

University Hospitals of Morecambe Bay NHS Foundation Trust

Furness General Hospital

Quality Report

Dalton Lane
Barrow-in-Furness
Cumbria
CA14 4LF
Tel: 01229 870870
Website: www.uhmb.nhs.uk

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

Ratings

Overall rating for this hospital

Requires improvement



Urgent and emergency services

Requires improvement



Medical care

Requires improvement



Surgery

Requires improvement



Critical care

Requires improvement



Maternity and gynaecology

Requires improvement



Services for children and young people

Requires improvement



End of life care

Good



Outpatients and diagnostic imaging

Good



Summary of findings

Letter from the Chief Inspector of Hospitals

Furness General Hospital is one of three locations providing care as part of University Hospitals of Morecambe Bay NHS Foundation Trust. It provides a full range of hospital services including emergency care, critical care, a comprehensive range of elective and non-elective general medicine (including elderly care) and surgery, an oncology unit, a neonatal unit, children and young people's services, maternity services and a range of outpatient and diagnostic imaging services.

University Hospitals of Morecambe Bay NHS Foundation Trust provides services for around 360,000 people across North Lancashire and South Cumbria with over 700 beds. In total, Furness General Hospital has 239 beds.

We inspected University Hospitals of Morecambe Bay NHS Foundation Trust as part of our comprehensive inspection programme in February 2014. Following our inspection in February 2014 we rated the Furness General Hospital as 'Requires Improvement' overall. We judged the hospital as 'Inadequate' for safe, 'Requires Improvement' for responsive and well led and 'good' for effective and caring. CQC was specifically concerned about nursing staffing shortfalls, particularly in the critical care and high dependency units as well as medical wards in this hospital. Patient records, including risk assessments and care planning documentation were not always accurately and comprehensively completed. We also found the trust's governance and management systems were inconsistently applied across services and the quality of performance management information required improvement.

We carried out this inspection to see whether the hospital had made improvements since our last inspection. We carried out an announced inspection of Furness General Hospital between 14 and 17 July 2015.

Overall we rated Furness General Hospital as 'Requires Improvement'. We have judged the service as 'good' for caring, and 'requires improvement' for safe, effective, responsive and well-led care.

Our key findings were as follows:

Cleanliness and infection control

- The trust had infection prevention and control policies in place which were accessible to staff.
- We observed good practices in relation to hand hygiene and 'bare below the elbow' guidance and the appropriate use of personal protective equipment, such as gloves and aprons, while delivering care.
- 'I am clean' stickers were used to inform staff at a glance that equipment or furniture had been cleaned and was ready for use.
- Overall, patients received care in a clean, hygienic and suitably maintained environment. Staff were aware of and applied infection prevention and control guidelines.
- In surgical services, between April 2014 and February 2015, there had been seven avoidable cases in the surgical and critical care division at Furness General Hospital. On one ward there had been three cases in two months. This had resulted in additional information regarding control of this infection and hand hygiene being provided to all staff during the safety huddles.
- According to the submitted and verified intensive care national audit and research centre data (ICNARC), the unit performed as well and sometimes better than similar units for unit acquired methicillin-resistant staphylococcus aureus (MRSA) and clostridium difficile infection rates.

Nurse staffing

- Care and treatment were delivered by committed and caring staff who worked hard to provide patients with good services.

Summary of findings

- The trust had actively recruited nursing staff from overseas to try to improve staffing levels. However, vacancy rates remained high and shortfalls were covered by bank and agency staff. Senior staff said that they tried to use the same bank and agency staff to ensure that they had the required skills to work on the ward. Agency staff were given an induction before commencing work on the wards.
- Nurses recruited from overseas were supernumerary while they awaited registration with the Nursing and Midwifery Council. However, in surgical services there was a lack of clarity about their role and responsibilities.
- Staffing establishments had improved since the last inspection however on some wards nurse staffing remained a challenge, particularly within medicine. A review of staffing within medicine showed that the skill mix did not always fall in line with the trust's 'red rules' initiative. The principles of this initiative included: one registered nurse should deliver care to no more than eight patients and the minimum skills mix on a ward should be 60% registered nurses to 40% health care assistants.

Medical staffing

- Medical treatment was delivered by skilled and committed medical staff.
- The trust had identified areas where medical staff shortages presented risk to patient care and treatment and were working hard to recruit and retain consultants.
- Recruitment of consultants was a challenge particularly in Emergency and urgent care services, and respiratory and gastroenterology.
- In surgical services, 21% of medical staff posts were vacant in May 2015. This had resulted in increased locum medical cover with the highest use being in the urology speciality where 55% of medical cover was by agency staff in May 2015.
- There were ongoing vacancies within the radiology service. Managers said they were actively recruiting and had introduced the use of extended roles for advanced practitioners to help manage the case load. The service leads felt there had been some improvements in staffing but the recruitment of experienced radiology staff remained a challenge.
- There was a sufficient number of medical staff to support outpatient services. The majority of clinics were covered by specialist consultants and their medical teams.

Mortality rates

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

Nutrition and hydration

- Patients had a choice of nutritious food and an ample supply of drinks during their stay in hospital. Patients with specialist needs in relation to eating and drinking were supported by dietitians and by the speech and language therapy team.
- The patient records we reviewed included an assessment of patients' nutritional requirements based on the malnutrition universal screening tool (MUST).
- Where patients were identified as being at risk, there were fluid and food charts in place. However, the recording of fluid balance charts was inconsistent.
- Parents told us there was a good selection of food on the menu for children and young people. Children were also offered snacks and food was available as it was required.

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

Importantly, the trust must:

Summary of findings

- Ensure that all premises used by the service provider are clean, secure, suitable for the purpose for which they are being used, properly used, properly maintained and appropriately located for the purpose for which they are being used. This is particularly in relation to services provided from critical care and outpatients.
- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed in order to meet the needs of the patients. This is particularly in relation to medical care, children and young people's services, and radiology, dermatology and allied health professionals.
- Ensure that staff receive appropriate support, training, supervision and appraisal to enable them to carry out the duties they are employed to perform, particularly in Accident and Emergency, medical and surgical services and Children and Young People's services.
- Ensure that staff understand and act in accordance with the requirements of the Mental Capacity Act 2005 and associated codes of practice.
- Ensure referral to treatment times in surgical specialities improve.
- Ensure that staff follow policies and procedures around managing medicines, including intravenous fluids particularly in children and young people's and critical care services.
- Ensure that risk registers clearly identify all risks within the division, the actions taken to mitigate those risks and demonstrate timely review, particularly in medical care.
- Maintain securely an accurate, complete and contemporaneous record in respect of each service user, including medical and nursing, and food and fluid charts, particularly in medical and surgical services.

In addition the trust should:

In urgent and emergency services:

- Take action to improve waiting times and ambulance handovers.
- Ensure action plans following CEM audits clearly state the steps required to secure improvement.
- Improve staff engagement, knowledge and awareness of the strategy for the service.

In medical care services:

- Ensure there are clear plans in place to reduce the number of falls occurring within the service.
- Improve the management of people with a stroke in line with national guidance.
- Consider improving arrangements for clinical supervision to ensure they are appropriate and support staff to effectively carry out their responsibilities, offer relevant development opportunities and enable staff to deliver care safely and to an appropriate standard.
- Take action to reduce the number of patients staying on medical wards that are not best suited to their needs and to reduce the number of moves between wards.

In surgical services:

- Ensure all staff understand the process for raising safeguarding referrals in the absence of the safeguarding lead.
- Reduce and improve re-admission rates.
- Ensure all procedures are performed in line with best practice guidance. Where practice deviates from the guidance, a clear risk assessment should be in place.

In critical care services:

- Ensure that there is timely access to medical care for patients out of hours and that any delays do not result in patient harm.
- Consider how it is going to improve performance in reducing the number of delayed and out of hours discharges of patients from critical care.
- Ensure that any delayed discharges from critical care do not result in a breach of the government's single sex standard.

Summary of findings

- Ensure that all entries in patient records are appropriately signed and dated.
- Consider the provision of a supernumerary clinical co-ordinator on duty 24/7.
- Consider how it intends to respond to the latest Health Building Notes guidance for critical care units in planning its vision and strategy for the service.

In maternity and gynaecology services:

- Ensure that the actions of the Kirkup recommendations are implemented within timescales and embedded across the trust.
- Ensure there are clear lines of responsibility and accountability at ward manager and matron level within maternity so that staff feel supported and barriers to communication and change are removed.
- Implement the recommendations of and monitor compliance with, the PHSO Report 'Midwifery supervision and regulation: recommendations for change' (2013) with regard to Trust/Midwifery Supervisory investigations, so that parent(s) receive a joint set of recommendations and a single timeframe resulting from the investigation.
- Ensure that the 'Five steps to safer surgery' (World Health Organisation) is embedded in obstetric theatre practice.
- Ensure that a physical test is carried out in line with trust policy to ensure that the infant abduction procedures work correctly and that staff understand how they work.

In children and young people's services:

- Ensure that there are clearly defined and formalised job plans in place for consultant paediatricians.
- Consider reviewing the investigation process of patient safety incidents with full consideration given to the reporting of the professional's account of events and concerns.
- Ensure that there are measures in place to monitor the effectiveness of joint working within medical staff teams.

In end of life care services:

- Ensure there is a clear and accessible system in place to identify and monitor risks within end of life care services.
- Continue to take action to improve those areas identified by the NCDAH.
- Ensure all DNACPR forms are completed to the appropriate standard.

In outpatients and diagnostic imaging:

- Continue to build relationships and develop closer team working to develop a one trust culture.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Requires improvement

Rating



Why have we given this rating?

Overall, we rated Urgent and emergency care as requires improvement. The department was small and unable to cope with the numbers of patients coming through, on regular occasions flexing the use of cubicles. If the resuscitation bay was in use ambulances were diverted though the main department. In the business plan 2015/17 there were plans to redesign the urgent and emergency care floor and to incorporate improvements in department with the expansion of the resuscitation room. Documentation was not always fully completed. Medicines were not stored in accordance with legislation and guidelines. Nurse staffing had been reviewed and an increase was identified as needed however a business case was awaiting approval. Consultant cover was below the College of Emergency Medicine recommendations due to recruitment difficulties although the number of associate specialist posts was higher. Mandatory training completion levels were below the trust's target.

Pathways of care complied with the National Institute for Health and Care Excellence (NICE) guidelines and the College of Emergency Medicines' (CEM's) clinical standards for emergency departments. Performance in these audits was mixed: in the sepsis pathway overall performance was below the England average and the CEM audit for the treatment of a fitting child indicated no children (out of 15) had their blood glucose checked. Action plans were in place to address the areas for improvement. The unplanned re-attendance rate to the emergency department within seven days of discharge (January 2013 to January 2015) was consistently better than the England average. There was evidence of multidisciplinary working.

From April 2014 to April 2015 the department had not always met the standard of percentage of patients discharged, admitted or transferred within 4 hours of arrival to A&E. The hospital had experienced 166 black breaches between 1st March 2014 to 1st March 2015, whereby the time from an

Summary of findings

ambulance's arrival to the patient being formally handed over to the department was longer than 60 minutes. These varied between none as a minimum per week to 9 per week. Access to mental health services for patients was not timely. This meant patients waited in the ED a long time before they were seen by appropriate mental health services. None of the staff we spoke with could articulate the current strategy and vision for the service. The department had a risk register, which identified risks and control measures to mitigate these. Risk register reports provided by the trust did not include details of actions taken to mitigate risk. However, the trust told us they use a live electronic risk register that includes all mitigating actions, status and progress history.

There was little evidence of innovation and cross – departmental working with the emergency department at the Royal Lancaster Infirmary. Staff were motivated and described a supportive team-working environment. However, none of the staff we spoke with felt they had been actively engaged or that their views were reflected in the planning and delivery of services. The trust had identified this as an area for improvement.

The department provided a caring and compassionate service. Patients were treated by staff with respect. Staff were caring, attentive and helpful and kept patients well informed. The department had a strong culture of investigating incidents, learning the lessons of those incidents and communicating these to staff. Staff were committed to providing patients with a good safe service and were clear about their responsibilities in gaining consent from people. Staff felt supported by their managers and appraisal and learning systems were in place.

Medical care

Requires improvement



During our inspection in 2014 we rated the hospital as requires improvement for medical care. During that inspection, we identified that staffing levels, skill mix, systems and processes all required improvement to secure and maintain the safety and effectiveness of the service. The quality of nursing records required improvement and some patient records and risk assessments were incomplete.

Summary of findings

Wards and departments were not always well-led at a senior level and there was a dis-connect between the staff providing hand-on-care and the Executive team.

We found that although significant changes had been made to improve the medical care services, further improvement was still required. Staffing establishments had improved however on some wards nurse staffing remained a challenge. Staff recruitment was in progress to fill staff vacancies but there were still medical staffing vacancies in some specialities. The trust was aware of these, but plans in place to address them had not been updated on the risk register. Nurse record keeping had improved but there was evidence that fluid charts were not always fully completed. Medical decisions were not always documented clearly in patient records. Staff understanding and awareness of assessing people's capacity to make decisions was variable.

Recent national audits indicated that although there had been progress, the service still needed to make improvements to the care and treatment of people who had suffered a stroke. Medical patients were often on other wards in the hospital (medical outliers) and it was unclear how these were managed.

Divisional governance board meetings were held on a monthly basis. Minutes from the meetings showed that a monthly report, which included risk registers, mortality incidents, audits and safety alerts, was discussed at the meeting. However, it was not always clear how the learning was then cascaded to ward staff or whether it had already been shared. Staff were committed and passionate about providing good quality care. They were aware of how to report incidents and could clearly show how and when incidents had been reported. Staff felt confident about raising incidents through the reporting system and demonstrated learning from the incidents. Staff generally felt supported and valued.

Surgery

Requires improvement



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

Summary of findings

The referral to treatment times for patients admitted to the hospital were worse than the England average; however trust wide initiatives had been launched to reduce these and improvements had been made. The written policies and procedures held on the wards for guidance had not been reviewed within the timescales documented. Not all staff were up to date with their appraisals and there was a lack of clarity about the support for newly qualified staff. The majority of staff were not clear about how the mental capacity of a patient impacted on their role and responsibility. Not all consent forms were correctly completed. Written consent was routinely obtained on the day of surgery. Not all records were securely stored or adequately maintained.

Incidents were reported and a system was in place to share learning and change practice. The environment and equipment were visibly clean and tidy with good infection control measures in place. There were safe systems in place for the management of medicines. The written policies and procedures for medicine administration, which were being used by staff at the time of the inspection, were out of date. However, the electronic versions were in date. The majority of mandatory training was up to date. Systems were present to respond to and reduce risks to patients. Staff in theatres had put additional measures in place to enhance the safety of surgical procedures at the hospital. Nurse staffing was adequate to meet the needs of the patients and the vacancy rate was low. Theatre staff had been innovative in their approach to increase staff numbers. The majority of mandatory training was up to date. Systems were present to respond to and reduce risks to patients. Staff in theatres had put additional measures in place to enhance the safety of surgical procedures at the hospital.

Care pathways including pre-operative assessments and enhanced recovery were based on the relevant national guidance. Staff attended to patients quickly when they requested assistance and treated them with respect. Patients said they were involved in their care as much as they required and had been given explanations of procedures and opportunities to ask questions.

Summary of findings

Staff shared a vision of improving services for the patients through learning from feedback, being open to learning from shortcomings in their own service and sharing good practice from other trusts. Staff felt well supported by their immediate line managers and the divisional matrons and told us they felt included in the development of services and could make suggestions for change, especially in the operating theatres.

Critical care

Requires improvement



Following the last inspection in February 2014, overall, the critical care service provided at the Furness General Hospital required improvement with safety being of particular concern. We judged safety at that time as inadequate due to the staffing levels and skill mix in the critical care and high dependency units. In addition, we had concerns about the medical leadership in critical care which at that time had no named consultant lead. These concerns were reported to the trust executive team at the time and steps were taken to ensure that the staffing levels on the combined HDU/CCU matched patient acuity.

There was a lack of clarity regarding the level of care patients staying in the PPU and CCU required. From our observations and interviews with staff it was clear that both areas did look after patients that were classed as level 2 using the recognised critical care minimum data set acuity assessment. During our interviews, the surgery and critical care divisional management team clearly told us that the only funded level 2 beds were the three in the intensive care unit. The PPU and CCU were not contributing to the submission of ICNARC data by the hospital. We had no concerns in those areas about the appropriateness of the nurse staffing numbers and skill mix to care for level 2 patients. At this inspection we have similarly judged overall that the critical care service provided in the intensive care unit required improvement in the specific areas of safety and responsiveness. There were sufficient numbers of suitably skilled nursing staff to care for the patients. However, there was no commissioned supernumerary nurse on duty and the unit did not have any funded practice educators in post. There was access to a consultant and middle grade anaesthetist at all times,

Summary of findings

although out of hours the on-call anaesthetist had responsibilities for other specialities; such as maternity, theatres and accident and emergency. On the day of our inspection we witnessed a delay in a deteriorating patient receiving timely medical interventions as a consequence of poor communication between medical shift handovers. This was raised with the trust at the time. Despite the recent addition of more storage rooms on the unit corridor, the clinical area had limited space and fell short of the most recent health building note specifications (HBN-04-02). There were no clearly defined plans available for how this shortfall was to be addressed. We found that drugs and intravenous fluids were not always stored securely.

When people required intensive care, there were no significant delays in that care being delivered; however, there was often a delay in discharging patients once they had been judged as medically fit for discharge. This often also resulted in a breach of the Department of Health's single sex accommodation standard. Additionally, there were occasions when, owing to capacity and bed availability, patients requiring critical care were looked after in the theatre recovery area. We saw that it was not uncommon for those patients being cared for in recovery to be at level 3 in terms of their acuity.

Intensive Care National Audit and Research Centre (ICNARC) data showed that patient outcomes were within the expected ranges when compared with similar units nationally. The unit was a member of the Lancashire and South Cumbria Critical Care Network (LSCCN). The unit did not provide a formal commissioned outreach service. There were robust systems and processes in place for reporting incidents and there was evidence that learning from incidents was disseminated. We saw that critical care was being delivered by caring, compassionate and committed nursing staff. We saw patients, their relatives and friends being treated with dignity and respect.

Maternity and gynaecology

Requires improvement



At the last inspection in February 2014, we rated maternity and gynaecology services as requiring

Summary of findings

improvement for being responsive and well led, this was in relation to patient's access and flow, governance and risk management arrangements and the vision and strategy for the service.

During this inspection, we found that although good progress had been made in the implementation of recommendations following the Morecambe Bay investigation, maternity services at Furness General Hospital required improvement for being safe and well-led.

Governance structures and processes were developing. There was a maternity dashboard in place however, this required further work to ensure that all risks were effectively identified and monitored in line with good practice guidelines. There was progress with the completion of actions against the Kirkup recommendations; this work was on-going and a number of areas were yet to be implemented and fully embedded across the trust. Midwifery supervision investigations were carried out separately to the trust's investigation process; it was therefore not clear how midwifery supervision investigations and the trust investigations would align.

Audits showed that the 'five steps to safer surgery' procedures (World Health Organisation safety checklist) were not completed consistently; this level of practice was inadequate. Staff were aware of the procedures for safeguarding vulnerable adults and children; however the infant abduction policy had not been tested for some time.

Care and treatment was planned and delivered in a way to ensure women's safety and welfare. There were some incidents where the service had recognised there were opportunities where action could have been taken to recognise and assess risks more effectively.

The transfer of women to theatre could be improved. However, the trust had provided written assurance after the inspection that risks of transferring women were evaluated and action had been taken to mitigate the risk of any delays, and plans were also in place for a major refurbishment of the estate by December 2017, which included a dedicated obstetric theatre next to the labour ward. There were items of equipment which were out of date. The trust had addressed this and a process for

Summary of findings

checking and rotating stock was in place. Medicines were not being stored securely on the labour ward; following our inspection, we received assurance from the trust that all emergency drugs were going to be stored in tamper proof boxes.

Staffing levels were set and reviewed using a nationally recognised tool and guidance. Medical and midwifery staffing was in line with national recommendations for the number of babies delivered on the unit each year. Although there was no dedicated anaesthetic cover for obstetrics the service felt the arrangements were sufficient for the intensity of the work although it was accepted that this fell short of national guidelines. There was multidisciplinary working between obstetrics and paediatrics.

The service participated in local and national audits and external peer reviews to improve patient care. Processes were in place for infection prevention and control. Trust outcomes of care for women were meeting expectations in most areas and where areas required improvement, action was taken. Women were receiving care in line with current evidence-based guidance and standards.

Services for children and young people

Requires improvement



Following our previous inspection in February 2014, we rated children and young people's services at this hospital as "Requires Improvement". We identified issues regarding staffing, resuscitation equipment, insufficient mental health support and mandatory training.

At this inspection we found that incidents were reported appropriately; however for patient safety incidents a rapid review was completed for incidents that were identified as moderate, major or catastrophic. Subsequently not all significant incidents were subject to a thorough investigation where lessons learned could be identified, potentially meaning that incidents could re-occur. For those incidents that did undergo an investigation, the lessons learned identified had been shared with staff by newsletters and within 'safety huddles'. The trust's abduction policy was not being adhered to as it stated a physical test should be carried out on the policy annually but this had not happened for a number of years.

Summary of findings

Medical staffing was a concern, with consultant paediatrician vacancies ranging between 33% and 18%. Consultant paediatricians raised concerns around a lack of job plans and also the lack of junior and middle grade doctors. Concerns were raised to us from consultant paediatricians in that they felt when they raised concerns with senior leaders they were not acted upon or investigated appropriately. We were told of patient safety incidents of deteriorating patients that were not identified to a consultant paediatrician in a timely manner. When these incidents had been raised on the incident reporting system, they had not had a root cause analysis completed and were not dealt with as significant incidents.

At our inspection in February 2014 we identified that there was insufficient child and adolescent mental health services (CAHMS) to meet the needs of the children who required this service. However the trust had completed work in this area and had improved links with the service and had identified specific training to be undertaken by nursing staff to improve their knowledge with child and adolescent mental health issues.

Children and young people's needs were assessed appropriately with care and treatment delivered in line with current legislation and evidence based guidance. Policies and procedures were in place and staff were aware of how to access them.

