ad-hoc conversations with specialist nurses when they were on the ward.

An end of life command centre had been implemented to support the increasing pressure on the acute and community system during COVID-19. Primarily, this was around mapping changes in demand alongside staffing capacity, logging syringe driver availability and supporting the logistics, providing advice and guidance for frontline staff around the end of life COVID-19 pathway.

The command centre focused on proactive information gathering and appropriate dissemination around trends and supporting the redeployment of resources. It also provided support for frontline community staff dealing with urgent end of life queries such as medication management.

The command centre had ten clinical and four administrative redeployed staff who identified a specific amount of time they were able to dedicate to the centre. A rota was drafted, and staff had received initial training. The centre was live from Friday 24 April 2020 operating slightly reduced hours with the potential to step up to 8am to 8pm working, if required.

The specialist palliative care team developed a syringe driver decision making tool to ensure that the most appropriate patients were allocated from the limited stock of syringe drivers on a priority basis. On one occasion in recent weeks, two integrated care communities were in the position of needing to borrow syringe drivers from a neighbouring integrated care community. This demonstrated that levels of such equipment had quickly become critically low. Following the inspection, we were informed that the trust had approved purchase of further drivers following escalation by the service.

We found that during COVID-19 the SPCT had created and embraced the ‘attend anywhere’ virtual clinics. Staff found that the virtual clinic enabled clinicians to see patients from each end of the local area (patch) in one day, with consultant attendance if necessary, and that greater triage had increased productivity overall, releasing time for responsiveness to urgent situations.

End of life care

It was also felt by the SPCT and recorded in minutes of their team meeting that joint consultation with palliative care consultant could be organised via 'attend anywhere' clinic or teleconference in a reactive, timely fashion and problems dealt with much quicker. In addition, better relationships had been formed with GPs and district nurses with frequent phone contact leading to increased collaborative working.

We saw an example of a patient fast tracked from hospital at 9.30am to home by 4.30pm as a preferred place to die, which was their wish. However, during our core service inspection, we found evidence of a patient at the end of their life who had expressed a wish to die at home, however, their discharge had not been progressed in a timely manner and the patient was too unstable to transfer home.

Is the service well-led?

We did not inspect this domain on this occasion.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Community health services

Background to community health services

North Cumbria Integrated Care NHS Foundation trust provides a full range of community services across North Cumbria. The trust also provides services in South Cumbria.

Services include:

- Community health services for children and young people
- Community services for adults and long-term conditions
- Community end of life care
- Community dental services
- Community sexual health services
- Community inpatient health services

Summary of community health services

This is the first time we have inspected North Cumbria Integrated Care NHS Foundation Trust, since it was formed.

We conducted this responsive focused inspection in response to escalating concerns of risk to patient and staff safety. The inspection was undertaken using specific elements of key lines of enquiring of the safe and responsive domains in the community adults services.

Please see the inspection findings for community health services below.

Community health services for adults

Key facts and figures

We carried out a focused inspection at North Cumbria 02-11 September 2020 to review staffing and access and flow within the community health service for adults core service. We looked at parts of the safe and responsive domains. We did not rate services because this was a focused, short notice inspection in response to specific areas of concern.

Community Hospitals

West Cumberland Hospital - 18 beds

Keswick Hospital - 16 beds

Workington Hospital - 16 beds

Brampton War Memorial Hospital - 16 beds

Cockermouth Hospital - 11 beds

Penrith Community Hospital - 28 beds

Community Health - Integrated Care Communities

Integrated Care Communities (ICCs) - An integrated care community is where teams work together to improve the overall health and wellbeing of their community. Health and social care professionals, GPs, the voluntary and third sector along with the community will work as one team to support the health and wellbeing of local people.

North Cumbria has been divided into eight ICCs based on groups of GP practices and their patients.

- Carlisle healthcare
- Carlisle network
- Brampton and Longtown
- Copeland
- Eden
- Keswick and Solway
- Maryport and Cockermouth
- Workington

As part of the inspection we interviewed the service managers for both the integrated care community and the community hospitals.

Summary of this service

- The service did not always have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave staff a full induction.
- People could access the service when they needed it and received the right care in a timely way.

Community health services for adults

Is the service safe?

Nurse Staffing

The service did not always have enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

In some areas there were shortfalls in staffing due to sickness, inability to recruit and maternity leave. The service used bank staff were possible and managers were on call and would attend if needed. Staff could be moved around the county when required.