Parents and children were generally satisfied with the care they received and felt they had been kept well informed. They told us staff were compassionate and caring.

The service met the needs of the children, young people and their families. The environment in each area of the service for children and young people was a child friendly environment. We saw numerous examples of the way the service was able to meet the needs of children and young people and parents could be with their child at all times. Interpreting services were available as required.

End of life care

Good



At the last inspection in February 2014, we rated end of life care as good overall, with safe as required improvement. This was in relation to the variation in the standard of DNACPR records and documentation.

Summary of findings

During this inspection, we found that improvements in a number of areas had been made. Staff had used the 'Guidance for health care professionals caring for patients in the last days of life' until December 2014. Since then a replacement advanced care plan had been piloted across two wards and was now fully implemented across the trust following a programme of staff training. An audit was completed in January 2015 by the trust to check DNACPR documentation. Following the findings of the audit, training had been provided and staff were working on the actions. However, there were some shortfalls in records particularly around staff understanding and awareness of how to assess people's capacity to make decisions.

Staff were committed and passionate about providing good quality care. There had been an increase in palliative care consultant cover however there remained insufficient palliative care consultants to cover Furness General Hospital. This post had been vacant for eight years and the service was currently managed with the existing palliative care consultants.

Processes for incident reporting and learning were in place. Some wards had received Gold Standard Framework (GSF) accreditation. Arrangements for medications were well planned and managed including the prescription of anticipatory medication.

There were effective processes for rapid discharge that enabled patients to be discharged from hospital to home in the last hours or days of their lives. There was currently no joined up system for information sharing however there were plans to introduce the electronic palliative care co-ordination systems (EPACCS) from July 2015. The trust had developed a palliative and EOL strategic plan in line with 'Better Care Together' which was still in draft form. Nursing and medical staff worked with primary and secondary health care professionals to adopt nationally recognised best practice tools.

Summary of findings

Outpatients and diagnostic imaging

Good



Since our last inspection, there had been improvements to the service such as in the provision of records.

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

During our last inspection we noted that there was no information available in the departments for patients who have a learning disability or written information in formats suitable for patients who had a visual impairment. During this inspection we noted that this was not the case. Main outpatients have specific information /leaflets for patients with learning disabilities. Main outpatients and the Ophthalmic department have information/ leaflets in easy read formats; or written in formats suitable for those patients who have a visual impairment. However, staff we spoke with in outpatient departments across the site were not able to tell us how written information in an ‘easy read’ format could be accessed.

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

Summary of findings

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

Furness General Hospital

Detailed findings

Services we looked at

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

Detailed findings

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Background to Furness General Hospital

Furness General Hospital is one of three acute hospitals forming University Hospitals of Morecambe Bay NHS Foundation Trust. University Hospitals of Morecambe Bay NHS Foundation Trust became a Foundation Trust on 1 October 2010 and provides a range of acute and support services for around 350,000 people across North Lancashire and South Cumbria.

In total, the trust had 708 beds across three acute hospitals and employs around 4409 staff. Furness General Hospital has 239 beds.

Furness General Hospital provides medical, surgical, critical care and maternity services, and services for children and young people, for people across North Lancashire and South Cumbria. The hospital also provided emergency and urgent care (A&E) and outpatient services.

The emergency department, otherwise known as the accident and emergency department, operates 24 hours a day, seven days a week. The emergency department saw 28,933 patients in 2014, of which 4903 were children.

The medical care services at this hospital provided care and treatment for a wide range of medical conditions, including general medicine, cardiology, respiratory, and gastroenterology.

The hospital carries out a range of surgical services including: urology, ophthalmology, trauma and orthopaedics and general surgery (such as colorectal

surgery). During 2014 13,200 patients were admitted for surgery at this hospital. 61% of patients had day case procedures, 16% had elective surgery and 23% were emergency surgical patients. There are three surgical wards, a day case ward and seven theatres that carry out emergency and elective surgery procedures as well as some day case surgery.

The critical care unit at Furness General Hospital was commissioned to provide six beds in total, three level 3 and three level 2 beds, which were used flexibly as the service demanded. We were informed that on occasions the unit had accommodated six level 3 patients. The facility included two side rooms, which were used for the isolation of patients with a specific infection control issue.

In maternity and gynaecology services, the maternity ward had 22 beds for antenatal and postnatal care; there was a Day Assessment Unit and a labour ward. The gynaecological ward at Furness has eight overnight beds with the flexibility to accommodate up to 12 if required. Between June 2014 and June 2015 there were 1,129 births at Furness General Hospital.

The children and young people's service at the Furness General Hospital includes a 14 bedded inpatient ward, comprising of five side rooms, one high dependency room and two bays of four beds each. There is a children's assessment unit which comprises of a four bedded bay and an eight bedded day case service. There

Detailed findings

is a children's outpatient's department, a tier 1 special care baby unit and two transitional cots. During the period 1st June 2014 to 31st May 2015, 6881 children and young people were seen in the emergency department, 1527 were seen in the children's assessment unit and 1527 children were admitted to the children's ward.

At Furness General Hospital (FGH) patients with end of life (EOL) care needs were nursed on the general wards. There were 1,261 deaths across the three hospital sites in 2014. From April 2014 - January 2015, 896 patients had been referred to the specialist palliative care team (SPC). The hospital consultant-led Macmillan SPC nurses are ward based and developed treatment plans and symptom control for patients which the general nursing teams delivered. The Macmillan SPC lead nurse took the

lead role at FGH as there was no palliative care consultant for this site. The trust has a bereavement team who provide care and support to relatives and there are well established links with voluntary and charitable organisations providing hospice care, counselling and bereavement support.

The outpatient clinics at Furness General Hospital included ophthalmology, orthopaedics, Ear, Nose and Throat, Renal and respiratory, physiotherapy and diagnostic services. The hospital runs a range of diagnostic and screening procedures, including diagnostic imaging and reporting across a variety of modalities including CT/MR imaging, Nuclear medicine, Fluoroscopy, Mammography, Ultrasound and General Radiography.

Our inspection team

Our inspection team was led by:

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

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

The team included a CQC Inspection Manager, ten CQC inspectors and a variety of specialists including: Head of Clinical Governance, Associate Director of Nursing,

Professor of Respiratory Medicine, Consultant Radiologist, Consultant Obstetrician and Gynaecologist, Consultant Paediatrician and Neonatologist Consultant Anaesthetist, Consultant General Surgeon, Consultant in Medicine, Head of Midwifery and Supervisor of Midwives, Matron in neonatal services, Paediatric Nurse, Critical Care Nurse, and Paramedic. We also had experts by experience that had experience of using healthcare services.

How we carried out this inspection

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

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

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

- Accident and emergency
- Medical care (including older people's care)
- Surgery
- Intensive/critical care

- Maternity and family planning
- Services for children and young people
- End of life care
- Outpatients and diagnostic imaging

Before visiting, we reviewed a range of information we held about the hospital and asked other organisations to share what they knew about the hospital. These organisations included the clinical commissioning group, NHS England local area team, Monitor, Health Education England and Healthwatch.

We carried out an announced visit on 16 July 2015. During the visit we held a focus group with a range of hospital staff, including support workers, nurses, doctors (consultants and junior doctors), physiotherapists,

Detailed findings

occupational therapists and student nurses. We talked with patients and staff from all areas of the trust, including from the wards, theatres, outpatients, Accident and Emergency and maternity departments. We observed how people were being cared for, talked with carers and/or family members and reviewed patients' personal care or treatment records.

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

Facts and data about Furness General Hospital

University Hospitals of Morecambe Bay NHS Foundation Trust became a Foundation Trust on 1 October 2010 and provides a comprehensive range of acute and support hospital services for around 350,000 people across North Lancashire and South Cumbria with over 600 beds. The trust operates from three main hospital sites at the Furness General Hospital in Barrow, the Royal Lancaster Infirmary and Westmorland General Hospital in Kendal. The Queen Victoria Hospital in Morecambe provides outpatient services and Ulverston Community Health Centre provides nutrition, dietetics and breast screening.

Accident and Emergency attendances were 28,933 patients in 2014, of which 4903 were children. During 2014 13,200 patients were admitted for surgery at this hospital. There were a total of 438,436 outpatient appointments between January and December 2014.

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

Our ratings for this hospital







Our ratings for this hospital are:

Detailed findings

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

Notes

Urgent and emergency services

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

Information about the service

Urgent and emergency care and treatment was provided at Furness General Hospital by the emergency department, which forms part of the acute and emergency medical division. The emergency department, otherwise known as the accident and emergency department, operated 24 hours a day, seven days a week. The emergency department saw 33,262 patients in 2014, of which 4,903 were children. Daily attendance rates between April 2014 and April 2015 were on average 94 patients.

The emergency department is a designated trauma unit and provides care for all trauma patients. However, the most severely injured trauma patients will be taken by ambulance or helicopter to the nearest major trauma centre in Preston, if their condition allows them to travel directly. If not, they are stabilised at Furness General Hospital and either treated or transferred depending on their needs. There was a protocol to inform the medical team which patient's injuries would require treatment at a major trauma centre.

Emergency department patients receive care and treatment in three main areas: 'minors', 'majors' and 'resuscitation bays'. Patients with minor illnesses or injuries are assessed and treated in the minors area. There are two waiting areas, one for patients with minor illness or injury and one separate waiting area for children. Patients with a serious injury or illness who arrive by ambulance are triaged and seen in the majors area or the resuscitation room. The majors area has four bays and the resuscitation room has one bay. The majors

area and resuscitation room is accessed through a dedicated ambulance entrance, however if the resuscitation room is in use the ambulances are diverted through the main department.

We spoke to six patients and 21 staff from different disciplines including nurses, doctors, managers and support staff. We observed daily practice, reviewed paper and electronic records and documentation. Prior to and following our inspection, we reviewed performance information about the trust and reviewed information provided to us from the trust.

Urgent and emergency services

Summary of findings

Overall, we rated Urgent and emergency care as requires improvement. The department was small and unable to cope with the numbers of patients coming through, on regular occasions flexing the use of cubicles. If the resuscitation bay was in use ambulances were diverted though the main department. In the business plan 2015/17 there were plans to redesign the urgent and emergency care floor and to incorporate improvements in ED with the expansion of the resuscitation room. Documentation was not always fully completed. Medicines were not stored in accordance with legislation and guidelines. Nurse staffing had been reviewed and an increase was identified as needed however a business case was awaiting approval. Consultant cover was below the College of Emergency Medicine recommendations due to recruitment difficulties although the number of associate specialist posts was higher. Mandatory training completion levels were below the trust's target.

From April 2014 to April 2015 the department had not always met the standard of percentage of patients discharged, admitted or transferred within 4 hours of arrival to A&E. The hospital had experienced 166 black breaches between 1st March 2014 to 1st March 2015, whereby the time from an ambulances arrival to the patient being formally handed over to the department was longer than 60 minutes. These varied between none as a minimum per week to 9 per week. Access to mental health services for patients was not timely. This meant patients waited in the ED a long time before they were seen by appropriate mental health services. None of the ED staff we spoke with could articulate the current strategy and vision for the service. The department had a risk register, which identified risks and control measures to mitigate these. Risk register reports provided by the trust did not include details of actions taken to mitigate risk. However, the trust told us they use a live electronic risk register that includes all mitigating actions, status and progress history.

There was little evidence of innovation and cross – departmental working with the emergency department at the Royal Lancaster Infirmary. Staff were motivated and described a supportive team-working environment.

However, none of the staff we spoke with felt they had been actively engaged or that their views were reflected in the planning and delivery of services. The trust had identified this as an area for improvement.

Pathways of care complied with the National Institute for Health and Care Excellence (NICE) guidelines and the College of Emergency Medicines' (CEM's) clinical standards for emergency departments. Performance in these audits was mixed: in the sepsis pathway overall performance was below the England average and the CEM audit for the treatment of a fitting child indicated no children (out of 15) had their blood glucose checked. Action plans were in place to address the areas for improvement. The unplanned re-attendance rate to the emergency department within seven days of discharge (January 2013 to January 2015) was consistently better than the England average. There was evidence of multidisciplinary working.

The department provided a caring and compassionate service. Patients were treated by staff with respect. Staff were caring, attentive and helpful and kept patients well informed. The department had a strong culture of investigating incidents, learning the lessons of those incidents and communicating these to staff. Staff were committed to providing patients with a good and safe service and were clear about their responsibilities in gaining consent from people. Staff felt supported by their managers and appraisal and learning systems were in place.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement



The department was small and unable to cope with the numbers of patients coming through which meant that on regular occasions cubicles and the adjacent fracture clinic was used to provide additional space for patients. If the resuscitation bay was in use ambulances were diverted though the main department. In the business plan 2015/17 there were plans to redesign the urgent and emergency care floor and to incorporate improvements in department with the expansion of the resuscitation room. Nurse staffing had been reviewed and an increase was identified as needed; a business case was awaiting approval to increase nurse staffing. Consultant cover was below the College of Emergency Medicine recommendations due to recruitment difficulties although the number of associate specialist posts was higher. Mandatory training completion levels were below the trust's target. Documentation was not always fully completed. Medicines were not stored in accordance with legislation and guidelines.

There were processes in place for managing infection prevention and control. The environment was clean and hand hygiene was good. The department had a strong culture of investigating incidents, learning the lessons of those incidents and communicating these to staff.

Incidents

- There was a strong culture of reporting, investigating and learning from incidents.
- Staff used an electronic system to report incidents, which were sent automatically to the unit manager. Staff were encouraged to report incidents and staff told us they were aware of how to report an incident and had reported incidents.
- There were 2 serious incidents reported between May 2014 and April 2015 at this hospital. One in May 2014 and one in December 2014. These were both reported through the Strategic Executive Information System (STEIS). All serious incidents were investigated using a root cause analysis approach and action plans were implemented as a result.

- There were 471 incidents reported from 1 January 2015 to 1 June 2015. These were graded from no harm to moderate harm and related to areas such as safeguarding, delayed diagnosis, staffing and delay in mental health review.
- Staff received feedback from incidents by email and through discussion with their manager. Learning from incidents was discussed in the nursing handover at the beginning of each shift, within the monthly governance meeting and in the consultant meetings. Minutes of the divisional clinical governance meetings showed an overview of the numbers of incidents, the top five causes and root cause analysis.
- A board in the staff area displayed information from incidents which included lessons learnt.
- Staff told us they were aware of the statutory Duty of Candour, which sets out key principles, including a general duty on the organisation to act in an open and transparent way in relation to care provided to patients and, as soon as reasonably practicable after a notifiable patient safety incident occurs, to tell the patient (or their representative) about it in person. The department had a system in place to ensure patients were informed when something went wrong, given an apology and informed of any actions taken as a result.

Cleanliness, infection control and hygiene

- In the CQC's 2014 A&E survey, the service scored 8.6 out of 10 for the question: "In your opinion, how clean was the A&E department?". This was about the same as with other trusts.
- Medical and nursing staff were observed following the trust policies for hand washing and 'bare below the elbows' in clinical areas. There were hand gel dispensers available in each cubicle and in the department.
- Hand hygiene was audited on a monthly basis. The A&E results for April 2015 showed 100% compliance.
- The emergency department was visibly clean and tidy and we saw cleaning in progress during the visit.
- Protected clothing and equipment such as gloves and aprons was available and used by staff.
- Mattress checks were carried out quarterly. We inspected the mattresses for cleanliness and any breakage in the cover. We noted all the mattresses we checked were clean and did not have breakages.

Urgent and emergency services

- The majors and minors area had appropriate facilities for isolating patients with an infectious condition.
- Disposable screening curtains were in use.
- In the children's waiting area, we found that toys were cleaned and were visibly clean; however, this was not recorded or monitored. The bays had a cleaning checklist and we saw evidence these were cleaned daily.
- Staff had completed level one and level two infection control training. 98% of staff were compliant with level 1 and 88% of staff were compliant with level 2. The trust target for mandatory training was 95% compliance.

Environment and equipment

- The department was small and, at times, did not have sufficient numbers of cubicles for the number of patients. Staff told us they often had to use the majors cubicles as resuscitation bays, as one resuscitation bay was not sufficient. The cubicles allocated for patients with a minor illness or injury were often used for patients who had a major injury. The adjacent fracture clinic was used as an overflow area for minors patients if the department became full.
- There was a dedicated ambulance entrance that ensured patients had direct access to the resuscitation and majors areas. However, if the resuscitation bay was in use ambulances were diverted through the main department. The resuscitation bay was the main entrance usually used by ambulances.
- There was a cubicle used for deceased patients which was in a quieter part of the department but this was also used as a minors bay.
- In the business plan 2015/17 there were plans to redesign the urgent and emergency care floor and to incorporate improvements in ED with the expansion of the resuscitation room.
- People who self-referred used a separate entrance and all entrances were adequately signposted.
- The resuscitation bay was equipped appropriately. We checked a range of resuscitation equipment and found it accessible and fit for purpose. Equipment trolleys were labelled and matched with an equipment checklist.
- The department had access to a hoist to help lift patients. If necessary a bed was requested from the ward or a bariatric trolley could be hired. There were adequate stocks of equipment and we saw evidence of appropriate stock rotation.

- Most of the equipment had 'clean' labels attached documenting the time and date when it was last cleaned. This meant staff could be assured equipment they used was clean.
- In-service testing of electrical equipment (portable appliance or PAT inspection) had been carried out in the department. 'PAT tested' labels on electrical equipment confirmed this.
- All equipment was serviced on a rolling programme basis by the medical engineering department and we saw stickers on all equipment that confirmed servicing and maintenance had been completed.
- Security arrangements were in place 24 hours a day, provided from an external security company. One security guard was based in the emergency department; however, they covered the rest of the hospital and walked around the premises. During the day they provided security to the car parks. If extra cover was needed within the hospital we were told that this was provided by the security company. Closed circuit television (CCTV) was in operation.
- A GP out of hours service provided treatment from rooms next to the department and the reception desk was shared.

Medicines

- We observed keys were left unattended in two medicine cupboards which were visible to patients and the public. The drugs used for a major incident were stored in an unlocked cupboard.
- Controlled drugs were stored separately and suitable records were kept. Controlled drugs, because of their potential misuse, are medicines that require extra checks and special storage arrangements.
- Daily temperature checks were recorded for the locked medicine fridge.
- We checked 12 sets of patient records which all had the patients allergy status recorded.

Records

- Patient records were in paper and electronic format. Patients were recorded onto an electronic system and then a paper copy of the patient notes was printed.
- We reviewed 12 sets of patients' notes found completion of documentation was variable. For example, in three sets of notes pain scores were not completed.

Urgent and emergency services

- The electronic system allowed for alerts to be displayed. For example, if a patient had a previous infection or a known safeguarding concern.
- At the end of the visit reception staff collated and filed the notes, generated a GP letter and arranged safe storage of notes.
- All the staff we spoke to told us time was set aside for mandatory training within the off-duty and if the department was quiet they had time for training. The management was keen to support training and if mandatory training fell behind they would receive an email reminder.
- New staff received a corporate induction programme which included face to face mandatory training.
- Completion of mandatory training for the emergency department was not up to date. The trust's target of 95% mandatory training completion was only met in five out of the 19 areas (equality and diversity training, health, safety and welfare, infection prevention level 1, safeguarding adults level 1 and safeguarding children level 2). The department averaged an overall completion rate of 78%.

Safeguarding

- The department had systems in place for the identification and management of adults and children at risk of abuse (including domestic violence).
- We reviewed six children's records. All the children had been assessed regarding safeguarding; however the adults' records did not include an assessment.
- Staff informed us they were aware how to recognise and report both adult and children safeguarding concerns.
- We were told good links were in place with the local authority. A paediatric nurse described the process for reporting a concern and maintaining links with social services to receive feedback.
- A safeguarding lead was available at Royal Lancaster Infirmary who provided support and guidance to this hospital.
- There was an up to date safeguarding policy on the intranet which explained processes and gave contact details and staff were aware of how to access this.
- The senior nursing staff felt unsure if junior staff would know how to report a safeguarding concern, but felt confident they would seek advice from a senior nurse.
- Mandatory training records indicated that: 98% of staff were compliant with safeguarding adults level 1 training; 80% of staff were compliant with safeguarding level 2 training; 90% of staff were compliant with safeguarding children level 1 training; 82% of staff were compliant with safeguarding children level 2 training and 39% of staff were compliant with safeguarding children level 3 training. The trust target was 95% compliance for all mandatory training.

Mandatory training

- Staff completed mandatory training using e-learning however, there were some clinical skills which resulted in taught sessions which were competency based and specific to emergency nursing.

Assessing and responding to patient risk

- Patients who walked into the department were seen by a receptionist and were booked in and directed to a clearly signposted waiting room where they were triaged by a nurse.
- Patients arriving by ambulance were booked in within the majors area.
- Ambulance handover was given to the nurse taking over the care of the patient, using an electronic device and the nurse signed to confirm handover had been completed. This system had been in place for approximately 8 months.
- Guidance issued by the College of Emergency Medicine (CEM) states a face to face assessment should be carried out by a clinician within 15 minutes of arrival or registration. From July 2014 to June 2015, the service's median performance against the 15 minutes standard ranged from 15 and 21 minutes.
- For May 2015, the average time from ambulance to initial assessment for this trust was 11 minutes, which was worse than the England average of 5 minutes.
- For May 2015, the average time to treatment for this trust was 39 minutes, which was better than the England average of 53 minutes.
- The national early warning score (NEWS) escalation process for the management of acutely unwell adult

Urgent and emergency services

patients was used to identify patients who were becoming unwell. This ensured early and appropriate intervention from skilled staff. This was audited daily and demonstrated 100% compliance in April 2015.

- Staff told us that if they had concerns regarding a patient's condition, doctors were always available. A central monitoring system was in place, for all patients who required enhanced monitoring. This was viewed electronically at the bedside and on a monitor in the main department which was easily accessible.
- A handover process to the wards was used known as 'SBAR'. (This is used to describe a patient's medical Situation, Background, Assessment and Recommendations). This allowed staff to communicate assertively and effectively, ensuring key information was passed to relevant staff and reducing the need for repetition.
- If the department became overcrowded an escalation process was in place which gave staff actions to manage patient numbers and capacity.

Nursing staffing

- In February 2015 the department completed a nurse staffing audit using a recognised workforce planning tool. The tool had been developed by the RCN Emergency Care Association and Faculty of Emergency Nursing and was specifically for use in emergency departments. It allowed any disparity between nursing workload and staffing to be highlighted. During the audit period, the tool analysed the volume and pattern of nursing workload and tracked this against the rostered staffing level and calculated the workforce and skill mix which would be required to provide the nursing care needed in the department. The team compared this with the National Institute for Health and Care Excellence draft guideline which advised emergency departments on how to ensure there are safe levels of nursing staff.
- There were 5 registered nurses (RNs) on an early shift; (this allowed 2 nurses to work in the minors area, 1 in majors, 1 in triage and the nurse in charge to support the majors area), and 5 registered nurses on the late shift with one clinical support worker (CSW). In addition, a CSW worked a twilight shift 4pm to 12 midnight. The night shift had 4 RNs and one CSW. There was a paediatric nurse who was on duty 10am until 10pm. To

have one nurse in the majors area including resuscitation together with the nurse in charge was insufficient. The clinical support workers role did not allow them to take patient observations.

- We were told a business case had been developed and was awaiting approval for increased nurse staffing. We were told that in the last 18 months there has been an increase of five registered nurses and four healthcare support workers which was over the budgeted establishment. Within the five year plan there was the adoption of the February 2015 NICE guidelines recommendations for safe nurse staffing in ED's.
- Shift times had changed to match the demanding times in the department.
- The Royal College of Paediatrics and Child Health (RCPCH) 'Standards for Children and Young People in Emergency Care Settings (2012)' identifies that there should always be a registered children's nurse in the emergency department, or trusts should be working towards this. From September 2014, a paediatric nurse was on duty between 10am and 10pm, 7 days per week. During the hours the paediatric nurse was not on duty, support was provided as needed from the paediatric department. Paediatric nurses did a six month rotational post between the ED and the paediatric ward.
- In May 2015, there were no staff vacancies in the department. The department had more nursing staff in post (15%) than their baseline figures.

Medical staffing

- At the time of our inspection, there was one clinical lead, two consultants, nine associate specialists, and five junior doctors plus one junior doctor working two days per week. Consultant cover was below the College of Emergency Medicine recommendations which states that trusts should aim to provide 10 whole time equivalent (WTE) Consultants as a minimum in every Emergency Department.
- The trust had decided to use associate specialist doctors due to the difficulties in recruiting consultants. This grade was recognised by the General Medical Council (GMC) to be able to work as independent practitioners and is not regarded as junior or middle grade posts.

Urgent and emergency services

- Consultant and Associate Specialist rotas demonstrated that an Associate Specialist was present in the department 24 hours each day, 7 days per week. Consultants' presence in the department varied from 6 hours daily to none. However, a Consultant or associate specialist was always available as first on call.
- When an Associate Specialist is working in the department (when there is not an A&E consultant in the hospital or first on-call), further arrangements for consultant cover were in place, including direct clinical support from a consultant, telephone advice from the consultants on-call at the Royal Lancaster Infirmary site and telephone advice from the ED consultant.
- The staffing skill mix was higher than the England average for middle grade doctors but lower for consultant, junior and registrar grades.

Major incident awareness and training

- There were designated store rooms for major incident equipment. We found the hazardous materials (HAZMAT) protective suits had an expiry date of May/June 2015. This was checked with the company who supplied the suits and we were informed they were safe to use and new suits were on order.
- Staff received annual training which included table top exercises. Plans were in place for a multi-disciplinary team major incident training exercise in September 2015.
- Staff could describe processes and triggers for escalation. They described to us the arrangements to deal with casualties contaminated with HAZMAT such as chemical, biological or radiological materials.
- Staff had received training on how to care for someone who may have symptoms of Ebola.

Are urgent and emergency services effective?
(for example, treatment is effective)

Requires improvement



There were a range of pathways that complied with the National Institute for Health and Care Excellence (NICE)

guidelines and the College of Emergency Medicine's (CEM) clinical standards for emergency departments. Performance in these audits was mixed: in the sepsis pathway overall performance was below the England average and the CEM audit for the treatment of a fitting child 2014/15 indicated no children (out of 15) had their blood glucose checked. Action plans were in place to address the areas for improvement. The unplanned re-attendance rate to the emergency department within seven days of discharge (January 2013 to January 2015) was consistently better than the England average. There were action plans in place as a result of the audits however, there was no evidence of completed actions. Appropriate pain relief was offered to patients however pain scores were not routinely recorded. The trust also scored worse than other trusts in the A&E survey in relation to pain management.

There was evidence of multidisciplinary working. Clinical nurse specialists came to the department to provide clinical expertise and review patients. However, access to mental health services was not timely and this was a concern to staff. We were told there were plans in place to try and address this issue. Staff felt supported by their managers and there were appraisal systems in place. 82% of nursing staff had received an appraisal in the last 12 months. All medical staff were up to date with their appraisals. Staff understood the requirements of the Mental Capacity Act 2005.

Evidence-based care and treatment

- Care pathways in place complied with the National Institute for Health and Care Excellence (NICE) guidelines and the College of Emergency Medicine's (CEM's) clinical standards for emergency departments.
- The trust participated in the national College of Emergency Medicine (CEM) audits and benchmarked its practice against other emergency departments. The department was up to date with CEM audits.
- Clinical care pathways were in place for patients with a suspected stroke, head injury and fractured neck of femur. There was an emergency department pathway which was under review.

Pain relief

- We reviewed 12 patients' notes and we found three did not have a pain score documented.

Urgent and emergency services

- In the CQC's 2014 A&E survey, the trust scored 7.5 out of 10 for the question: "Do you think the hospital staff did everything they could to help control your pain?". However, they only scored 6.4 out of 10 for the question: "How many minutes after you requested pain relief did it take before you got it?". Both scores were about the same as for other trusts.
- The patients we spoke with told us they were asked if they required pain relief.

Nutrition and hydration

- We noted in the patients' records that staff rarely recorded that food and drink had been offered to patients, although staff told us patients were asked hourly and we did witness patients offered and given food and drink.
- There was a notice on the wall to inform patients to ask staff if they could eat, however, this message was within other information and could easily be missed.
- We were informed by staff that patients were offered hot and cold drinks. A snack box was available. They told us there was a system in place to offer breakfast, dinner and supper. If patients wanted a hot meal one could be given although hot meals were not routinely offered.
- If needed, baby food was accessed from the children's ward.

Patient outcomes

- The unplanned re-attendance rate to the emergency department within seven days of discharge (January 2013 to January 2015) was consistently better than the England average but worse than the standard of 5%.
- The department had achieved mixed outcomes in the CEM 2013/14 audits on severe sepsis and septic shock. The CEM recommends that 100% of patients who present to an ED with signs of sepsis or severe shock should receive a dose of antibiotics prior to leaving the department (ideally within 4 hours). We found that out of 32 patient records 94% of patients had received antibiotics within 4 hours.
- The hospital participated in the CEM audit 2013/14 for the treatment for paracetamol overdose. The fundamental standard was that a patient who had an overdose received treatment within 1 hour of arrival to ED. The results showed 60% of patients had the recommended treatment.

- In the CEM audit 2014/15 for the treatment of a fitting child one fundamental standard was that the child has a blood glucose check whilst actively fitting. The results showed no children (out of 15) had their blood glucose checked.
- There were action plans in place as a result of the audits however, there was no evidence of completed actions.

Competent staff

- Appraisals for both medical and nursing staff were undertaken and staff spoke positively about the process.
- 82% of nursing staff had received an appraisal in the last 12 months. This was below the trust target of 90%. There were four outstanding appraisals to complete, however a rolling programme for appraisals was in place to ensure completion.
- Medical staff were all up to date with their appraisals.
- The 2014 staff survey indicated 81% of staff in the department felt their manager supported them to receive training, learning and development.
- New nursing staff received emergency department specific competency based training. They were supported by a mentor and were supernumerary for a period of time which varied depending on their previous experience and learning needs.
- We were told junior doctors were supported by their senior colleagues and had time to discuss any issues and access training.

Multidisciplinary working

- Link nurses for several disciplines were employed and came to the department to provide clinical expertise and review patients such as the stroke nurse specialist, palliative care and respiratory nurse specialists.
- There were strong links with the local police and a new process had been developed to help support patients at risk of domestic violence.
- A new project caring for the frail elderly was in place. An elderly care consultant reviewed patients in the ED to provide clinical expertise and prevent inappropriate admission.
- Staff told us there was no access to the necessary drug and alcohol support teams for patients.
- Staff told us access to mental health services was not timely. There was a mental health liaison service which was hospital based and accessed Monday to Friday

Urgent and emergency services

between 8am and 6pm, and Saturday and Sunday 10am to 6pm. Out of hours mental health cover was provided by the crisis team only, which was a community based service. This meant patients waited in the ED a long time before they were seen. We were told there are plans within the 'Better Care Together' project and 'Front Door' project to improve access to mental health services.

Seven-day services

- Access to radiology services was available 24 hours a day, seven days a week.
- A Consultant or associate specialist was available between 8am and 10pm. Most days an associate specialist was in the department for 24 hours. When they were not in the department they provided an on-call service.
- Senior cover was provided as a minimum from middle grade doctors who were continuously present in the department.

Access to information

- Medical and nursing staff could access current information for each patient in the department displayed on an IT system. The status of the trust's two emergency departments (Royal Lancaster Infirmary and Furness General Hospital) could be viewed on either site, thus enabling an overview of the demands on each service and effective use of resources.
- Access to previous notes, including past ED attendances, past clinic letters, past discharge letters and previous results were accessible via the electronic patient record system and paper records. Patients' previous medical notes were held on site for five months before being archived off-site. If required they could be requested and staff told us they were accessible.
- Staff had access to relevant guidance and policies via the trust's intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Where possible, doctors and nurses obtained verbal consent from patients before providing care and treatment. We heard staff explaining treatments and diagnoses to patients, checking their understanding, and asking permission to undertake examination and perform tests.

- Training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards was included within the mandatory safeguarding training. We were told there was also a consultant lead for this area.
- Staff were clear about their responsibilities in gaining consent from people including those who lacked capacity to provide informed consent to care and treatment.
- Staff used Gillick competency principles when assessing capacity and obtaining consent from children. The 'Gillick Test' helps clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment. They must be able to demonstrate sufficient maturity and intelligence to understand the nature and implications of the proposed treatment, including the risks and alternative courses of actions.

Are urgent and emergency services caring?

Good



The emergency department provided a caring and compassionate service. We observed staff treating patients with dignity and respect. Patients told us staff were caring, attentive and helpful and kept them well informed.

Responses to the family and friends test indicated that the majority of patients would recommend the service to family or friends. Patients told us staff ensured they understood medical terminology and patients were given literature about their condition when required. A range of information leaflets were available for patients to help them manage their condition after discharge.

Compassionate care

- The trust had a response rate for the Friends and Family Test in March 2015 of 29.1%. Of which 87% of patients would recommend the trust to family and friends. In April and May 2015 the response rate was 30%, with 91% recommending to family and friends.
- In the CQC's 2014 A&E survey, the trust scored similar to other trusts in all 24 questions relating to caring with an overall score of 7.8 out of 10.

Urgent and emergency services

- During our inspection we observed staff treating patients with dignity and privacy. Patients we spoke with were complementary of the staff. One patient described their care as 'excellent', stating that they had received rapid attention and they described how staff had explained to them every step of the way, and that staff are polite and spoke in layman's terms. Another patient described their care as: 'the staff could not have been nicer, they explained everything in a way I could understand and they were very good to me'.

Understanding and involvement of patients and those close to them

- Patients told us staff ensured they understood medical terminology and patients were given literature about their condition when required.
- We saw literature was available in English only however information could be accessed in different languages if required.
- Patients told us staff explained every step of treatment in terms they could understand and staff were polite and asked for consent before any procedures.

Emotional support

- We observed staff offering emotional support to patients who were anxious. They spent time reassuring them and explaining what was happening and why.
- There was support available for the bereaved from the chaplaincy and the bereavement office.

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

(for example, to feedback?)

Requires improvement



From April 2014 to April 2015 the trust had struggled to meet the Department of Health's four hour access target. Data for this period showed the hospital had only achieved the 95% standard for 15 out of 52 weeks. The

percentage of patients leaving before being seen was worse than the England average, aside from July 2014 and January 2015 where the trust performed better than the England average.

Total time in A&E (average per patient) was generally worse than the England average. Data for September 2014 to January 2015 showed this had improved and times were better than the average.

The hospital had experienced 166 black breaches between 1st March 2014 to 1st March 2015, whereby the time from an ambulance's arrival to the patient being formally handed over to the department was longer than 60 minutes. These varied between none as a minimum per week to 9 per week. From 3rd November 2014 and 29th March 2015 the Trust had 1,266 delays over 30 minutes for ambulance handovers. Compared to other trusts over the winter period this was within the middle range.

We were informed there were several link nurses who provided up to date expertise to support the team. Access to other teams was available, such as palliative care teams. However, access to mental health services for patients was not timely 'out of hours' and staff were concerned patients were waiting a long time for assessment of their mental health. For patients with problems with alcohol or drug misuse there was no access to support services.

Complaints feedback was given to staff face to face or by email. Any lessons learnt were discussed in governance meetings and in handover. A board in the staff area displayed lessons learnt information and recent complaints and incidents. A monthly report was discussed within the governance meetings.

Service planning and delivery to meet the needs of local people

- Information provided by the trust showed that the number of patients attending the emergency department had reduced over the last few years. In 2010-2011 there were 89,456 attendances whilst in 2013-2014 there had been 87,772 attendances. We were unable to determine why there had been a reduction in attendances.
- In order to manage the changing demands in health and social care, the trust was working on a strategy called 'Better Care Together' which outlined new plans of

Urgent and emergency services

delivering health care. The strategy aimed to reduce the number of patients needing to attend hospital, by working collaboratively with GPs and community services.

- During our visit the department was not overcrowded and a sufficient number of treatment rooms and cubicles were available, although at times of peak demand staff informed us ambulances did sometimes queue in the department.
- Within the waiting room there were a number of notice boards. One was a 'how are we doing' board. This had information regarding action taken by the service in response to patient feedback using a 'what you said and what we did' format. There was a patient and visitor's information board and a 'welcome to the emergency department' board that provided key useful information to patients and visitors about the service.

Meeting people's individual needs

- The department was accessible for people with limited mobility and people who used a wheelchair. Wheelchairs were available in the department. There was no immediate access to a bariatric trolley although one could be hired externally and, if needed, a bariatric bed could be made available on a ward.
- There was not a specific cubicle used for patients with dementia however we were told the service used the butterfly scheme which identified patients with dementia.
- We were informed there were several link nurses who provided up to date expertise to support the team.
- Access to other teams was available, such as palliative care teams if needed.
- We observed that patients were given a clear explanation at discharge and were advised what to do if symptoms re-occurred.
- A range of information leaflets were available for patients to help them manage their condition after discharge however leaflets were available in English only but, if required, could be obtained in other languages.
- Staff told us they did not have any specific guidance to assist them to manage patients with a learning disability. They told us they encouraged their carer to stay with the patient to help alleviate any anxieties. There was a room for relatives to use if they needed access to a telephone and drinks.

- The viewing room for deceased patients was used to undertake clinical treatments if it was not in use. The environment was clinical without the comforting features needed to help relatives and friends during difficult times.

Access and flow

- The Department of Health's target for emergency departments is to admit, transfer or discharge patients within four hours of arrival. From April 2014 to April 2015, the trust struggled to meet this target. From November 2014 onwards the trust had performed better than the England average but was still not meeting the target.
- Between April 2014 and April 2015 Furness General Hospital achieved the 95% target for 15 out of 52 weeks.
- The percentage of emergency admissions through A&E waiting 4 to 12 hours from decision to admit until being admitted was better than the England average.
- The trust scored the same as other trusts for the responsive questions in the A&E survey, scoring between 7.2 and 9.3 out of 10.
- The percentage of patients leaving before being seen was worse than the England average, aside from July 2014 and January 2015 where the trust performed better than the England average.
- Total time in A&E (average per patient) was generally worse than the England average. Data for September 2014 to January 2015 showed this had improved and times were better than the average.
- The hospital had experienced 166 black breaches between 1 March 2014 and 1 March 2015, whereby the time from an ambulance's arrival to the patient being formally handed over to the department was longer than 60 minutes. These varied between none as a minimum per week to nine per week. These were recorded and monitored from the North West ambulance service. From 3rd November 2014 and 29th March 2015 the Trust had 1,266 delays over 30 minutes for ambulance handovers. Compared to other trusts over the winter period this was in the middle range.
- We assessed 16 case notes for patients who had arrived by ambulance. Time to initial assessment was between 0 and 31 minutes, with an average of 18 minutes.
- Following a patient flow review held in October/ November 2014 the timeliness of patients appropriately transferred to a ward had improved. Patient flow meetings took place at least three times a day with an

Urgent and emergency services

escalation plan in place to increase to four times a day if necessary. These included representation from senior managers within each speciality, the discharge planner, radiographer, transport liaison, bed management team and the co-ordinator from ED.

- The patient flow meeting was also linked with the Royal Lancaster Infirmary team via teleconference. We were told the meeting included key decision makers and the ED co-ordinator who discussed issues preventing good patient flow through the department. This improved patient experience and expedited the transfer of the patient to the correct ward or department. During the inspection we observed the flow of patients and reviewed waiting time information. We spoke to four patients in the waiting room who had been waiting between 5 and 15 minutes to be seen by the triage nurse and no longer than 25 minutes to be given treatment.

Learning from complaints and concerns

- There were 10 complaints made between 1st June 2015 and 31st May 2015. The majority of these were related to staff attitude. We were unable to establish if any specific training had been given to staff as a result of this.
- Staff told us they were aware of how to deal with complaints. We were told, doctors looked at the complaints which involved medical staff or medical care and the unit manager looked at the complaints which involved the nursing staff or nursing care. The complaints department team produced a draft letter to the complainant and this was checked by the person investigating the complaint.
- Feedback was given to staff face to face or by email. Any lessons learnt were discussed in the governance meeting and in handover. A board in the staff area displayed lessons learnt information. A monthly report would be discussed within the governance meetings.

Are urgent and emergency services well-led?

Good



Monthly governance meetings were held and attended by the clinical director, divisional management and senior nursing staff. Items covered included workforce, risks, health and safety, effectiveness, complaints and lessons

learnt. The clinical director was visible in the department and was positive regarding the future capital build which would expand and improve the department. The staff we spoke with were positive and described a good supportive team and enjoyed their work. We found there was an open culture in the department and staff were not afraid to express concerns informally or formally.

None of the staff we spoke with could articulate the strategy and vision for the trust but were aware of the plans for the department and increase in nurse staffing. There was little evidence of innovation and cross – departmental working with the emergency department at Royal Lancaster Infirmary. This resulted in the department working in isolation with the opportunities to share lessons, education and good practice not realised. The department had a risk register, which identified risks and control measures to mitigate these. Risk register reports provided by the trust did not include details of actions taken to mitigate risk. However, the trust told us they use a live electronic risk register that includes all mitigating actions, status and progress history

Vision and strategy for this service

- None of the staff we spoke with could articulate the current strategy and vision for the service.
- Some staff shared their knowledge of the 'Better Care Together' project and they were aware that building work was planned for the department.

Governance, risk management and quality measurement

- The department was part of the Acute and Emergency Medicine division. Each clinical division was headed by a clinical director, supported by a divisional general manager and an assistant chief nurse. A governance lead was also allocated to each division.
- Monthly governance meetings were held, attended by the clinical director, management and senior nursing staff. Items covered included workforce, risks, health and safety, effectiveness, complaints and lessons learnt.
- The emergency department had a service risk register. Risk register reports provided by the trust did not include details of actions taken to mitigate risk. However, the trust told us they use a live electronic risk register that includes all mitigating actions, status and progress history.

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- The main risks on the risk register were associated with low staffing levels, which could result in failure to deliver high quality, safe and effective care, including a delay in patient assessments and observations not being recorded. The risk register was completed and managed by the matron.
- We were told that work had been undertaken regarding workforce efficiency and development days for nurses had been introduced by the senior nursing team, in which information and learning was cascaded.

Leadership of service

- Staff were motivated and described a supportive team-working environment. We were told recent changes in the management structure had resulted in managers and senior nursing staff becoming more visible and supportive.
- The Chief Nurse had introduced development days for managers.

Culture within the service

- Staff reported the service was supportive and a friendly environment to work in.
- Staff were encouraged to learn from mistakes and education and training was available.
- In the staff survey July 2015, 90% of staff said the organisation encouraged them to report errors, near misses or incidents. We found there was an open culture in the ED and staff were not afraid to express concerns informally or formally.

- There was a positive morale in the medical and nursing team.
- The trust's "Acute and Emergency Medicine Division Staff Survey & Pulse Survey Action Plan 2015-16" identified three key areas for improvement: Staff motivation and engagement, lessons learnt and feedback to staff from reporting of clinical incidents, and staff to be appropriately trained and skilled. The action plan had clearly defined actions that had been allocated to members of staff with timescales for completion.







Public and staff engagement

- The department sought views from the public through the NHS Friends and Family Test. In January 2015 the response rate was 22.9%. Of those 90% would recommend the department to friends and family. This had been made easy for children to understand through the use of coloured pictures.
- The trust had run engagement events and workshops around the development of their vision and values.

Innovation, improvement and sustainability

- There was little evidence of innovation and cross – departmental working with the ED at Royal Lancaster Infirmary. This resulted in the department working in isolation with the opportunities to share lessons, education and good practice not realised.

Medical care (including older people's care)

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

Information about the service

The medical care services at the hospital provided care and treatment for a wide range of medical conditions, including general medicine, cardiology, respiratory, and gastroenterology.

During our inspection, we visited ward six (stroke and elderly care unit), ward seven (respiratory and general medicine), ward nine (cardiology, gastroenterology and oncology), CCCC (coronary and higher level of care) and the medical admissions unit. We reviewed the environment, staffing levels and looked at 23 care records and 20 medication charts. We spoke with two family members, 16 patients and 50 staff of different grades, including nurses, doctors, ward managers, matrons, a domestic assistant and the leads for medical services.

We received comments from people who contacted us to tell us about their experience, and we reviewed performance information about the trust. We observed how care and treatment was provided.

Summary of findings

During our inspection in 2014 we rated the hospital as requires improvement for medical care. During that inspection, we identified that staffing levels, skill mix, systems and processes all required improvement to secure and maintain the safety and effectiveness of the service. The quality of nursing records required improvement and some patient records and risk assessments were incomplete. Wards and departments were not always well-led at a senior level and there was a dis-connect between the staff providing hand-on-care and the Executive team.

We found that although significant changes had been made to improve the medical care services, further improvement was still required. Staffing establishments had improved however on some wards, nurse staffing remained a challenge. Staff recruitment was in progress to fill staff vacancies but there were still medical staffing vacancies in some specialities. The trust was aware of these but it was unclear from the information provided by the trust at the time of the inspection, if plans in place to address the vacancies had been updated on the risk register. Nurse record keeping had improved but there was evidence that fluid charts were not always fully completed. Medical decisions were not always documented clearly in patient records. Staff understanding and awareness of assessing people's capacity to make decisions was variable.

Recent national audits indicated that although there had been progress, the service still needed to make

Medical care (including older people's care)

improvements to the care and treatment of people who had suffered a stroke. Medical patients were often on other wards in the hospital (medical outliers) and it was unclear how these were managed.

Divisional governance board meetings were held on a monthly basis. Minutes from the meetings showed that a monthly report, which included risk registers, mortality incidents, audits and safety alerts, was discussed at the meeting. However, it was not always clear how the learning was then cascaded to ward staff or whether it had already been shared.

Staff were committed and passionate about providing good quality care. They were aware of how to report incidents and could clearly show how and when incidents had been reported. Staff felt confident about raising incidents through the reporting system and demonstrated learning from the incidents. Staff generally felt supported and valued.

Are medical care services safe?

Requires improvement



Staffing levels were varied on some wards and on ward 6 there were concerns about the low number of registered nurses on duty at night. There were a number of nurse vacancies in the trust and actions were in place to improve recruitment. Nurse record keeping had improved but there was evidence that fluid charts were not always fully completed. Medical decisions were not always documented clearly in patient records. Staff attended mandatory training courses; compliance was low in some areas. Safety data regarding harm free care was collated on a monthly basis and showed that from January to June 2015 there had been a high number of falls. The high number of falls had been on the risk register since 2012 but from the information provided by the trust, at the time of the inspection, it was not clear what action was being taken as a result.

There were appropriate protocols for safeguarding adults and children. Staff were clearly aware of their role and responsibilities in relation to safeguarding. There were procedures in place to support staff in reporting incidents. The number of incidents reported had increased and learning generally took place at ward level as well as divisional level. Wards we visited were clean and staff followed good practice guidance in relation to infection control. There was good management of medicines.

Incidents

- Staff were familiar with and encouraged to use the trusts procedures for reporting incidents. They understood their responsibilities to raise concerns and record safety incidents.
- Between April 2014 to March 2015 the trust reported 1378 incidents. This was an increase from the previous year. The trust was in the top 25% of incident reporters which showed a positive culture towards reporting of incidents.
- In the last six months prior to the inspection the medical division at the hospital reported 758 incidents of which 495 were either a near miss or resulted in no injury or harm.

Medical care (including older people's care)

- Two staff, a clinical lead and a nurse, had completed investigating incidents training in the hospital. Five other members of staff were booked onto the training to be completed later in the year.
- A monthly newsletter, which outlined lessons learnt from incidents, was displayed on the staff noticeboard.
- There were systems to support shared learning from incidents across medical wards. Most staff told us they received feedback from incidents but some staff did not know the outcome of incidents that were reported.
- Senior staff told us general feedback on patient safety information was discussed at ward staff meetings. On the majority of wards senior staff facilitated time with ward staff to look at lessons learnt from incidents.
- The workforce, efficiency, safety, effectiveness and experience, (WESEE) report highlighted incidents and risks. Senior staff said these were discussed with staff on the wards and with the matrons. Ward meeting meetings confirmed this.
- Ward meeting minutes on wards at the hospital showed clear actions and the member of staff responsible for the implementation of the action. These included learning from incidents. On ward six staff had signed to say they had received the minutes and read them.
- Staff were able to outline a recent incident and the lessons learnt. An example of this was that following an incident there was no doctor available to discuss the care required when a patient arrived late on the ward and needed transferring. Following the investigation, advanced nurse practitioners were now available 'out of hours' for advice.
- Following incidents, ward staff told us that they received feedback from the person reviewing the incident through the computerised system. This included lessons learnt and any actions taken.
- Minutes of the medical divisional governance meeting showed that a monthly report, which included learning from incidents, was discussed at the medical divisional governance meeting. However, it was not always clear how the learning was going to be shared or if it had already been shared.
- Since the duty of candour regulations were introduced in 2014, an audit of compliance had been carried out by the trust. During the period April to June 2015, we saw evidence that people had been informed of an incident and the actions taken to prevent recurrence.
- The NHS safety thermometer is a national improvement tool for measuring, monitoring and analysing harm to people and 'harm free' care. Monthly data was collected on pressure ulcers, falls, urinary tract infections (UTI for people with catheters) and blood clots (venous thromboembolism or VTE).
- Staff confirmed that the safety thermometer was undertaken once a month, and this information was displayed on wards. A ward manager told us that they did not receive formal feedback on the findings although they were aware of changes in practice that had taken place as a result of a recent audit such as the review of mattresses used and changes to catheter care.
- The number of pressure ulcers, falls and UTI's remained relatively consistent throughout March 2014 to March 2015. There was a small rise in the number of UTI's between August 2014 to October 2014 but these have since dropped to a more consistent rate. Six grade 3 hospital acquired pressure ulcers were reported in the same time period.
- Between January 2015 and June 2015 the total number of incidents recorded as falls was 225. Ward six had the highest number of falls at 80. The statistics provided did not indicate how many of these resulted in moderate to significant harm. The high number of falls had been on the medical services risk register since 2012 with a moderate score of 12. No actions were identified on the risk register to mitigate this risk.
- Mortality and morbidity meetings were held weekly and were attended by representatives from all teams within the relevant divisions. As part of these meetings, attendees reviewed the notes for every patient who had died in the hospital within the previous week. Any learning identified was shared and applied

Cleanliness, infection control and hygiene

- Wards and communal areas we visited were visibly clean and odour free. Personal protective equipment (PPE) was available for staff to use. All wards had antibacterial gel dispensers at the entrances and by people's bedside area.
- All wards we visited had facilities for isolating patients with an infectious disease. There was a patient on ward six who had MRSA and there was appropriate signage on the bedroom door informing people of the care required when entering the room.
- Generally cleaning schedules had been completed as required. Domestic staff told us there were sufficient

Safety thermometer

Medical care (including older people's care)

supplies of cleaning materials available for their use. They were able to tell us about the national colour coding scheme for hospital cleaning materials and equipment. This ensured that these items were not used in multiple areas, therefore reducing the risk of cross-infection. There was a guide on the wall of the store room.

- Cleaning storerooms were generally clean and tidy.
- Staff followed good practice guidance in relation to the control and prevention of infection.
- This included the use of 'I am clean' stickers to inform colleagues at a glance that equipment or furniture had been cleaned and was ready for use.
- Toilets were visibly clean and had appropriate hand washing facilities. The cleaning schedule had been signed and dated to say that they had been checked.
- In the last six months, prior to the inspection, there were no cases of *Clostridium difficile* reported in the medical division at this hospital.

Environment and equipment

- The environment was generally clean and tidy and the décor was well maintained. Clinical areas were generally well maintained.
- There were systems in place to maintain and service equipment as required. Hoists had been serviced. Portable electrical equipment had been tested regularly and had electrical safety certificates which were in date.
- Resuscitation equipment was available on all the wards we visited and tamper seals were in place. These had been checked daily in line with trust policies and Emergency drugs were available and in use by date. These were stocked in line with national emergency drug guidelines.
- We noted that the door on the dirty utility room on ward 6 was left open and bottles of cleaning chemicals were left in an unlocked cupboard. These chemicals were hazardous and presented a risk of harm to people's health.
- There was a therapy room on ward six which was used by patients. Staff co-ordinated patient activities on a daily basis. On the day of our visit there were both female and male patients sitting together in their nightclothes. This was brought to the attention of the ward manager who informed us that not all patients had day clothes with them. However, it was observed that the staff worked hard to maintain patients' dignity at all times.

- On ward six there were adequate supplies of medication and equipment such as needles, syringes and dressings.

Medicines

- Recording of medication on the medication charts was good and there was no excessive prescribing of sedative medicines on the wards we visited.
- The Pharmacist had access to the wider prescription record, including dose and frequency of administration, from GP's but other staff had more limited information. This had been highlighted as a risk by pharmacy. To mitigate this risk pharmacists were printing off information so that they were able to help the prescribers ascertain medication history for patients.
- There was an electronic system available on some of the wards that gave clear information around the number of patients that had received medicines reconciliation together with the request and availability of medicines for patients who are being discharged.
- Controlled drugs were stored securely and access was limited to qualified staff employed by the trust. Registers were completed in line with trust procedures.
- Medicines requiring storage at temperatures below eight degrees centigrade were appropriately stored in fridges. Daily temperature checklists were consistently completed. There was a system identified to follow up if there were gaps in these records.
- Intravenous fluids were in date and there was an effective system in place to monitor the expiry dates of these products. This meant that IV fluids were always available on the wards.
- Medication was all in 'use by' date.
- Staff showed us how they managed a patient's own medication and the use of individual patient lockers. This meant that medication was always available for patients.
- There was a clear and consistent understanding by all staff of the systems in place for managing medicines. There were regular safety huddles which discussed any incidents relating to medicines.
- There was access to an on-call pharmacist for 'out of hours' medication requests.
- On ward 7 medicines due in the morning were still being administered at 10.30. Staff said this was due to being distracted by patients and staff. This meant that patients did not receive their medication on time. This may have been a risk if the medication was to have been taken with food.

Medical care (including older people's care)

Records

- During the inspection we reviewed 43 care records.
- The hospital used paper-based and electronic records.
- Wards had lockable patient note trolleys.
- The electronic patient boards that were visible in ward corridors respected patient confidentiality by using codes instead of patient names.
- We looked at the documentation kept to record people's vital signs, fluid balance charts and food intake. The details of nutritional intake and fluids were not always recorded accurately within patients' records. Out of six fluid charts on ward six, four had not had the total daily fluid intake recorded.
- Some doctor's entries were illegible though generally nursing entries were legible. All were signed and dated.
- In a care record we reviewed on ward six a consultant had not fully completed documentation or assessments.

Safeguarding

- Safeguarding policies and procedures were in place and understood by staff who knew how to refer a safeguarding issue in order to safeguard adults and children, from abuse.
- The trust compliance target for safeguarding training was 80%. The compliance rate for safeguarding adult level 1 training was 95% and for level 2 training was 92%. For safeguarding children training the compliance rate for Level 1 training was 95% and for level 2 training was 94%. However, the compliance rate for level 3 safeguarding children training was only 8%.
- Data suggested that staff were raising safeguarding concerns appropriately in line with the trust's policies and procedures. 326 referrals were made to the adult safeguarding team between July 2014 and July 2015. This was 35% of the total number of patient safety incidents reported during the last 12 months.

Mandatory training

- Staff received mandatory training on a rolling annual programme which was mainly available on line. The band 6 nurse in the nursing team was responsible for ensuring that staff were up to date with their training.
- The trust compliance target for mandatory training was 80%. This was being met for some areas such as equality and diversity, information governance and

infection prevention. However, it was below the target for conflict resolution at 70%, fire safety at 58%, resuscitation at 79% and some moving and handling modules which were between 59% and 61%.

Assessing and responding to patient risk

- The trust had its own early warning trigger system, called 'Physiological Observation Track and Trigger System' (POTTS). This was a basic set of observations such as respiratory rate, temperature, blood pressure and pain score. Staff were able to tell us about its use. The data from this system was used to update the patient information computerised system that was available on some of the wards.
- Falls risk assessments were based on patient history of falls and this determined the care and bed location. This is similar to the method used by other hospitals in the area.
- There was a risk assessment bundle that was completed for each patient on admission. This included risk assessment for bed rails, manual handling, pressure ulcers, a falls care bundle, and a MUST screening tool (Malnutrition Universal Screening). During the inspection we saw completed risk assessment bundles.
- Staff were not aware of any trust policy for urgent or unplanned medical admissions to the ward to ensure they were assessed by a relevant consultant within 12 hours of admission. They told us that they would liaise closely with the emergency department and expect all the admission paperwork and assessments to have been done by the emergency department staff. If there were any issues they would escalate these to the clinical service manager.
- Consultants undertook ward rounds twice a day, once in the morning and again in the afternoon. This meant patients were seen by a consultant within 12 hours of being admitted onto a ward. During our visit we observed these ward rounds which were effective and well attended by multidisciplinary staff.

Nursing staffing

- Each ward had a planned nurse staffing rota and reported on a daily basis if shifts had not been covered. The National Institute for Health and Care Excellence (NICE) guideline 'Safe staffing for nursing in adult inpatient ward in acute hospitals' was used by the trust but not consistently by all wards.

Medical care (including older people's care)

- One of the principles of the 'red rules' initiative required that one registered nurse should deliver care to no more than eight patients and the minimum skills mix on a ward should be 60% registered nurses to 40% health care assistants. We saw evidence from the trust that this was being implemented.
- During May 2015 there were a number of medical wards when staffing shifts were not filled as planned for registered nurses. This is known as 'fill rate'. Ward 6 percentage fill rate was 75% in the day and 88% at night; Ward 7 fill rate was 82% in the day and 95% at night; Ward 9 fill rate was 83% in the day and the medical assessment unit fill rate was 98% in the day. Review of staffing over a two month period for two wards showed that the number of registered nurse to patients varied and that the staffing levels did not always fall in line with the red rules initiative. Ward 6 had closed six of the beds due to lack of staffing and was now a 30 bedded unit. From 20 April 2015 to 17 May 2015 there were 10 occasions when the number of registered nurses on duty at night was one for 15 patients. On one occasion there was only one registered nurse on duty for 30 patients and one clinical support worker. The trust told us this was due to sickness. There were also 20 early shifts and 13 late where the staffing levels fell below one registered nurse to eight patients. Again the skill mix showed that there were more clinical support workers on duty than registered nurses on those occasions.
- From 15 June 2015 to 12 July 2015 there were 16 occasions when the number of registered nurses on duty at night was one for 15 patients. There were also three early shifts and 14 late shifts where staffing levels fell below one registered nurse to eight patients. There were a higher number of clinical support workers than registered nurses on duty on those occasions.
- Ward 7 was a 24 bedded unit. From 20 April 2015 to 17 May 2015, there was only one occasion when the staffing levels fell below one registered nurse to eight patients on an early shift, three occasions on a late shift and two occasions on the night shift. On those occasions there were more clinical support workers on duty than registered nurses.
- The coronary care unit was staffed on a ratio of one nurse to two patients in the day and one nurse to three patients at night. The critical care minimum data set standards were used on a daily basis to ensure safe staffing levels.
- Senior staff said that they tried to use the same bank staff to ensure that they have the required skills to work on the ward.
- Ward six had 10 registered nurse vacancies with two new starters commencing in August 2015. A review of the staffing levels on the ward had resulted in the closure of 6 beds. Actions have been put in place. These included international recruitment, the use of skills for health care apprentices and the increase of clinical support worker numbers. It is planned that when up to full establishment of nurses that these beds will re-open.
- The total number of whole time equivalent nurse vacancies was 28. The average turnover of nursing staff at the hospital was 10%.
- Medical wards we visited displayed nurse staffing information on a board at the ward entrance. This includes the staffing levels that should be on duty and the actual staffing levels. This meant that people who used the services were aware of the available staff.
- Wards at the hospital had recently commenced an e-rostering system. This was a central system for managing information such as shift patterns, annual leave, sickness and staffing skill mix.
- Staffing establishments had improved since the last inspection however failure to provide adequate staff was still on the divisional risk register and still had a score of 20, which had not improved since the last inspection.

Medical staffing

- The percentage of consultants working in the trust was 44% which was higher than the England average of 34%. The percentage of registrars was 28% which was below the England average of 39%. Middle grade and junior doctor levels were the same percentage as the England average.
- There was a lack of consultants in some services, such as respiratory and gastroenterology and this was noted on the risk register. It had been on the risk register since 2011 and significant enough to score 16 which was high. There were actions identified to mitigate the risk however, the target date for completion of the actions was January 2015 and two actions were still outstanding. These actions were internal training for a potential candidate for a senior post and a business case.

Medical care (including older people's care)

- The total number of whole time equivalent medical vacancies was 2.9. The average turnover of medical staff in the hospital was 8.12%.
- Junior doctors said that they always had the contact number for consultants and were always supported. They said that they were sometimes stretched when there were patients in different locations who required more medical input.
- There was an on-call rota which ensured that there was a consultant available 24 hours a day seven days a week for advice.
- There has been an increase in the number of cardiology consultants from two to six. These consultants work across the trust on a six week rotation basis. This had improved patient care and facilitated earlier discharges. It had also reduced the angiogram waiting list from 18 months to three weeks. The consultants were supported by nurse practitioners and specialist nurses.
- Senior management staff said there had been new appointments made in diabetes services and there was succession planning in rheumatology services.
- The hospital used advanced practitioners in gastroenterology services to support the consultants.
- The medical division utilised agency locums booked through an external organisation. Agency locum use was high due to difficulties recruiting to medical vacancies. There was no system in place in medical services to ensure that employment checks, such as disclosure and barring (criminal checks) and validation, had taken place prior to working in the division.
- Over the past six months the locum cover was as high as 72 % of the whole time equivalent medical staff in some specialities at this hospital.

Major incident awareness and training

- Staff were aware of what they would need to do in a major incident. They demonstrated how they would find the trust policy and how to access key documents and guidance.
- A continuity plan had been put in place on ward 6 due to doors on the ward not functioning correctly. A request had been put in to repair the doors.
- On the mandatory training information that was provided by the trust there was no record of any major incident training for staff.

Are medical care services effective?

Requires improvement

Care was provided in line with national best practice guidelines and medical services participated in the majority of clinical audits which they were eligible for. Recent national audits indicated that although there had been progress, the service still needed to make improvements to the care and treatment of people who had suffered a stroke. Most staff said they were supported effectively but the appraisal completion for the division was below the trust target of 90%, ranging from 63% for medical staff to 89% for nursing staff in bands one to seven. Nutrition and fluid intake were not always recorded correctly. We found that staff members' understanding and awareness of assessing people's capacity to make decisions about their care and treatment was variable. Some assessments correctly recorded specific decisions and the reasons for the judgment made, while others did not. Not all staff had received deprivation of liberty safeguards (DoLS) or Mental Capacity Act (MCA) training.

There was a multidisciplinary approach to care and treatment that involved a range of professionals. There was a joined up approach to assessing and managing patients' needs. There was evidence of progress towards providing services seven days a week.

Evidence-based care and treatment

- The service was using national and best practice guidelines to care for and treat patients. Specific National Institute for Clinical Excellence Guidance (NICE) were included in consultants' objectives.
- The service participated in all but two of the clinical audits for which it was eligible through the advancing quality programme. These were the diabetes audit and the coronary artery bypass graft audit.
- In February and March 2015 they were not meeting the appropriate care score threshold for stroke, sepsis and for chronic obstructive pulmonary disease (COPD).
- The hospital had a care pathway in place for managing patients who had a stroke and for patients admitted to ambulatory care. Ambulatory care is medical care provided on an outpatient basis. Staff were able to describe the care pathways.

Medical care (including older people's care)

- On the coronary care unit there were care pathways in place for deep vein thrombosis (DVT), self-harm and mental health. These all were in line with NICE guidance but were not audited by the hospital.
- Staff gave examples of how they were working to improve the stroke care pathway. These included working with the ambulance service to pre-alert the hospital to patients who may require medical care for a stroke and posters around the hospital informing people about how to recognise a stroke.
- There were examples of recent local audits that had been completed on the wards. These included cleanliness, documentation and discharge audits. Staff said that they received the results of the audits and any learning was shared with them by email.
- Lead consultant objectives included the review and delivery of national institute of clinical excellence guidelines (NICE) for each speciality in medicine.
- Aseptic technique NICE guidelines (An aseptic technique ensures that only uncontaminated equipment and fluids come into contact with susceptible body sites) and acute kidney injury NICE guidelines are part of the quality and innovation scheme for the trust for 2015/16.
- The coronary care unit was developing a standard operating procedure for the unit and for telemetry.

Pain relief

- Wards had effective systems in place to assess and provide pain relief for patients.
- Patients generally told us that they received appropriate pain relief when required.
- We saw a nurse responding appropriately to a patient who had requested pain relief.

Nutrition and hydration

- Patients told us that the food was good and they had a choice. Catering staff had access to information of any special dietary requirements for patients.
- Patients were assessed regarding their nutritional needs and care plans put in place if appropriate.
- We observed that the details of nutritional intake and fluids were not always recorded accurately within patients' records. Out of six fluid charts on ward six four had not had the total daily fluid intake recorded.
- Nasogastric tube charts were completed and fully legible.

- We observed an evening meal time on ward six. Staff interacted well with the patients and ensured that they received the food they had requested. Meals were put in reach of all the patients.

Patient outcomes

- The hospital does not provide primary coronary intervention (PCI) as this is provided at the Cardiac Catheter Centre at Blackpool Teaching Hospital NHS Foundation Trust. However, the number of patients diagnosed with a non-ST segment elevation myocardial infarction seen by a cardiologist prior to discharge was above the national average at 100% (non-ST- a type of heart attack that does not benefit from immediate PCI). This was higher than at the last inspection. That said, only 35.4% of patients with an non-ST are admitted to a cardiology ward. This is lower than at the last inspection.
- The trust was highlighted as a 'risk' for the in-hospital mortality indicator - Cerebrovascular conditions in the CQC Intelligent monitoring report May 2015.
- The Sentinel Stroke National Audit Programmed (SSNAP) is a programme of work that aims to improve the quality of stroke care by auditing stroke services against evidence-based standards. This highlighted that the service still needed to make improvements to the care and treatment of patients who had suffered a stroke. The hospital is now scoring an overall 'D' grade which is an improvement than the lowest grade 'E' awarded at the time of the last inspection. Staff said that there was an action plan in place to improve the overall grade awarded.
- An analysis of the National Diabetes Inpatient Audit 2013(NaDIA) showed the hospital performed better than the England average for 12 out of the 21 indicators and worse than the England average for nine of the indicators. Of particular concern was data showing that only 23% of patients had a foot risk assessment during their hospital stay compared with the England average of 42% and there were 52% of medication errors compared with the England average of 37%. The trust had an action plan in place to improve the outcome for patients with diabetes. The actions included early identification and management of diabetic foot disease and a new insulin chart together with a rolling education programme. The completion date for the action plan was late 2015.

Medical care (including older people's care)

- The trust did participate in the joint advisory group on GI Endoscopy (JAG). The JAG ensures the quality and safety of patient care by defining and maintaining the standards by which endoscopy is practised.
- The average length of stay for non- elective medicine at the hospital was below the England average at 6.2 days. The England average was 6.8 days. Forelective medicine it was slightly above the England average at 4.8 days. The England average was 6.8 days.
- The re-admission rates for the hospital was below those expected for the majority of specialities apart from gastroenterology which was slightly higher.
- The Trust had been working with Lancaster University, to support the development of clinical leaders. The division was supporting two members of staff on the clinical leadership development level 7 programme.
- On the coronary care unit all band 6 nurses were trained in advanced life support. The rest of the staff on the unit were trained in intermediate life support.
- Local induction was completed for all new staff. Records we reviewed showed that these were completed within the first couple of week of commencing work on the wards.

Competent staff

- The trust had no clinical supervision policy. Qualified staff told us that there were no formal systems in place for clinical supervision. A senior clinician said that they had tried to implement clinical supervision but found resistance from band 5 nurses and senior management staff. However, staff did have access to meetings with their line manager on request. The purpose of clinical supervision is to provide a safe and confidential environment for staff to reflect on and discuss their work. The focus is on supporting staff in their personal and professional development and in reflecting on their practice.
- Most staff informed us that they had had an annual appraisal in the last 12 months; appraisals included objectives which were based on trust and divisional objectives as well as personal objectives.
- The appraisal completion rate was below the trust target of 90%. Within the medical division, the lowest completion rate was medical staff at 63% and the highest completion rate was for staff in bands one to seven at 89%. The trust has recently recruited a number of international nurses. These were assigned a mentor on the ward and worked alongside practice educators. They undertook nurse duties under supervision until they were registered with the national medical council (NMC).
- The trust was involved in the apprenticeship nursing scheme with the skills for health academy and were undertaking a national vocational qualification (NVQ) in care. This helped ensure that any future applications for nursing posts were from competent people who had the skills and experience required.

Multidisciplinary working

- There was a multidisciplinary approach to care and treatment that involved a range of professionals. There was generally a joined up approach to assessing the range of patients' needs.
- We observed handovers, which included clinical support workers. There was effective communication and they were well structured.
- On most of the wards we visited they held daily ward meetings. These were called board rounds and they reviewed discharge planning and confirmed actions for those people who had complex factors affecting their discharge. We observed two board rounds and saw that they were well attended by a range of professionals.
- Staff told us that multidisciplinary working on the stroke ward was excellent, with clear handovers that discussed the needs of patients and action points for staff. The stroke ward held combined multidisciplinary meetings once a week to facilitate effective communication.

Seven-day services

- There was a multidisciplinary team who specialised in stroke services in the hospital which covered seven days a week.
- A plan had been developed so that acutely ill medical patients in the hospital had the same access to medical care on the weekends as on a week day. The plan outlined some key objectives such as a consultant presence on wards over 7 days with ward care prioritised in doctors' job plans. The plan outlined an analysis of gaps and actions required but there was no date for full implementation. The trust had a doctors' on-call rota for evenings and weekends.
- Staff told us that diagnostic services were available 24 hours a day, seven days a week.

Medical care (including older people's care)

Access to information

- Medical and nursing staff reported information systems to be good with timely access to results of investigations and tests.
- Discharge information was sent through to GP's following discharge. Staff said that if it was a complex case then they would telephone the GP directly with the information.
- There were computers available on the wards we visited which gave staff access to patient and trust information.
- Policies and protocols were kept on the hospital's staff intranet which meant all staff had access to them.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There were systems in place to obtain consent from patients before carrying out a procedure or providing treatment.
- Staff understanding and awareness of assessing people's capacity to make decisions about their care and treatment were variable. Some assessments correctly recorded specific decisions and the reasons for the judgment made, while others did not. On ward six four patient records, who had had a stroke, showed no record of capacity assessments or best interest meetings even though they had given consent for procedures.
- On ward seven it was observed that bedrails were in place for two patients who had dementia. There was no record in their notes or care plan that a MCA had been done, or a best interest decision had been made, as outlined in the trust standard operating procedure for using bedrails safely and effectively. There was no MCA assessment. Staff on the ward were not aware that this may have been seen as restraint.
- Some clinical staff told us they had not received deprivation of liberty safeguards (DoLS) or Mental Capacity Act (MCA) training. This training was included in the safeguarding training for clinical professionals. 92% had completed level 2 safeguarding training.
- Senior management staff recognised that there was a lack of recent in-depth training on MCA and DoLS.
- Within the risk assessment bundle documentation, there was clear guidance on the Mental Capacity Act 2005 and deprivation of liberty safeguards.

- Within the trust there had been an increase in the number of DoLS applications. These were monitored by the trust safeguarding lead to ensure that they were authorised appropriately.

Are medical care services caring?

Good



During the previous inspection we found response rates to the Friends and Family test were below the national average. At this inspection we found response rates had improved and the majority of patients would recommend the service to their family and friends.

Patients told us staff were caring, kind and respected their wishes. We saw staff interactions with people were generally person-centred. Staff were kind and caring to people. Most people we spoke to during the inspection were complimentary about the staff that cared for them. Patients received compassionate care and their privacy and dignity were maintained in most circumstances.

Patients were involved in their care, and were provided with appropriate emotional support in the majority of cases.

Compassionate care

- The friends and family test is a national initiative to gain feedback from patients following their admission to hospital. The average response rate for ward seven had increased since the last inspection from 12 to 43 people at the time of this inspection. At the time of the inspection the percentage of patients who would recommend the medical wards to friends and family ranged from 67% for ward six to 100% for ward seven. 97% of patients would recommend the hospital to friends and family.
- Patients and those close to them were treated with respect, including when receiving personal care.
- Patients generally felt supported, well cared for and involved in their care. We saw that interactions between staff and other people were generally positive, respectful and caring.
- Most people we observed were well presented and appeared comfortable in their surroundings.

Medical care (including older people's care)

- People's dignity was respected while they were being supported with personal care tasks and dignity curtains were used when staff were assisting patients.
- We saw that people had access to call bells and staff responded promptly.
- On ward six toilets on the wards could be used by both female and male patients. Staff told us that a notice on the toilet doors was used to denote if the toilet was to be used by male or female patients. We observed that a notice on one toilet was turned to state male but was outside a female bay.

Understanding and involvement of patients and those close to them

- Patients all had a named nurse and consultant. Patients were aware of these and they were displayed on a board above the bed.
- Patients said that they had been involved in their care and were aware of the discharge plans in place. Most patients could explain their care plan.
- Patients said that they felt safe on the ward and had received orientation to the ward area on admission.
- Family members said that they were generally kept well informed about how their relative was progressing.

Emotional support

- Some staff said that they had sufficient time to spend with patients when they needed support, but other staff felt that time pressures and workloads meant that this did not always happen.
- Staff said that an extra staff member could be requested if a person needed specific one-to-one support but that this did not always happen due to lack of available staff.
- Visiting times met the needs of the relatives to whom we spoke. Open visiting times were available if patients needed support from their relatives.
- Chaplaincy services were available for patients.

Are medical care services responsive?

Requires improvement



Over the last 6 months prior to our inspection bed occupancy rate for the hospital was consistently above 106%. There were a number of patients who had multiple ward moves during their stay and medical patients were

often on other wards in the hospital. There were lead consultants who were responsible for reviewing outlying patients. Matrons would verbally report if outlying patients had been seen by a member of the medical team but this was not formally documented on the daily patient flow report. This issue was on the risk register; however there were no actions identified and no target date for review.

The trust was working in partnership with other organisations to help meet the needs of people. There was a focus on effective discharge planning for patients and the implementation of electronic whiteboards had improved the information available to staff to improve patient care. There were good facilities for patients who had had a stroke on one ward and there was evidence that there was learning from complaints. There were systems in place to support people living with dementia however staff told us that there had been difficulties in accessing mental health services.

Service planning and delivery to meet the needs of local people

- Senior staff said that the trust was planning a winter pressures plan to cope with increased demand for beds in the coming months. The trust was engaging with partner organisations, such as the local authority and clinical commissioning groups, to address this area of concern.
- Senior management staff explained that each year they looked at capacity and demand from the previous year to plan the services required for the following year.

Access and flow

- Over the last 6 months prior to inspection bed occupancy rate for the hospital was consistently above 106%. This is worse than the England average. It is generally accepted that, when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the hospital.
- Information provided by the trust showed that there was a shortage of medical beds and patients had been placed on wards which were not specialist to their need. These were known as outliers. Between January 2015 and June 2015 data showed that there had been 1061 outliers at the hospital. The medical services risk register

Medical care (including older people's care)

showed that medical outliers had been on the risk register since 2011 with a low score of six. There were no actions identified and no target date for review on the risk register.

- There was a standard operating procedure for outlying patients which was ratified on 28 June 2015. This was to be shared with staff by the matrons in July 2015. The development of the procedure was part of the emergency recover plans 2014.
- As part of this plan a new structure was placed around the patient flow meetings which included a ward status report completed by the matrons. The trust told us that matrons who had medical outliers on their ward would verbally report if they had been seen by a member of the medical team. This was not formally documented on the daily patient flow report. The only documented evidence that a medical outlier had been reviewed would be in the patient notes. There was no documented organisational overview that patient needs were being met apart from the total number of medical outliers.
- 1380 patients had moved wards more than once during their stay; this was 11% of the total patient admitted to the hospital between April 2014 to April 2015.
- The hospital had patient flow meetings regularly throughout the day during the week to review and plan bed capacity and respond to acute bed availability pressures. We attended a patient flow meeting during our visit. Although medical outliers were discussed this was not in detail considering the number of outliers there were.
- The referral to treatment times for cardiology, dermatology and gastroenterology were meeting the standard of 90%. (percentage seen within 18 weeks of referral).
- There was a clear focus on effective discharge planning for patients and wards had a designated discharge co-ordinator who was responsible for discharge planning.
- Electronic boards were in place for some of the wards which monitored the flow of patients. This included their medication, completed early warning scores, test results and any patient moves to other wards.
- Improvements had been made over the last 12 months with the delivery of a 5 day ward round. The trust was

looking at delivery of this best practice to 7 days a week. A ward round standard operating procedure had been developed which was being tested across all specialities. This was to optimise the patient journey.

- Stroke patients who had thrombolysis in the emergency department were transferred to the coronary care unit before moving to ward 6 (stroke ward). This was due to staffing levels. Staff told us that once staffing levels had increased on the ward, patients would be directly transferred from the emergency department following thrombolysis.
- Senior nurses said that there was good strategic management of bed capacity across the hospital site and effective liaison with clinical commissioning groups.

Meeting people's individual needs

- Most patients we spoke with knew who their consultant was and details were clearly displayed above their beds.
- Wards were using the trust's butterfly symbol on patient information boards to indicate that a patient was living with dementia.
- On some of the wards there were enhanced décor around doors and in toilets to help people with dementia. This included the use of red toilet seats to make them stand out from other sanitary wear.
- Patient leaflets were available on wards but not always in an accessible format but for people with a learning disability these were seen on Ward 23.
- There were translation services available through language line. This is a telephone interpreting service. Staff told us they had used this service in the past and it was effective.
- Call bells were available by each bed and easily accessible by patients.
- Staff told us that there had been difficulties in accessing mental health services and that calls made to the service were not returned in a timely way. They were not always responded to in the same day.

Learning from complaints and concerns

- People knew how to raise concerns or make a complaint. The trust encouraged people who used services, to provide feedback about their care. Complaint procedure leaflets were generally available on wards.
- Senior staff told us how, where possible, they were now working to achieve 'on the spot' resolutions of concerns.

Medical care (including older people's care)

- Examples were given of the last complaint received on the wards and the findings from the review of the concern raised. We saw evidence that themes had been identified from the complaints received by the medical division. These included inadequate care and treatment, communication and attitude of nursing staff.
- Patients had raised issues on one ward regarding the condition of a shower room and this was refurbished.
- Learning from complaints was shared at team meetings.

Are medical care services well-led?

Good



During our inspection in 2014 we found that wards and departments were not always well-led at a senior level and there was a dis-connect between the staff providing care and the executive team.

At this inspection we found that the medical care services were generally well-led with evidence of effective communication within staff teams. The visibility of senior management had improved and there were information boards to highlight each ward's performance. Most staff felt valued and supported and had seen an improvement in the leadership of medical services. There were generally good governance structures in place at ward level. All staff were committed to delivering good, compassionate care and were motivated to work at the hospital.

Divisional governance board meetings were held on a monthly basis. Minutes from the meetings showed that a monthly report, which included risk registers, mortality incidents, audits and safety alerts, was discussed at the meeting. Risk registers were in place. Risk register reports provided by the trust did not include details of actions taken to mitigate risk. However, the trust told us they use a live electronic risk register that includes all mitigating actions, status and progress history.

Vision and strategy for this service

- Senior staff spoke positively about the board's vision and strategy, 'Better care together'. Services were working in partnership with clinical commissioning groups and local health and care providers to review how patient services were delivered. Staff were able to tell us about the trust's values.

- Medical staff had clear objectives which reflected the trust's strategy such as ensuring services are delivered within financial plans and improving the quality of patient care.

Governance, risk management and quality measurement

- Staff at all levels knew that there was a divisional risk register and ward managers were able to tell us what the key risks were for their area of responsibility.
- Staff demonstrated how they were able to access the risk register on the trust systems.
- Risk registers were in place. Risk register reports provided by the trust did not include details of actions taken to mitigate risk. However, the trust told us they use a live electronic risk register that includes all mitigating actions, status and progress history.
- Matrons met monthly with ward managers to discuss the monthly performance reports and undertook a weekly ward round. This involved talking with patients and staff, looking at documentation and charts and checking equipment. These were formally recorded. Band 6 nursing staff from other units undertook the ward round on occasions to share learning.
- Every six months Matrons undertook the care quality assessment tool which incorporated the CQC standards. This identified areas of good practice and areas of improvement.
- The governance structure within the trust expected divisional governance board meetings to be held. These were held on a monthly basis. Here the divisional risk register, incidents, safety alerts, infections audits and mortality reviews were discussed.
- Senior staff were able to tell us how their ward's performance was monitored, and how performance boards were used to display current information about the staffing levels and risk factors for the ward.

Leadership of service

- The majority of staff told us leadership at ward level had improved, with clearer communication.
- Staff reported senior staff were visible and approachable.
- Staff could explain the leadership structure within the Trust and told us that the executive team were more visible and accessible to staff. Staff said that the static leadership had helped them know who to go to for help with any concerns.

Medical care (including older people's care)

- Matrons provided seven day cover on a rota basis as point of advice on site for all specialities.

Culture within the service

- Staff said they felt supported and able to speak up if they had concerns. They said there had been an improvement in staff morale.
- There has been an improvement in the number of senior staff walk rounds which gave staff the opportunity to raise concerns.
- Senior medical staff were now working more across all locations and reviewed policies were becoming more trust policies than location based policies.
- The pulse survey showed that in the medical division 84% staff were motivated to come to work.
- The staff survey showed that 49% of staff employed by the trust would recommend it as a place to work. The survey also showed 56% of staff would be happy for a friend or relative to have treatment at the trust.

Public engagement

- Board meeting minutes and papers were available to the public online which helped them understand more about the hospital and how it was performing.
- There was a limited approach to obtaining the views of people who use services and we saw no systems in place on the majority of wards we visited. On ward 6 they were seeking feedback from patients on the use of the activity room and also telephoned patients who had been discharged to see if they required any additional help.
- The trust monthly board meetings included a patient story to highlight patients' experiences of using the hospital's services.
- This hospital participated in the NHS friends and family test giving people who used services the opportunity to provide feedback about care and treatment. 97% of patients would recommend the hospital to friends or a relative.







Staff engagement

- The trust celebrated the achievements of staff by having a 'star of the month' which colleagues nominated. The medical services had had a number of staff recognised for their work at the trust.
- Staff participated in the staff survey. This included how staff felt about the organisation and their personal development. 60% of staff felt the training and development they had undertaken had helped them to deliver a better patient experience and 65% felt it had helped them to do the job more effectively. 59% felt that they were valued by the organisation.

Innovation, improvement and sustainability

- Innovation and improvement was encouraged, for example utilising a 6 bedded bay area that had been closed, due to low staffing numbers, as a therapy room for patients. Also a ward manager was actively taking part in a project trialing the use of computerised tablet devices to record early warning scores. However, staff told us that they were not always able to recommend changes to processes due to time pressures. Some staff felt well supported in being able to voice their opinions on how services should be run, while others did not.
- The trust had developed an in-house e-Whiteboard system for the medical wards. This interacted with other trust computerised patient systems and simplified access to information for nurses and facilitated active management of patient journeys, discharge processes and bed state.
- A doctor on the medical assessment unit (MAU) had identified that acute kidney injury was a national issue and fluid balance recording at the hospital was poor. This was raised through the trust listening into action processes. Support was given for a project on MAU to improve balance recording and reduce acute kidney injury. This has been evaluated and is going to be rolled out across the trust. The project was awarded a certificate of achievement and details were displayed on a learning board at the entrance of the unit.

Surgery

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

Information about the service

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

Hospital episode statistics 2014 data showed that 13,200 patients were admitted for surgery at the hospital. The data showed that 61% of patients had day case procedures, 16% had elective surgery and 23% were emergency surgical patients.

There are three surgical wards, a day case ward and seven theatres that carry out emergency and elective surgery procedures as well as some day case surgery.

As part of the inspection, we inspected the main theatres, the pre-operative assessment unit, the day case unit, ward 2 (the trauma and orthopaedic unit), wards 4 and 5 (the urology, ear nose and throat, maxilla-facial and general surgical ward). We spoke with nine patients. We observed care and treatment and looked at 13 care records. We also spoke with a range of staff at different grades including nurses, doctors, consultants, ward managers, general managers, the theatres managers, the assistant chief nurse, the matron for general surgery and critical care, the matron for quality assurance, the matron for theatres, the adult safeguarding lead nurse, and the divisional clinical lead. We received comments from people who contacted us to tell us about their experiences and we reviewed performance information about the trust.

Summary of findings

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

The referral to treatment times for patients admitted to the hospital were worse than the England average; however trust wide initiatives had been launched to reduce these and improvements had been made. The written policies and procedures held on the wards for guidance had not been reviewed within the timescales documented. Not all staff were up to date with their appraisals and there was a lack of clarity about the support for newly qualified staff. The majority of staff were not clear about how the mental capacity of a patient impacted on their role and responsibility. Not all consent forms were correctly completed. Written consent was routinely obtained on the day of surgery. Not all records were securely stored or adequately maintained.

Incidents were reported and a system was in place to share learning and change practice. The environment and equipment were visibly clean and tidy with good infection control measures in place. There were safe systems in place for the management of medicines. The written policies and procedures for medicine administration, which were being used by staff at the time of the inspection, were out of date. However, the electronic versions were in date. The majority of mandatory training was up to date. Systems were present to respond to and reduce risks to patients. Staff

Surgery

in theatres had put additional measures in place to enhance the safety of surgical procedures at the hospital. Nurse staffing was adequate to meet the needs of the patients and the vacancy rate was low. Theatre staff had been innovative in their approach to increase staff numbers. The majority of mandatory training was up to date. Systems were present to respond to and reduce risks to patients. Staff in theatres had put additional measures in place to enhance the safety of surgical procedures at the hospital.

Care pathways including pre-operative assessments and enhanced recovery were based on the relevant national guidance. Staff attended to patients quickly when they requested assistance and treated them with respect. Patients said they were involved in their care as much as they required and had been given explanations of procedures and opportunities to ask questions.

Staff shared a vision of improving services for the patients through learning from feedback, being open to learning from shortcomings in their own service and sharing good practice from other trusts. Staff felt well supported by their immediate line managers and the divisional matrons and told us they felt included in the development of services and could make suggestions for change, especially in the operating theatres.

Are surgery services safe?

Good



Surgical services at this hospital were safe. Incidents were reported and a system was in place to share learning and change practice. The environment and equipment were visibly clean and tidy with good infection control measures in place. There were safe systems in place for the management of medicines. The written policies and procedures for medicine administration, which were being used by staff at the time of the inspection, were out of date. However, the electronic versions were in date. The majority of mandatory training was up to date. Systems were present to respond to and reduce risks to patients. Staff in theatres had put additional measures in place to enhance the safety of surgical procedures at the hospital. Nurse staffing was adequate to meet the needs of the patients and the vacancy rate was low. Theatre staff had been innovative in their approach to increase staff numbers.

Not all records were securely stored or adequately maintained. Staff understood their responsibilities to protect adults in their care but were not confident to report any concerns to outside agencies. 21% of medical staff posts were vacant in May 2015. This had resulted in increased locum medical cover with the highest use being in the urology speciality where 55% of medical cover was by agency staff.

Incidents

- There had been one never event at another trust site and information regarding this with necessary actions to prevent recurrence was displayed in theatre at this hospital. Never events are serious wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.
- There were 25 serious incidents reported across the trust in the surgical services division between May 2014 and April 2015 which included six cases of delayed diagnosis and four grade 3 pressure ulcers. All serious incidents were subject to an investigation using a root cause analysis approach.
- Incident reports for April and May 2015 showed the majority of incidents reported at Furness General Hospital were patient falls or skin damage, which had

Surgery

not developed into a graded pressure ulcer. Staff highlighted at shift handover if patients were a high risk for either of these occurrences and discussed the care required for prevention.

- Staff knew how to report incidents and said they were confident to do so.
- There was no record of what constituted an incident which should be reported unless a staff member had begun the process, when a menu was present in the computerised system. Staff were unclear if they should report specific events, for example cancellations of operations, as an incident. One senior staff member told us they did not report many incidents as they did not have many falls or medicine errors on the unit. This meant staff were unclear what should be reported as an incident which could result in lack of investigation and actions to prevent recurrence.
- Staff received feedback from incidents they had reported and learning from investigations were shared with staff at ward meetings, through e-mail and the monthly newsletter. Ward managers discussed incidents and learnings across the surgical services during their managers meetings.
- Theatre staff shared learnings from incidents during their staff meetings, through display of the incident log with actions and informally during the daily morning meetings.
- Mortality meetings did take place and plans were being developed to improve the process and outcomes. 73% of the case notes for patients who died were reviewed at the hospital wide weekly mortality review meetings in the first six months of 2015. The mortality review report in June 2015 identified that each division must hold mortality meetings at least monthly and have a robust system for sharing lessons learned. In order to do this more clinicians would need to be trained to review case notes.
- In the surgical division the anaesthetists were involved in the mortality meetings on a bi-monthly basis and formed part of the mortality review group which met quarterly.
- When recurrent incidents had occurred this had been recognised, investigated and actions put into place to prevent recurrence. Foreexample, there were 34 incidents relating to the administration of blood products in the surgical and critical care division of the trust between January 2014 and January 2015. A task and finish group was set up, an investigation completed and measures,

such as additional training, prompt cards and individual feedback was put into place. Long term measures to prevent recurrence included ongoing quarterly monitoring of performance were also set up.

- Senior staff we spoke with were aware of their obligations with regard to the duty of candour.

Safety thermometer

- Information about harm free care was displayed on boards at the entry to all wards and departments. These had been changed recently to provide more information for patients which included recent positive and negative comments with resulting actions, number of falls, required and actual staff numbers and infections such as MRSA and Clostridium Difficile.
- Between January 2015 and June 2015 there had been a decrease in the severity of harm caused by falls and pressure ulcers recorded on surgical wards within this hospital.
- Staff told us this information was used to inform them, during ward meetings and shift handovers, of any identified shortfalls in harm free care and changes to practices as a result.

Cleanliness, infection control and hygiene

- The wards, theatres and clinical areas were visibly clean and tidy.
- Cleaning schedules were completed and specific areas and equipment were subjected to spot checks for cleanliness, such as commodes. There were three recorded failures in the commode audit at Furness General Hospital in February 2015. A system was in place to ensure compliance with the required level of cleanliness, which involved staff training and increased monitoring.
- We saw staff wearing personal protective equipment which was available as required.
- Pre-operative screening for MRSA was carried out.
- Between April 2014 and February 2015, there had been seven avoidable cases in the surgical and critical care division at Furness General Hospital. On one ward there had been three cases in two months. This had resulted in additional information regarding control of this infection and hand hygiene being provided to all staff during the safety huddles. The physiotherapists and occupational therapists had been included in this to try to reduce the risks of infection.

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- Information from the 'Public Health England surgical site infection surveillance report' showed that over a period of four years, there had been no surgical site infections for hip or knee replacements.
- There were measures in place to separate patients who had undergone elective or trauma surgery. The day unit was used for elective patients and if a patient had an extended stay they would have a side room on the trauma ward.
- There were hand wash sinks and hand gel dispensers throughout the wards. There were signs at the hand wash sinks to remind staff how to properly clean their hands and we saw staff doing so.
- The trust hand hygiene audit in February 2015 showed 84% of staff throughout the trust were adequately washing their hands. This did not meet the trust's target of 90% and we were told additional spot checks had been introduced.

Environment and equipment

- The wards, clinical areas and theatres were suitable to meet the needs of patients and fit for purpose.
- The Elective Orthopaedic unit provided an environment away from the busy wards, with ten single en-suite rooms. The route to theatre from this unit was through waiting areas of the outpatient department. Staff were aware of the potential lack of privacy and dignity associated with this and if patients were able they could walk to theatre fully clothed. Where this wasn't possible staff discussed how they ensured the privacy and dignity of patients was protected. There were no alternative routes to theatre.
- Staff on the wards and in the theatres told us they had the equipment necessary to do their jobs. Theatre staff said there had been some rarely used equipment which was not specific to one of the trust sites but was used across all three sites. They said this had reduced as the need for some of this to be on site had been accepted by the managers.
- Records showed that equipment was serviced and maintained within the necessary timescales.
- Most of the resuscitation equipment had been checked on a daily basis with a full check of all equipment, including testing of items, done on a weekly basis. The day surgery unit had been closed for three days prior to our inspection and had re-opened on the day of our visit. On the 16 July 2015 the resuscitation equipment had not been checked since 12 July 2015.

- All equipment in the theatres had been checked on a daily basis.
- There was a dedicated paediatric recovery bay which had been appropriately decorated and had specific equipment for paediatric recovery.

Medicines

- We observed nursing staff safely administered medicines to patients. The identity of the patient was checked against the correct record, medicines were explained to the patient and consent was sought to give them their medicines.
- Medicines were safely stored including medical gases. Individual lockable storage was available for patients who wished to store their own medicines if this met with the risk assessment.
- Controlled drugs were safely stored and records were kept, including a daily check. Although it was documented in two consecutive dates in June that the controlled drugs were "not checked".
- Temperatures of cold storage were checked and recorded.
- The written policies and procedures for medicine administration, which were being used by staff at the time of the inspection, were out of date. However, the electronic versions were in date.

Records

- Not all records were adequately maintained to ensure patients' care could be clearly understood. We reviewed the records of 15 patients. These included nursing and medical records. We found that entries in five sets of notes were not legible or signed, others contained loose papers and, in the medical notes, there was no clear division to separate the latest episode of care from previous ones.
- Some records were stored securely in locked cabinets and others were easily accessible on top of desks and cupboards in open administration areas. In one ward the keys to the locked cabinet were left on a desk. This resulted in a lack of security for the confidential storage of patient records.
- For elective surgery the pre-operative assessment was recorded which included a detailed medical history, results of observations and examinations and a venous thromboembolism assessment. These were fully completed in the files we reviewed.

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- The operation records could either be handwritten by the surgeon or a printed copy could be obtained from the computer. When staff were asked if the notes of the operation were always available from the recovery area, so that the patient never returned to the ward without these being present, we received a varied response. Some staff told us they were always present others said they would print them off themselves once they returned to the ward. Whilst staff said they always got a verbal handover from the recovery staff, patients could return to the ward without recorded information about the procedure which had taken place or the medicines administered.
- The nursing records we saw contained comprehensive information which included: risk assessments for pressure ulcer prevention, mobility and nutrition with relevant plans of care, details of the assistance needed for personal hygiene and any specific communication issues with evidence of family involvement. Those we reviewed were up to date.

Safeguarding

- Staff we spoke with had received training in the recognition of abuse, the types which may occur and their responsibilities to report it. In the critical care and surgery division 92% of staff had completed safeguarding of adults and children to level one.
- Additionally the lead for adult safeguarding at the trust had completed more in depth training for 1800 staff members across the trust since December 2014. This included all grades of nursing and medical staff and they received information about abuse, domestic violence, and prevention of terrorism. External speakers attended this course and those staff we asked said it had enhanced their understanding.
- Despite this training, staff were unclear of the process to follow to report any concerns they had with regard to the protection of an adult. Those we spoke with, including ward managers, would report their concerns, using an incident form, to the safeguarding lead nurse for the trust. This nurse was available Monday to Friday 9am to 5pm with no one on-call outside of these hours. This meant whilst staff were aware of the need to raise concerns vulnerable people may not be protected in a timely way.

Mandatory training

- Mandatory training was delivered as a mix of e-learning and face to face training which staff said was adequate to meet their needs.
- We were told there had been issues of staff not being able to be released for mandatory training in the past, due to pressures of work; however this had improved.
- The majority of mandatory training in May 2015 was over 90% with exceptions being conflict resolution at 64% and resuscitation at 70%. This meant 73 staff members who may be required to provide resuscitation were not up to date with this training.

Assessing and responding to patient risk

- If the pre-operative assessment identified potential complications following surgery an admission from recovery to the patient progression unit would be planned. This unit provided a higher level of nursing support to patients with one critical care trained registered nurse to two patients.
- Theatre recovery and nursing records included an early warning score and these had been fully completed.
- Staff were aware of how to obtain medical assistance should a patient's condition deteriorate. Some staff raised concerns that in the evenings and weekends the resident medical officer, the only on site surgical medical support, could be busy in the emergency department or on other wards. However, they said they had not encountered delays which had put patients at risk.
- Medical staff said their assistance was requested in a timely way if a patient's condition was deteriorating and they were confident nursing staff monitored patient's conditions satisfactorily.
- In theatres, the 5 steps to safer surgery was used appropriately. Theatre managers monitored this by auditing 10 time out records monthly. In June 2015, 95% of these had been fully completed. Where they were not, individual discussions took place and practice was monitored to improve compliance.
- Some issues had been identified with the debrief sessions at the end of the theatre lists. Practice had been changed, with the debrief now taking place on closure to ensure all members of the team remained on site. This was being monitored to assess compliance.
- An additional safety step had been introduced in theatre where one representative from all the theatres operating that day attended a meeting at 10am. This was led by one staff member, who wore a red hat for the

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day so as to be easily identifiable as the co-ordinator. Issues discussed included staff absence, availability of scrub staff and any additional patient safety concerns. Plans were made for the day and records kept of these meetings. Theatre managers used these records to identify any themes arising which may require changes to systems.

Nursing staffing

- The NICE guidelines “Safe staffing for nursing in adult inpatient wards in acute hospitals” was used to establish the numbers of qualified staff required in each clinical area. We saw and records confirmed that the ratio of one nurse to eight patients was maintained with clinical support workers providing additional assistance.
- Staff talked readily about the “red rules” being used. This meant every day and at each shift change the numbers of staff in the wards was assessed against the needs of the current patient population to ensure their needs could be adequately met. This was overseen by the matron for that area who did several “walk rounds” per day to ensure they were aware of any changes.
- In the theatres the staffing numbers for theatre and recovery areas were discussed at the 10am meeting and staff moved between areas if necessary.
- The ward boards showed the numbers of staff which should be on duty and the numbers which were actually available. The wards we visited had the necessary numbers of staff on duty.
- There was a low vacancy rate for nursing staff with 1.4 whole time equivalent being required. Recent recruitment had been successful including overseas nursing.
- There had been no use of agency nursing staff on the surgical wards in May 2015.
- In February 2015, 22 apprentices in clinical healthcare started working at the hospital. It was hoped they would offer additional support to the nursing team and assist in the ongoing recruitment of permanent staff.
- In theatres there were 3.5 whole time equivalent vacancies and we were told recruitment and retention of staff was difficult. In May 2015, 6% of staffing in theatres had been provided by agency staff. Where possible there was consistency of agency staff who were familiar with the processes and procedures.
- Theatre managers had some innovative ideas for the recruitment of staff including visiting local colleges to aid understanding of the operating department

practitioners’ role, the use of cadets and the development of a training package for student nurses. They were also looking at ways to encourage their own clinical support workers to complete operating department practitioner qualifications.

- Comprehensive information was shared during the nurse handover we observed. This included the medical and social needs of the patients, any plans for surgery or discharge, and any ongoing issues including mental health and specific care required, such as increased observation. The information was shared in a confidential environment and in a way which showed respect for the patients.

Surgical staffing

- 21% of medical staff posts were vacant in May 2015. This had resulted in increased locum medical cover with the highest use being in the urology speciality where 55% of medical cover was by agency staff in May 2015. We were told recruitment was difficult due to the geographic location of the hospital. Some discussions regarding working across all three trust sites had taken place, but no clear plans were in place. One oncology consultant was due to return from long term absence which meant this locum use could decrease.
- Where possible the locum cover was provided by consistent staff that were familiar with the systems within the hospital.
- Daily ward rounds took place on all surgical wards in the hospital, this included weekends.
- There was a rota for consultants for all specialities within the surgical services. All specialities had a designated on-call consultant of the week, with the exception of urology where consultant cover on site was provided Monday to Friday 9am -6pm. On- call and weekend cover was provided with help of associate specialists, apart from a Friday evening which was covered by the team at Royal Lancaster Infirmary using the treat and transfer policy.
- There was a vacancy for an anaesthetist which had proved difficult to appoint. Recently three suitable candidates had applied and all three had been appointed with a view to trust wide working.
- There was a resident medical officer for surgery on site from 8.30pm to 8.30am seven days per week. Two doctors covered one week on and one off which we were told was acceptable to them as they did not work during the day. There was a junior doctor in the

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emergency department until midnight and one on the surgical wards until 9pm. Additional assistance could be provided from the resident medical officer for medicine who was on site at the same times. Should additional surgical support be required, for example in an emergency, there was a registrar on call who we were told attended within 10 to 15 minutes. An orthopaedic registrar was also available within 15 to 20 minutes. The clinical managers we spoke with said they had been concerned about the lack of medical cover for the surgical wards at the hospital, but the provision of the resident medical officer had reduced the risk. The trust confirmed this was an ongoing post.

- This resident medical officer was not included in any ward meetings or ongoing performance reviews or audits of practice. They did have a meeting with the surgical team every three months but said they felt isolated and would welcome being more included.
- Structured face to face or telephone handovers between the resident medical officer and each speciality doctor took place at set times each evening and morning.
- Nursing staff reported they had good and prompt support from medical doctors of all grades should it be required.

Major incident awareness and training

- Some staff we spoke with were aware of their part in a major incident. Others knew where the policy was held and how to access directions should it be required.
- Some staff had completed awareness training for issues such as the Ebola virus outbreak and felt assured that their managers and matrons would make them aware of any further information they required.

Are surgery services effective?

Requires improvement



Surgical services required improvement in terms of being effective. The written policies and procedures held on the wards for guidance had not been reviewed within the timescales documented. Not all staff were up to date with their appraisals and there was a lack of clarity about the support for newly qualified staff. The majority of staff were not clear about how the mental capacity of a patient impacted on their role and responsibility. Not all consent forms were correctly completed. Written consent was

routinely obtained on the day of surgery. Evidence was gathered for audit of care and treatment but the outcomes and resulting actions were not known to all relevant staff. Patients' pain was assessed; however there was no dedicated pain team. Re-admission rates were worse than the England average. Following a hip fracture patients were not seen by an ortho-geriatrician within timescales that were in line with national guidance.

Care pathways including pre-operative assessments and enhanced recovery were based on the relevant national guidance. Patients received adequate pain relief in a timely manner. Systems were in place to monitor the nutrition and hydration of patients, offer food and drink at all times and request assistance of professionals should this be required. There was participation in national and local audits. Not all clinicians and relevant staff were aware of the outcomes of these audits or changes needed to practice as a result. There were good examples of effective multi-disciplinary working.

Evidence-based care and treatment

- Staff were aware of the relevant local and national guidelines for their area of work. They said adherence to guidelines was discussed as part of ward meetings, speciality medical meetings and multi-disciplinary meetings.
- Whilst the written policies we saw referenced national guidance most of these had not been reviewed within the timescale documented on them. This meant there was potential for the guidance referenced to be out of date. Those we saw stored on the internal computer system were in date which meant there were two different policies in some instances.
- Clinical assessments such as the venous thromboembolism assessment met current guidance.
- There were clear pathways in place for the care of a patient whose condition had deteriorated. This included the option of two levels of enhanced care in the patient progression unit and critical care unit. Staff were clear about the assessment of patients both pre- and post-operatively to ensure they received the correct level of care.
- Pre-operative nurse practitioners were aware of the NHS initiative "Advancing quality" and measures were in place to adhere to this guidance.

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- The care of patients prior to and following elective knee or hip replacement followed the enhanced recovery guidance. This included pre-operative multi-disciplinary education classes.

Pain relief

- Pre-operative assessments of pain were carried out for all patients. Pain relief was prescribed to ensure there was no delay should a patient require this post operatively.
- The hourly assessment of patients included monitoring a person's pain by asking them for their own assessment. We observed pain relief was offered if patients stated they had pain.
- Patients said if they had requested pain relief they had received it quickly.
- There was no dedicated pain team; however staff told us they would have the assistance of anaesthetists should a patient require additional support for pain. There was one clinician with a lead for chronic pain in the trust. They provided support for other clinicians should this be required.

Nutrition and hydration

- Patients said the food they had was good, served hot and they had a choice. The food was served from a trolley by ward staff which meant patients could change their choice and request small or large portions.
- A patient group had identified that meals were not as good as they would have expected. A focus group was set up with clinical support workers, representatives from the catering department and a dietician. As a result the menus were to be changed.
- We saw the Malnutrition Universal Screening Tool (MUST) was in use on the wards. This had been completed, including the patient's weight and actions taken where necessary for example dietician input.
- There were new magnetic boards in place above each patient's bed. There were symbols to be used one of which indicated the patient required assistance to eat and drink. These were replicated on the menu. This meant staff knew the patient required help in a discreet way.
- There were "beverage stations" on the wards where staff could provide hot drinks and toast to patients who had returned from theatre. Patients said this had been provided at whatever time they had requested it.

- As part of the enhanced recovery programme patients were nil by mouth for as short a time as possible pre-operatively and offered a drink in theatre recovery and food as soon as possible, dependant on their operative procedure.
- Where it was necessary to measure fluid input and output these charts were in place and up to date.

Patient outcomes

- Staff we spoke with of all grades and in all wards and departments had the provision of positive outcomes for patients at the centre of their work. They discussed how they strived to make improvements through learning from shared practice with other centres of excellence and understand how they could continually improve the outcomes for their patients.
- Overall the trust was matching the improvement seen nationally in Patient Recorded Outcome Measures' (PROMs) and had a lower proportion of patients who reported an outcome worse than they expected compared to the England average.
- In the Hip fracture audit 2014 Furness General Hospital scored better than the England average for 6 of the 10 indicators. However the number of patients having a pre-operative assessment by a geriatrician was 5.8% in 2014 against the England average of 51.6%. We were told this was due to a lack of consultant geriatricians in the trust and was thought to be contributing to a higher than national average length of stay and poorer outcomes for patients.
- In the Lung Cancer audit 2014 the trust scored better than or similar to the England average in all 3 questions.
- The trust scored good for two indicators, and better than the England average for two indicators in the National Bowel Cancer audit 2014. The trust scored worse than the England average for "Seen by clinical nurse specialist".
- In the National Laparotomy Audit 2014 (NELA) 20 out of 28 measures at Furness General Hospital were not available. We were given data collected at Furness General Hospital for the 2015 National Emergency Laparotomy Audit (NELA). This showed several indications were better than the national average. One example was 80% of patients received a pre-operative

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review by a consultant surgeon and anaesthetist versus 58% nationally. Furness General Hospital was also one of the top 10 hospitals in the country for direct admission to critical care following emergency surgery.

- The average re-admission rates for trauma and orthopaedics, both elective and non-elective, were above the England average. This indicator had not been audited by the trust as part of their measure of outcomes for patients which meant they were not aware of the reasons for the re-admissions nor had actions to address this. When it had been identified as part of the data collection for this inspection a retrospective audit of records for three months between April 2015 to June 2015 was completed. 100 patients were re-admitted in that time with 23 being at Furness General Hospital. 33% of the trust wide admissions were as a result of the previous admission. An action plan was developed which included consideration of a rapid review for any patients re-admitted with an infection and a further analysis of 800 patients.
- Nursing and medical staff in theatres were aware of the audits which were ongoing in their department such as auditing the 5 steps to safer surgery checklist and the utilisation of the theatres. Some staff on the wards were aware of the audits ongoing in their immediate area such as hand hygiene and mattress audits; however they were unaware of the outcomes or any impact on their own practice. One ward manager said they were unaware of any other practices being audited, another told us they were unclear how outcomes of audits affected practice and a doctor told us they provided performance data but did not know what the outcome was. A medical staff member had presented the outcome of an audit regarding emergency laparotomy performance; however senior managers had not discussed this latest data with inspectors. This indicated that whilst practices and performance audits were taking place, the resulting information was not always shared with those clinicians whom it may affect.
- Information provided by the trust showed the day case rate to be 80% which did not reach the trust's target of 84% in May 2015.

Competent staff

- The trust's target for appraisal rates was 95%. Information we received indicated that it was met in only one of four staff groups. 73% of nursing staff in bands 1 to 7 were compliant and 83% of medical staff.

None of the three band 8a and above with staff responsibility had completed an appraisal. This meant not all staff were receiving an adequate opportunity to discuss their performance and development on an annual basis.

- The non-medical prescribers in the trust had set up a support group with meetings every three months. This gave them an opportunity to discuss any issues specific to their role and responsibility.
- A competency assessment for band 5 registered nurses was available which included assessments for administration of medicine, blood transfusions and discharge of patients. Despite this we were told by staff there was no formal preceptorship programme and one band 5 nurse had asked their manager for this support when they had started work. They did then attend a three day course and were given some written information. This meant there was a lack of clarity regarding the support provided for band 5 nurses and expectations of their competence.
- A ward manager told us they had set up a "buddy" system to help support new staff as the recent recruitment had led to an increase in new staff members. There was also funding made available for three qualified nurses to complete a mentorship course.
- Nursing staff told us they could access additional training and support if required. This could be for specific clinical issues or on a more general basis regarding practices and procedures. They said the senior nurses, ward managers and matrons were all visible and approachable and they were comfortable to seek assistance if necessary.
- The clinical director told us the re-validation process at the trust was well managed. Reminders for non-compliance were sent to the clinical director for follow-up. They said all staff members were re-validated.

Multidisciplinary working

- Staff on the wards described good support from physiotherapists and occupational therapists on at least a daily basis. We saw records from the multi-disciplinary team in patients' records so all staff could follow a patient's progress.
- There were trust wide multidisciplinary teams with established links with local speciality teams such as

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head and neck surgery and urology. Meetings took place as video conferences and were recorded with the outcome discussed at medical staff meetings and handovers.

- Staff of all grades discussed how there was good multidisciplinary working between them. This included ward meetings which were open to all grades of staff with an expectation they would attend or read the minutes and sign their understanding.
- There were specific clinics, such as the joint school for the education of patients who were to have a knee or hip replacement, which included nursing, physiotherapy and occupational therapy staff.
- The need for support from professionals such as dieticians was discussed at nurse handover.
- Staff and patients told us support from therapists to enable mobilisation as soon as possible following surgery was readily available.
- In the theatres all grades of staff worked well as a team. This approach was supported by the recognition for clinical support workers from qualified staff and their inclusion in projects and leading on the daily cross-theatre meetings.

Seven-day services

- Daily ward rounds took place on all surgical wards in the hospital. This included weekends when the resident medical officer would complete a ward round and contact the consultant if necessary for additional support or advice.
- There was some working towards a seven-day service such as operating theatres being used on Saturdays. Some of this was long term practice and some was to reduce the waiting times for patients. The additional services such as diagnostic imaging were available when the theatres were in operation.
- The day surgery unit was sometimes open at the weekends to reduce the waiting lists; however we saw that it had been closed recently due to a lack of consultant availability.

Access to information

- Medical and nursing staff said they had access to the information they required. They said the notes were almost always available for clinics and always for surgical procedures.

- We were told of some concerns that not all necessary information was available for patients who attended the one stop clinic. This was thought to be potentially an issue with triage where incorrect x-rays had been ordered by the GP during the initial referral process.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We looked at six consent forms for surgical procedures. There was incorrect or incomplete information in four of them. This included altered dates in two sections without the alteration being signed or dated, no contact details for the doctor obtaining consent and no record that the patient had accepted their copy. This meant the procedures for correctly recording consent prior to surgery were not being followed.
- Patients and staff told us the surgical procedure was discussed with them in advance of the surgery taking place. This could have been at an outpatient clinic or pre-admission assessment. Written consent was routinely obtained on the day of surgery. The Department of Health's "Reference guide to consent for examination or treatment" states: "If a person is not asked to signify their consent until just before the procedure is due to start, at a time when they may be feeling particularly vulnerable, there may be real doubt as to its validity". This meant, because patients' consent was routinely documented immediately prior to the procedure starting, the procedures do not meet with best practice.
- Staff we spoke with had completed some training with regard to the Mental Capacity Act and Deprivation of Liberty Safeguards which was included in the safeguarding mandatory training. We found a varied level of understanding of the implications on their role and responsibilities that would result from a patient's lack of mental capacity. Most staff could not explain when an assessment might be indicated, how it would be requested or who would complete it. This meant patients may not receive an appropriate assessment of their mental capacity or the support which may be indicated as a result.
- There was a similar lack of clarity with regard to Deprivation of Liberty safeguards and how and when these may apply.

Are surgery services caring?

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Good



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

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

Compassionate care

- We saw staff were kind, caring and considerate to patients. We were told staff were patient and polite. Patients described their experience as “good” and “excellent”.
- Staff attended to patients' requests for assistance promptly and patients said staff were consistently helpful.
- We saw staff protect the privacy and dignity of patients on the wards and in all departments.
- Information from the May 2015 national friends and family inpatient survey showed an average of 97% of patients would recommend the surgical wards at Furness General Hospital. This was better than the national average of 95%. The average response rate for surgery within this hospital was 70%.

Understanding and involvement of patients and those close to them

- Patients told us staff had spent time explaining procedures to themselves and their family members, including when other specialists needed to be involved.
- One patient explained how a surgeon had used diagrams to explain a procedure and provided time for them to ask questions.
- Patients spoke highly of how staff had spent time with other patients with communication difficulties to offer them choices and help their understanding.
- Staff told us any patients with additional needs for support, such as dementia, could have a family member with them as much as they required.

Emotional support

- Staff told us emotional support for patients was provided by the chaplaincy service and any staff who felt able to offer this.
- There were no specialist support nurses for emotional or psychological support. There was a nurse who specialised in supporting patients who had limb amputations; however the vascular service is not now provided from the hospital and this service has ceased.
- There were no recorded assessments for anxiety and depression in the files we reviewed. Relatives and patients told us staff had recognised when someone was low in mood and had responded well to address their concerns.

Are surgery services responsive?

Requires improvement



Surgical services at this hospital required improvement to be responsive. The referral to treatment times for patients admitted to the hospital were worse than the England average; however trust wide initiatives had been launched to reduce these and improvements had been made. Surgical procedures were sometimes cancelled at short notice; procedures were in place to ensure patients were rescheduled as soon as possible (within 28 days).

There were services available to reduce the numbers of visits needed for patients who had to travel long distances to the hospital. There were one stop minor operation clinics to enable patients to attend once to have their consultation, pre-operative assessment and small surgical procedure completed. Joint working arrangements with other local centres of excellence were in place. Services were in place to assist patients with complex needs and communication problems. Additional support from carers for patients with complex care needs was welcomed onto the wards. Arrangements would be made, if possible prior to admission, for family members or carers to be present with the patient. Learning from complaints was shared with staff.

Service planning and delivery to meet the needs of local people

- Managers and staff were aware that the population who attended the hospital could live a long distance from

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the hospital due to the largely rural location. Services such as the one stop minor operation clinic were partly designed to assist patients in that they could visit once to have their consultation, pre-operative assessment and small surgical procedure completed.

- Staff on the wards discussed how they would assist visitors by allowing additional visits or those outside of normal visiting times should their distance from the hospital or difficult transport links necessitate this.
- Joint working arrangements with local specialist centres, for example the cancer specialist centre, meant support would be obtained through multi-disciplinary meetings to ensure where possible the patient did not need to visit hospital sites in another geographical area.

Access and flow

- Information provided by the trust showed that in March 2015 all seven of the surgical specialities monitored were not meeting the referral to treatment target of 90% in the admitted pathway. This was in line with the national amnesty on the admitted standard to fail the standard by prioritising the treatment of the longest waiting patients. Orthopaedics had succeeded in treating the greatest proportion of the longest waiting patients at 43.2% against the admitted standard and Oral Surgery the least at 82.8%. Measures had been put in place to further improve this position. These included changes to the waiting list management, use of local independent hospitals, assessing theatre utilisation, re-assigning sessions to increase availability for the longest waiting patients and providing additional operating lists at weekends. This had reduced the number of patients waiting in excess of 18 weeks, across the specialities, from 1091 in January 2015 to 712 in July. However, following this amnesty the trust continued to not meet the referral to treatment target of 90% in the admitted pathway. In April 2015 it was 70%, May 2015, 90% and June 2015, 77%.
- Measures to continue to reduce the waiting times included commissioning additional external private companies to complete procedures, introduce seven-day working and utilise the theatres more fully in all three trust sites. Theatre usage at Furness General Hospital had increased in five of the six theatres between January 2015 and March 2015.

- Changes to the management of the waiting list meant those had been waiting longest were now being offered the quickest appointments. This meant fewer patients were waiting extended periods.
- In June 2015, 63 operations were cancelled on the day with 17 for non-clinical reasons. All of these met the guidance of being offered an alternative date within 28 days.
- The process for admission varied dependent on the speciality and surgical procedure. Where possible admission was on the day of surgery with a pre-operative overnight stay only being used when additional preparation was required.
- In June 2015 the average length of stay trust wide for non-elective admissions was 5.11 days, which was slightly above the trust's target of 5 days. In the elective day surgery unit at Furness General Hospital an extended stay was classified as over four days. This was not audited to assess compliance with this target.
- NICE guidance states that patients admitted following a hip fracture should be operated on the day of or after admission. Data in 2014 showed that 76.9% of patients admitted to Furness General Hospital following a hip fracture were operated on the day of or day after admission which was better than the England average of 73.8%.
- A monthly audit of immediate discharge summaries had been carried out. The information for March showed the summary had been completed within 24 hours of discharge in 91% of patients which was an increase on 86% in February. They were not meeting the targets set by Cumbria CCG which was 95% or Lancashire CCG which was 100%.
- Surgical patients being cared for on a medical ward was an unusual occurrence at the hospital. There had been one recorded episode in June 2015.

Meeting people's individual needs

- Staff told us additional support from carers for patients with complex care needs was welcomed onto the wards. Arrangements would be made, if possible prior to admission, for family members or carers to be present with the patient.
- Staff in the day surgery unit and those who completed pre-admission assessments said translation services

Surgery

would be used to complete consent for surgery if this was necessary for people for whom English was not their first language. This was usually language line but face to face translators could be accessed if required.

- Other communication needs would be assessed and additional aids such as picture formats could be accessed if required.
- There was a discreet trust wide system for the identification of a patient with dementia who may require additional assistance. We saw this in use on the wards, along with information boards for families and friends of patients with dementia, to inform them of the additional support available.
- At the staff handover nurses discussed the specific approach needed for interventions with a patient who was dis-orientated and another with diagnosed mental illness. This showed there was a holistic approach to care which included the mental and emotional needs of the patients.
- The written information for patients was all in English. Staff said they could get leaflets in other languages if they needed to, but did not keep any and had never done so.
- On one ward an area had been identified to make into a sitting room. This would be specifically useful for mobile patients who found it difficult, due to cognitive impairment, to follow directions not to walk alone. They could do so in a more uncluttered environment and with additional staff supervision to reduce the number of falls.
- We were told recruitment had taken place to appoint a trust wide nurse lead to advise on the care of patients with a learning disability. This nurse would assess the current provision for support and plan for improvements where necessary.

Learning from complaints and concerns

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

Are surgery services well-led?

Good



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

Risk register reports provided by the trust did not include details of actions taken to mitigate risk. However, the trust told us they use a live electronic risk register that includes all mitigating actions, status and progress history. There was an open culture where staff could discuss concerns with appropriate people. Staff told us they felt included in the development of services and could make suggestions for change, especially in the operating theatres.

Vision and strategy for this service

- The knowledge of the vision for the trust varied between the staff we spoke with regardless of their grade. Some were aware of the vision and how it affected their work, others were not.
- All staff we spoke with shared the vision of improving the patient experience within the surgical services. This included improving the patients' journey through the service, becoming more financially aware, increasing activity and enhancing their own learning to improve patient care.
- There was an enthusiasm from all the staff to provide the best care and find new ways of doing this. The staff in the operating theatres were particularly driven to provide a better service.

Governance, risk management and quality measurement

- The ward managers had monthly meetings in order to discuss hospital wide issues, learn from each other and share lessons from incidents and complaints.
- The surgery and critical divisional governance assurance group met on a monthly basis to review incidents, risks and complaints.

Surgery

- Risk register reports provided by the trust did not include details of actions taken to mitigate risk. However, the trust told us they use a live electronic risk register that includes all mitigating actions, status and progress history.
- Staff in specific wards and departments were aware of the risks in their area and measures in place to reduce them. This included: increased observation in bays, by the addition of administration desks to reduce falls and change of timing of debrief in theatres, to reduce the risk of unsafe closure of the operating list.
- The quality assurance matron had been appointed to the trust wide corporate governance team. They discussed how they had spent at least two days per week at the Furness General Hospital site to discuss the quality of care, with particular focus on the ward accreditation schemes. This had been based on similar schemes in other hospitals which had been visited and involved rated quality assessments which led to an overall accreditation for wards which maintained the highest standard for three assessments. The specific assessments were designed to encourage team work as they included varied care and support themes. This showed a focus on continued quality improvement.

Leadership of service

- It had been recognised through discussions with staff that some grades needed to have leadership training. An external trainer was being used and 120 band 6 and 7 nurses across the trust had completed this training. One we spoke with said it had helped their understanding of the management of services and staff and working as a team.
- Staff said their managers provided clear direction, were approachable and supportive.
- All grades of staff spoke highly of the matrons. Comments included that they provided a good link to the operations managers and they were visible and approachable providing practical support when necessary.
- Additional leadership posts in the surgical services included a matron for theatres who would work across all the trust sites. This was seen as a very positive move by all the theatre staff we spoke with who said it would increase the visibility of the trust wide management team for them. This post had been created as a direct result of a review of the theatre working at the trust.

Culture within the service

- Nursing and medical staff we spoke with discussed how they wanted to keep improving the service. Discussions shared a common theme of learning from other trusts.
- There was an open culture with a willingness to accept complaints and incidents as an opportunity to learn and improve practice. There was a willingness to accept the need for change as long as it was focussed on the care of the patients.
- We found the culture at Furness General Hospital to vary from that at the other two trust sites in that there was more enthusiasm for learning and change. This included sharing experiences and practice issues with colleagues from the other trust sites.

Public engagement

- A patient focus group had been set up by the engagement manager to develop new menus and systems for ordering and delivering food to the wards. This group had been set up with volunteers and met monthly until the project was completed.
- Feedback forms were available on the wards and departments we visited with post boxes for patients and visitors to leave them. Patients told us they were actively encouraged to complete these.
- Informal feedback from patients was sought and we observed staff to be asking patients' opinions about various aspects of the service they provided.

Staff engagement

- Staff told us they felt as though their opinions about the specific ward or department they worked in was sought and they could make suggestions for change which were listened to.
- A series of "away days" had been organised where staff attended separated into the various bands. These were designed to engage staff in governance issues, discussing practices across the three trust sites and suggesting changes. To date 96 staff had attended these workshops. Staff told us they had enjoyed them and found the discussions helpful.







Innovation, improvement and sustainability

Surgery

- Theatre staff had visited other trust sites to observe their practice in order to make improvements to systems. One such visit had resulted in coloured hats being used to identify the varied roles in theatre, with boards visible which helped patients understand this colour coding.
- There was recognition that should practice differ at this trust site from the other two there was no need for

conformity so long as the outcome for patients was good. This meant there was opportunity for staff at Furness General Hospital to suggest changes which could be implemented without needing to go through a prolonged approval process. This had happened with ward information boards and theatre practices.

Critical care

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

Information about the service

The critical care unit at Furness General Hospital was commissioned to provide six beds in total; three level 3 and three level 2 beds, which were used flexibly as the service demanded. We were informed that the unit had occasionally accommodated six level 3 patients. The facility included two side rooms, which were used for the isolation of patients with a specific infection control issue. ICNARC data indicates that the unit has around 350 admissions per year. At the time of our inspection the unit had three empty beds.

Since the inspection in February 2014, the trust had reconfigured some of its critical care provision so that the only formally commissioned level 2 and level 3 beds were in the intensive care unit itself. Patients requiring a higher level of care than the general wards were able to provide, were now cared for in either the eight bedded complex and coronary care unit (CCCU) or the four bedded patient progression unit (PPU). We saw that the CCCU was medically led and the PPU was surgically led. These areas also operated as 'step down' facilities for patients discharged from the intensive care unit but who still needed a higher level of care than the general surgical or medical ward could provide.

The unit sat in the surgical and critical care division of the trust. During the inspection, we spoke with two medical staff, six members of the nursing team, one patient and two sets of relatives. We also reviewed patient records, policies, guidance and audit documentation.

Summary of findings

Following the last inspection in February 2014, overall, the critical care service provided at the Furness General Hospital required improvement with safety being of particular concern. We judged safety at that time as inadequate due to the staffing levels and skill mix in the then combined coronary care and high dependency unit. In addition, we had concerns about the medical leadership in critical care which at that time had no named consultant lead. These concerns were reported to the trust executive team at the time and steps were taken to ensure that the staffing levels on the combined HDU/CCU matched patient acuity.

There was a lack of clarity regarding the level of care patients staying in the PPU and CCCU required. From our observations and interviews with staff it was clear that both areas did look after patients that were classed as level 2 using the recognised critical care minimum data set acuity assessment. During our interviews, the surgery and critical care divisional management team clearly told us that the only funded level 2 beds were the two in the intensive care unit. The PPU and CCCU were not contributing to the submission of ICNARC data by the hospital. We had no concerns in those areas about the appropriateness of the nurse staffing numbers and skill mix to care for level 2 patients.

At this inspection we have similarly judged overall that the critical care service provided in the intensive care unit required improvement in the specific areas of safety and responsiveness.

Critical care

There were sufficient numbers of suitably skilled nursing staff to care for the patients. However, there was no commissioned supernumerary nurse on duty and the unit did not have any funded practice educators in post. There was access to a consultant and middle grade anaesthetist at all times, although 'out of hours' the on-call anaesthetist had responsibilities for other specialities; such as maternity, theatres and accident and emergency. On the day of our inspection we witnessed a delay in a deteriorating patient receiving timely medical interventions as a consequence of poor communication between medical shift handovers. This was raised with the trust at the time. Despite the recent addition of more storage rooms on the unit corridor, the clinical area had limited space and fell short of the most recent health building note specifications (HBN-04-02). There were no clearly defined plans available for how this shortfall was to be addressed. We found that drugs and intravenous fluids were not always stored securely.

When people required intensive care, there were no significant delays in that care being delivered; however, there was often a delay in discharging patients once they had been judged as medically fit for discharge. This often also resulted in a breach of the Department of Health's single sex accommodation standard. Additionally, there were occasions when owing to capacity and bed availability, patients requiring critical care were looked after in the theatre recovery area. We saw that it was not uncommon for those patients being cared for in recovery to be at level 3 in terms of their acuity.

Intensive Care National Audit and Research Centre (ICNARC) data showed that patient outcomes were within the expected ranges when compared with similar units nationally. The unit was a member of the Lancashire and South Cumbria Critical Care Network (LSCCN). The unit did not provide a formal commissioned outreach service. There were robust systems and processes in place for reporting incidents and there was evidence that learning from incidents was shared. We saw that critical care was being delivered by caring, compassionate and committed nursing staff. We saw patients, their relatives and friends being treated with dignity and respect.

Are critical care services safe?

Requires improvement



There were sufficient numbers of suitably skilled nursing staff to care for patients. However, there was no commissioned supernumerary nurse on duty and the unit did not have any funded practice educators in post. There was access to a consultant and middle grade anaesthetist at all times although 'out of hours' the on-call anaesthetist had responsibilities for other specialities, such as maternity. On the day of our inspection we witnessed a delay in a deteriorating patient receiving timely medical interventions as a consequence of poor communication between medical shift handovers. This was raised with the trust at the time. Despite the recent addition of more storage rooms on the unit corridor, the clinical area had limited space and fell short of the most recent health building note specifications (HBN-04-02). There were no clearly defined plans available for how this shortfall was to be addressed. We found that drugs and intravenous fluids were not always stored securely.

Not all the medical and nursing records that we examined had entries that were dated, signed and indicated the author's GMC or NMC (professional registration) number.

Incidents

- Incidents were reported using an electronic system; all the staff we spoke with were familiar with the system.
- All incidents were reviewed and their details collated and presented at the weekly divisional management meeting/patient safety summit and the monthly divisional governance meeting. This enabled emerging trends to be monitored and the effectiveness of interventions tracked. For example, Section 4.2 of the March 2015 divisional governance and assurance group meeting minutes stated that there have been 64 reported blood transfusion errors in the year to date for the trust. Subsequently, a cross-divisional working group had been established to focus on root cause and improve compliance in this area. All staff failing to undertake the transfusion process received a letter from their divisional clinical lead and associate chief nurse.

Critical care

- We saw a range of methods used to share learning both trust wide and from within the unit. These included newsletters, patient safety group and staff meetings and shift handover notes.
- Mortality and morbidity discussions were held at a number of meetings, at least monthly and it was the role of the divisional governance lead to ensure that learning was shared within the division. Links between mortality and the quality of care provided in hospitals has been shown to have an inverse correlation; the higher the mortality, the lower the quality of care. The trust held a quarterly mortality and morbidity review meeting in order to monitor consistency of approach to divisional management of mortality and morbidity.
- Staff understood the concept of duty of candour and reference was made to duty of candour discussions with patients and their families in the actions sections of the risk register.
- The clinical area was generally clean, although the storage areas were at times untidy with boxes of stores and fluids stored on the floor. These store rooms also had locks but were found to be open.
- In the small domestics' room we found mops left in buckets of dirty water.
- The unit was aware of a pseudomonas risk and this was on their risk register. This had been identified previously in a hand washing tap. The taps were changed and equipped with a 'filter'. The domestics also had a schedule where the taps were run 2/3 times per day and the trust estates department sampled the water regularly. The staff also incorporated a raft of measures such as not using the risky taps for patient washes and increasing the hand gel usage. However, we noted on entering the unit by the locked outer door/ intercom system that there were no hand gel dispensers or hand wash sink; the nearest gel dispenser being by the doors into the patient area itself. During our visit, we observed staff entering the ward/patient clinical area without applying anti-bacterial gel to their hands.

Safety thermometer

- We saw that safety thermometer information was collected and available, although it was not displayed at the entrance to the unit.
- Safety thermometer information for January 2015 to June 2015 indicated that the unit had no pressure ulcers; catheter acquired urinary infections (CAUTIs) and venous thromboembolism (VTE). There had been 2 falls recorded during the same time period.

Cleanliness, infection control and hygiene

- The trust had infection prevention and control policies in place which were accessible to staff.
- Hand hygiene audits and compliance with aseptic non-touch techniques (ANTT) were audited monthly and the results produced both graphically and numerically to show performance against trajectory. For the year 2014/2015, hand hygiene competency was measured overall at 88% against a trajectory of 90%. For ANTT, the overall average competency for the same period was 82% against the trajectory of 90%. (It should be noted that these figures represent performance across the surgery and critical care division).
- Personal protective equipment was available for staff and we saw it being used appropriately. Staff adhered to the 'bare below the elbows' policy that was in place. There were sufficient hand washing facilities and antiseptic gels.

Environment and equipment

- Entrance to the critical care unit was controlled by a key pad and intercom system.
- There was a small relatives' room available just outside the unit entrance.
- The main clinical area held six patient bays; two of which were housed in side rooms. The side rooms did not have double doors with an air lock or have the facility for positive or negative pressure air flows. They were used however to isolate patients with infection control issues. Each bed space was capable of managing a level 3 patient.
- The environment currently fell short of the latest building specifications (HBN -04-02). The divisional business strategy included reference to locating all the hospital's high dependency and critical care facilities on one floor, providing the funding is available. However, at this stage there was no firm date for this to happen with staff telling us anything from 18 months to five years.
- We saw resuscitation equipment (adult and paediatric), including defibrillators and difficult airway management trolleys that were all checked daily.
- We also saw the recently acquired Ferno transfer trolley being replenished and re-checked after overnight use.

Medicines

Critical care

- Allergies were clearly documented in the prescription records that we looked at.
- Medicines, intravenous fluids and controlled drugs were stored in an open room behind the nurses' station.
- Controlled drugs were stored in a locked double cupboard, with the keys held by any of the registered nurses on duty. We were told that the stocks were reconciled every 24 hours by the night staff and not on handover between the shifts.
- At the time of inspection, we found that not all drugs were securely locked away. There were glass doors to the medicine storage areas that had locks but we saw and were told that they were 'never' locked. The temperature of the fridge was being monitored.
- Boxes of fluids were also stored on the floor in store room one. This room was also left open, although it did have a keypad lock in place.

Records

- The unit used paper based records, which were completed by the multi-disciplinary team. They contained a range of risk assessments and care bundles which were generally completed, legible and up to date. For example, pressure sore scoring tools and delirium risks. However, not all entries in the nursing and medical records were dated, signed and indicated the author's GMC or NMC number. In some cases we saw that the staff member used a stamp alongside their signature, which gave the required detail, though the use of the stamp was inconsistent.
- Physiological observations and prompts for care and treatment were recorded on a large intensive care record sheet at the foot of the bed space.
- Where appropriate, patent diaries were being trialled.

Safeguarding

- The unit did take children for stabilisation prior to their retrieval and transfer to a specialised children's hospital.
- There was an internal system for raising safeguarding concerns and staff were aware of the process and could explain what constituted abuse and neglect.
- Safeguarding training formed part of the unit's mandatory training programme. We saw that staff received safeguarding training for both adults and children.
- At the time of inspection we saw records to indicate that 99% of the staff had received training in safeguarding

adults level 1, with a further 85% having completed level 2. So far as children's safeguarding was concerned, again 99% had completed level 1 and 85% had completed level 2.

Mandatory training

- Continuous records were kept of mandatory training. These were reviewed and reported on at the monthly Divisional Governance and Assurance Group meeting.
- Training was identified as a risk and was on the divisional risk register along with a series of actions being implemented to mitigate the risk. For example, an increase in the number of key trainers. The training topics with the worst levels of completion were for fire safety (67%) and moving and handling module D (65%). Other areas demonstrated a much higher completion percentage: equality and diversity (98%), health, safety and welfare (98%) and infection, prevention and control (99%). Resuscitation training recorded an overall completion figure of 84% though the data showed a lower number of medical staff had completed basic life support training as opposed to nursing staff.

Assessing and responding to patient risk

- The unit did not provide any formal critical care outreach. However, staff told us that wherever possible, they did visit and review patients within 36 hours of their discharge from the unit. Additionally, staff on the unit initiated a conference call at 11.30 each morning to include both the PPU and CCCU units to discuss their patients. This helped to better understand and facilitate the likely bed availability and possible patient moves for that day.
- The ward areas used a 'Physiological Observation Track and Trigger tool' (POTTS). This chart was designed to collect routinely charted vital signs and observations alongside an integrated early warning system.
- We also spoke with representatives of the resuscitation team who told us that the hospital contributed to the national cardiac arrest audit. They also reported a weekly audit of POTTS charts, which showed a reduction in cardiac arrests of 30% across all three trusts sites in the January to March 2015 period. A number of associated initiatives were also cited as contributing to this reduction such as absolute minimum four hourly observations and the introduction of manual sphygmomanometers in ward bed areas.

Critical care

- The patients' records contained a range of clinical risk assessments. For example, venous thromboembolism, moving and handling and visual infusion phlebitis (VIP) assessments.
- Follow up clinics were offered to patients two to three months after discharge from critical care when they had experienced an extended stay or been subject to artificial ventilation. This attendance included psychology input.
- We were told by staff that on occasions, there were delays in getting 'out of hours' medical assistance as the on-call doctors had to cover other areas within the hospital such as maternity, theatres and accident and emergency.

Nursing staffing

- The Intensive Care Society standard for patient acuity was used to determine the number of staff required.
- On the day of inspection, there were adequate numbers of suitably skilled and qualified nursing staff on duty to ensure that patients received safe care and treatment.
- On the day of inspection, three patients were being cared for on the unit.
- We saw that the unit was not funded to provide a supernumerary clinical co-ordinator (band 6/7) on duty 24 hours per day as per the Intensive Care Society standards. On the day of inspection this was made possible as the two ward managers were able to assist clinically on the unit if needed and the patient numbers were low.
- The trained nurses were supported on shift by both clinical and non-clinical support workers.
- There were no funded practice educator posts within the unit's nursing establishment. These posts are used to co-ordinate the education, training and CPD framework for critical care nurses.
- We saw that there were two shift handovers per day and in addition, a sister to sister handover took place to include any non-clinical issues.
- We saw that agency nursing staff were rarely used. Any additional shifts were first of all put out to the existing and/or bank staff. A text reminder service was used to quickly inform staff of available shifts.
- Additional shifts were often needed when capacity meant that patients were looked after in theatre recovery. These occasions were always raised as a

moderate incident and records showed that this had happened 20 times since July 2014, thirteen of which had been in the last four months. Nursing staff told us that it had been particularly busy in recent weeks.

- We were told there had been occasions when there had been six level 3 patients on the unit and only five registered nurses on duty. We were told that on such occasions the staffing was 'unsafe'.
- We were told there were no plans to develop the advanced nurse practitioner role.

Medical staffing

- The unit had a named clinical director.
- The unit operated with a named consultant for a period of 24 hours. The consultant responsible for the unit then changed each day. This arrangement did not lend itself to the same levels of continuity that having a consultant on for five days would provide.
- Consultant to patient ratio was normally no more than 1:6 which was in accordance with the Intensive Care Society standard.
- The consultant was supported occasionally during the day by a foundation year two (FY2) doctor.
- We were told that there should be a daily ward round at 09.00. On the day of our inspection, the consultant coming on duty received no initial handover and the trainee doctor who was on duty according to the rota did not arrive. This resulted in a delay in treatment to a patient who was deteriorating. The consultant on duty eventually rang the consultant from the previous day at home to establish the clinical details of the patient on the unit. This issue was raised with the trust at the time of the inspection.
- We were told that the consultant(s) of the day undertook a second ward round during the day but this was not always documented.
- Out of hours there was a consultant on-call. The first on-call, 'out of hours', was a member of the anaesthetic team who also had responsibilities for other areas in the hospital such as maternity, theatres and accident and emergency. This could lead to a delay in staff being able to obtain timely medical assistance 'out of hours'. This could potentially then result in a delay in an intensive care patient receiving treatment. A third trainee doctor was also on-call for the management of any out of hospital patient transfers.

Critical care

Major incident awareness and training

- Major incident and business continuity policies and protocols were in place and readily available.
- We did not see any evidence to demonstrate that the major incident plan had been practised.
- Not all the staff we spoke with were aware of the location of the major incident files.

Are critical care services effective?

Good



The unit continued to collect and submit data for the Intensive Care National Audit and Research Centre (ICNARC) for validation, so it was able to benchmark its performance against comparable units. This data showed that patient outcomes were generally within the expected ranges when compared with similar units nationally. The exception being for delayed discharges where the unit's performance was slightly worse than the England average. Care was delivered in line with evidence-based, best practice guidance, such as NICE guidance. There was a commitment to clinical audit and evaluation.

The trust was also part of the Lancashire and South Cumbria Critical Care Network (LSCCCN) and so worked with other stakeholders (acute trusts and clinical commissioning groups) with a commitment to sharing and promoting best practice in critical care services.

Evidence-based care and treatment

- The unit used a combination of national and best practice guidance to determine the care they delivered. These included guidance from the Intensive Care Society and the National Institute for Health and Care Excellence (NICE).
- The unit demonstrated continuous patient data contributions to ICNARC. This meant the care delivered and mortality outcomes for patients were benchmarked against similar units nationally.
- The unit was also subject to an annual peer review by the LSCCCN. The purpose of the review was to demonstrate evidence at unit level of the range of standards applicable to critical care as outlined in their service specification.
- Following the last LSCCCN review in November 2014, it was 'recommended' that the unit required a

rehabilitation lead to facilitate the effective development and implementation of rehabilitation documents such as 'NICE CG 83 Rehabilitation after Critical Illness' and 'NICE CG 103 Delirium'.

- We saw that there was a trust wide and departmental audit programme. The unit had a quality improvement lead (QIL) in post. The additional responsibilities for the clinical leader in post were overseeing the audit programme and looking at service improvements. Audit activity included the weekly collection of high impact intervention (HII) data that was then sent to the LSCCCN. Reports and lessons learned were then shared by the network. For example, the unit had been able to introduce a sling technique for the securing of naso-gastric tubes which had reduced the numbers of related pressure ulcers. Another aspect of the QIL role was the oversight and reviewing of policies.
- There was a range of local policies, procedures and standard operating protocols in place which were easily accessible through the trust wide intranet.

Pain relief

- There was access to the pain management team for support and guidance during the week.
- As part of their individual care plan all patients in critical care were assessed in respect of their pain management. This included observing for the signs and symptoms of pain. Staff utilised a pain scoring tool and analgesic ladder.
- We saw that epidurals and patient controlled analgesia systems were used in accordance with trust guidelines.

Nutrition and hydration

- Guidelines were in place for initiating nutritional support for all patients on admission to ensure adequate nutrition and hydration. Nutritional assessments were undertaken within six hours of admission.
- Nutritional risk scores were updated and recorded appropriately in the patients' notes.
- We saw strict fluid balance monitoring for patients, which included hourly and daily totals of input and output.
- The unit had access to a dietetic service in the week, although there was no dietetic service available during the weekend.
- Some attempts were made by the dietetic staff to attend ward rounds but this was not always possible.

Critical care

- We were told that nursing staff on the unit undertook patient swallowing assessments post intubation, as speech and language therapist input was only available on Wednesdays.

Patient outcomes

- The results from ICNARC showed that patient outcomes and mortality were within the expected ranges when compared with similar units nationally.
- The most recently verified ICNARC data that we saw (for the period April 2013 to March 2014) showed the following outcomes:
 - Hospital mortality was slightly worse than the England average.
 - The figures for unit acquired MRSA and infections in blood were in line with the England average.
 - The number of unplanned readmissions to the unit within 48 hours was better than the England average.
- The unit did not provide a formal outreach service for its patients though did endeavour to visit all discharged patients within 36 hours, providing they remained in hospital at that point. Minutes of the cross-bay critical care delivery group meetings showed that the percentage of patients transferred from critical care but who were still in hospital after 36 hours had increased from 30% in February 2015 to 71% in May 2015. This had a knock on effect on the unit staff to make sure that they were able to follow up their discharged patients in a timely manner.
- The unit participated in a range of national audits such as ICNARC, ICBIS (adult critical care transport audit) and the national cardiac arrest audit.
- At the time of the inspection, there were no outlying critical care patients. However, during the period July 2014 to June 2015, there had been 20 patients managed in the theatre recovery as an overflow from critical care. The trust was undertaking some work going back to 2009 to better understand the implications for all involved when patients ended up staying in recovery for longer than was planned. The current trust critical care admission, discharge and operational policy states that: 'ventilation of patients in recovery should only be undertaken in exceptional circumstances'.
- We were told that the patients cared for in recovery as 'outliers' were often level 3 patients, which was different to the response we had at the Royal Lancaster Infirmary

where we were told that outliers were more commonly level 2 acuity patients. We understood that the whole issue of outlying critical care patients was subject to a 'listening in action' scheme.

Competent staff

- The unit did not provide a practice development/educator in place to support staff and facilitate bed side teaching.
- Nursing staff received an annual appraisal. By March 2015, divisional records showed that 88% of nursing staff (bands 1-7) had received an appraisal in the last 12 months. The figure for band 8a upwards was also 88%. Trainee medical staff stated that they were well supported and had an appraisal and re-validation process in place with good opportunities for training. The March 2015 divisional figures showed that 86% of medical staff had received an appraisal in the last 12 months.
- All nursing staff were subject to an annual check of their registration with the Nursing and Midwifery Council.
- We saw that more than 50% of the registered nurses working on the unit had a post registration qualification in critical care.
- All band 6 nurses had the opportunity to complete advanced life support training (ALS) and all nursing staff completed paediatric intermediate life support (PILS) with some senior staff also having undertaken the European paediatric life support training (EPLS). We were told that staff completed their ALS as this gave them improved competencies in caring for patients when there might be a delay in getting appropriate medical assistance in a timely manner 'out of hours'.
- New staff to the unit were given a period of four weeks supernumerary status and were given the critical care 'step 1' competencies to work through. Step 1 competencies have been designed to provide the core competencies required to look after an adult critical care patient. This falls short of the six weeks as a minimum supernumerary status recommended by the intensive care society.
- We were informed that not all consultants working in the unit were yet fellows or associate fellows of the faculty of intensive care medicine.

Multidisciplinary working

- Multi-disciplinary ward rounds did not take place every day. It was not always possible for the ward round to

Critical care

include pharmacy and dietetic input in person. We were told that the physiotherapists did not attend the ward round but had a hand over from the nursing staff when they attended, which was twice a day, seven days a week.

- On the morning of our inspection, no formal ward round took place.
- We heard that there was, at times, pressure on the unit to take patients when it would mean the overall patient acuity was then greater than the numbers of staff available to care for them in accordance with the desired nurse: patient ratio.
- The critical care admission, discharge and operational policy detailed a number of multi-disciplinary arrangements both internal and external for the management of their patients. These included the frequency of patient team reviews and for the transfer of patients both within the LSCCCN and beyond to the wider networks should this be required.
- The unit did not provide a formal outreach service although every attempt was made to follow up discharged patients within 36 hours.

Seven-day services

- A consultant anaesthetist/intensivist was available seven days a week including 'out of hours'.
- Dietetic and pharmacy services were available Monday to Friday and by on-call at weekends. The physiotherapy team provided a seven-day a week service to the critical care unit.
- Imaging and diagnostic services were provided during the working week and then by on-call 'out of hours' and at the weekend.

Access to information

- The critical care unit used a paper based record system which was accessible at the patients' bedside. This enabled consistency and continuity of record keeping whilst the patient was on the unit, supporting staff to deliver effective care. The nursing notes were recorded in a separate document to the medical and allied health professional notes.
- We saw that when a patient was discharged to the ward then a transfer document was printed, which formed the basis for the nurse to nurse handover. The handover was undertaken face to face once the patient had been settled into their ward bed space.

Consent and Mental Capacity Act

- The staff we spoke to were able to demonstrate understanding of the issues of consent and capacity for patients in critical care. Staff did articulate that if they were unsure in any circumstances, they would seek guidance from senior staff or from the safeguarding lead.
- Training in mental capacity was provided online.
- There was an assessment of mental capacity recorded in the patient record. This was called the confusion assessment method for ICU or 'CAMICU'.

Are critical care services caring?

Good



We saw that critical care was being delivered by caring, compassionate and committed nursing staff. We saw patients, their relatives and friends being treated with dignity and respect. The care being delivered was patient focussed, taking their wishes into account.

Since the last inspection the unit was trialling the use of patient diaries, where appropriate, in specific bed areas to help people come to terms with their critical illness experience.

Compassionate care

- We saw that staff took the time to interact with patients being cared for on the unit and those close to them in a respectful and considerate manner.
- We noted that staff were encouraging, sensitive and supportive in their attitude.
- Patients' privacy and dignity was maintained during episodes of physical or intimate care. Curtains were drawn around people with appropriate explanations given prior to care being delivered.
- Overall, the percentage of those who would recommend the trust in the Friends and Family test was below the England average (ranging from 89.1% - 95%) compared to 94-95% nationally.

Understanding and involvement of patients and those close to them

Critical care

- We saw that staff communicated with people so that where possible they understood their care and treatment. This was confirmed by the two patients that we were able to speak with during the inspection.
- We spoke with the relatives of four patients on the unit. They were universal in their praise for the medical and nursing staff, reporting that they had been kept informed of everything that was going on with their relative.
- Since the last inspection, where appropriate, the unit was trialling the use of patient diaries in specific bed areas. Intensive care patient diaries are a simple but valuable tool in helping people come to terms with their critical illness experience. The diary is written for the patient by healthcare staff, family and friends. Research has shown that patient diaries often help the patient better understand and make sense of their time in critical care and help to prevent depression, anxiety and post-traumatic stress.
- Language interpreters and sign language interpreters were available to the unit should they be required.

Emotional support

- Staff demonstrated that they understood the impact of critical care interventions on people and their families both emotionally and socially.
- We spoke with some people who had been visiting their close relative on the unit for some months. They had no complaints and only praise for all the staff.
- Initial and on-going face to face meetings were implemented by nursing and medical staff to keep people informed about their relatives care and treatment plans.
- There was a senior nurse in post for discussing organ donation who worked closely with the critical team in managing the sensitive issues relating to approaching families to discuss the possibilities of organ donation.

Are critical care services responsive?

Requires improvement



In the last five months (February to June 2015), there have been 34 reported delayed discharges from critical care. In all of these cases the cause was reported as a lack of ward beds. Remaining in a critical care environment when it is no

longer required can be stressful for patients. Furthermore, when patients experienced a delayed discharge then the unit was unable to provide single sex accommodation and breaches of this standard did occur.

At times, the demand for critical care beds outstripped the availability and the unit had moved critical care patients to theatre recovery to be cared for. Records showed that this had occurred 20 times in the period July 2014 to June 2015. This situation brought into focus the skills set required to then look after that patient in recovery. If a critical care nurse moved with the patient, that then diluted the skill mix back on the critical care unit itself. The room available for relatives was small with limited seating.

The above issues were known to the trust and were noted in the division's strategy.

Service planning and delivery to meet the needs of local people

- There were a number of structured bed management meetings throughout the day (09.00, 12.00 and 16.00). These were attended by representatives from all the specialties including critical care. The meetings gave an overview of the bed management situation within the trust. Up to date access and patient flow information within the trust was discussed. Details about staffing levels were included as were planned patient admissions and the numbers of beds available.
- In addition the critical care unit initiated a tele-conference call with the PPU and CCCU at 11.30 each morning to better understand their respective demands and plan for any patient moves.
- When patients experienced a delayed discharge, then the unit was unable to provide single sex accommodation and breaches of the standard did occur.
- The divisional five year strategy set out objectives that all critical care, high dependency, PPU and CCCU services would be housed together on one floor although there was no definite time frame for this reconfiguration to occur.

Meeting people's individual needs

- Patients were usually being reviewed in person by a consultant within 12 hours of their admission.
- The care plans that we reviewed demonstrated that people's individual needs were taken into consideration before delivering care.

Critical care

- Interpreting services were available within the hospital if required.
- There were limited facilities for relatives adjoining the unit's entrance. There was a small room with five seats, toilet, TV and a drinks machine, for which relatives needed to pay. The space available was cramped and if the unit was full would be inadequate for the numbers of visitors likely to attend.
- Once discharged from critical care there was no formal outreach service provided. The unit was often contacted by ward staff for advice about patient management and the staff had stated to record details of how often this occurred.
- Staff were aware of the trust complaints policies and processes and any complaints were handled in accordance with trust policy.
- On the corridor outside the clinical area there was information for relatives and visitors about the patient, advice and liaison service (PALS).
- The trust employed a patient safety manager, whose role was to make sure that learning from any complaints were shared throughout the trust.
- The unit reported very few complaints and had not received a formal complaint since the last inspection. Staff told us they tried to deal with any issues promptly at the time to prevent the need for anyone to formally complain.

Access and flow

- The critical care unit had a clear written operational policy for admission and discharge.
- In the last five months (February to June 2015) there have been 34 reported delayed discharges from critical care. This represented about 10% of all admissions annually. Such a delay also often resulted in a breach of the Department of Health's single sex accommodation standard.
- From July 2014 to June 2015, 20 critical care patients have been cared for in theatre recovery. This represented 20 occasions where there had been no bed in critical care and the occupancy reached 100%. It is recognised that bed occupancy levels in critical care more than 85% can have an adverse effect upon the care provided. We were told by staff that on such occasions the unit struggled to find enough appropriately qualified nursing staff and on occasions band 5 nurses managed more than one level 3 patient.
- 'Out of hours' discharges had also been on the increase recently at Furness General Hospital as reported in the minutes of the June 2015 critical care delivery group. This was reported as being due to the unit's capacity.
- The most recently validated ICNARC data shows that:
 - For non-clinical transfers, the unit performed no worse or no better than similar units.
 - For 'out of hours' and delayed discharges the unit performed less well than comparable units in England.
- The performance of the critical care units across bay was monitored closely by the critical care delivery group that met monthly.

Learning from complaints and concerns

Are critical care services well-led?

Good



There had been significant changes to the leadership and structure of the division during the past 12 months, which were now starting to embed. For example, the formation of clinical business units. The divisional strategy aimed to empower its staff through an on-going commitment to engagement and leadership development.

There was an effective governance structure in place which ensured that all risks to the service were captured and discussed. The framework also enabled the circulation of shared learning and service improvements. We saw committed and capable clinical leaders and managers at unit and divisional level who had a clear understanding of the risks to the service. The risk register identified the key risks within the service and the actions taken to mitigate them.

Vision and strategy for this service

- The surgical and critical care division presented a five year strategy which was aligned with the wider trust principles of people, patients, promotion, performance, partnerships and premises. Many of the shortfalls highlighted during the inspection particularly relating to staffing in critical care and the premises were addressed in the strategic plan.

Governance, risk management and quality measurement

Critical care

- The service measured itself against both the Intensive Care Society core standards and the LSCCN service specifications. The unit was subject to annual peer review benchmarking against the present evidence base and agreed standards for critical care provision. The most recent network review took place in November 2014.
- There was an effective governance structure in place which ensured that all risks to the service were captured and discussed. The framework also enabled the circulation of shared learning and service improvements.
- The risk register for critical care was incorporated into the divisional risk register along with surgery. The top critical care risks recorded related to delayed discharges from critical care, the risk related to patient transfer outside the hospital, lack of critical care outreach and gaps in resuscitation training. The risk register outlined actions (both taken and planned) to reduce the above risks, though the actions detailed had not so far reduced the on-going risk assurance rating on the risk register.

Leadership of service

- There had been significant changes to the leadership and structure of the division during the past 12 months, which were now starting to bed in. For example, the formation of clinical business units.
- The critical care unit had a designated consultant clinical lead and the nursing team was enthusiastically led by a team of experienced ward managers and clinical leaders.
- During the morning of our inspection, we interviewed the consultant of the day as the clinical lead was on leave. We asked the consultant appropriate questions about operational policy and admission and discharge criteria and they were unable to satisfactorily answer the questions. They were also vague about incident monitoring