The trust's hard truths staffing report for July 2020 and September indicated that Workington and Keswick had an amber (medium risk) rating, which meant the ward had vacancies which impacted when all beds were occupied.

Work had commenced to review staffing levels in relation to caseloads and service provision. The new system would allow managers to accurately calculate the staff resource needed to deliver each patient contact.

The community hospitals usually operated with two registered nursing staff on each shift and where the hospital was isolated, those staff were responsible for everything including health and safety and security. We had concerns around staff safety and well-being. The trust was in the process of developing a staffing tool which would ensure that there were enough staff with the right skill mix to monitor the acuity or dependency of patients. However, the tool was not in place at the time of the inspection.

At the time of our inspection, the trust had 188 whole time equivalent staff vacancies. It was not clear how many of these vacancies were related to the community service. Following our inspection, we asked the trust for information related to staffing. We were provided with staffing information which was difficult to interpret and did not clearly show where the gaps were.

In response to national skills shortages, gaps in workforce and the local rural/geographical challenges the trust targeted attraction campaigns, an overhaul of recruitment processes and effective on-boarding, which were all currently being developed.

Senior managers were looking at innovative ways of tackling staff shortages which included skilling some staff up to take on more roles within the community partnership.

There was a shortage of rehabilitation or therapy staff and only two of the community hospitals had full time therapy staff. This limited the options for those patients requiring this service.

MEDICAL STAFFING

The service was supported by primary care services and Cumbria Health on Call (CHoC) to provide medical cover to keep patients safe from avoidable harm and to provide the right care and treatment at the right time.

CHoC provided primary health care services in and out of hours to the population of Cumbria. During the night two nurses covered the full area and worked closely with CHoC. Service managers were in discussions to have the night service part of the out of hours service to increase capacity.

Is the service effective?

We did not inspect this domain on this occasion.

Community health services for adults

Is the service caring?

We did not inspect this domain on this occasion.

Is the service responsive?

Access and flow

Most people could access the service when they needed it and received the right care in a timely way however, this was not always the case for patients requiring discharge from the acute hospitals.

The main function of the community adults service was to prevent hospital admissions, this accounted for 80% of the workload. However, the care group were still in the process of collecting robust evidence to show the effectiveness of the admission avoidance pathway.

We found that some joint work had begun between the community and hospital staff to understand what support patients could access in the community. However, this was in early development and the pathway between the acute hospital and the community was not fully developed.

A central referral system was in operation across the community hospitals which had replaced the previous system of individual hospitals managing beds. A community flow operational lead managed the referrals and discharges from the community hospials. However, this was not fully embedded into the acute hospitals discharge process. We were giving examples of where beds had been allocated to patients being discharged from the acute hospitals who did not arrive. The trust used two forms of patient transport, which could also be an issue in getting patients into community hospitals or back home.

The integrated care communities had a central coordination hub with a professional of the day.

The professional of the day was responsible for decision making and managing referrals and patient flow. Daily huddles took place to discuss referrals. The service had a list of patients who attended the emergency department but who had not been admitted. However, we found that community staff were not part of the daily discharge meetings at either of the acute hospitals.

Staff were not following the national discharge to assess pathway. Discharge to assess is about funding and supporting people to leave hospital, when safe and appropriate to do so, and continuing their care and assessment out of hospital. Senior managers told us that they were starting to implement the pathway but that this was not routinely being done despite this being introduced nationally from March 2020. Integrated care communities' staff were not part of the acute hospital discharge meetings and so were not fully engaged in discussions on who could be discharged. There were plans in place to ensure community staff were fully involved in the process.

The associate medical director for the care group was now completing ward rounds being accompanied by staff from the ICCs to discuss/facilitate discharge and flow. This was to provide learning to the discharge teams and provide information on services in the community and improve discharge process.

Since the last inspection the care group had been working more towards an integrated way of working. Leaders had developed a plan on a page to reflect the priorities of the ICC care group. Since July 2020 the care group has now expanded and during the months of August and September 2020 meetings had taken place to understand the new services, which were part of the care group. Leaders were starting to understand services, ways of working, and risks, to enable the establishment of a strategic direction.

Community health services for adults

Is the service well-led?

We did not inspect this domain on this occasion.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour

Our inspection team

Sarah Dronsfield, Head of Hospital Inspection, led this inspection. An executive reviewer, John Somers supported our inspection of well-led for the trust overall.

The team included five inspection managers, 24 inspectors, an executive reviewer and one specialist adviser.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ.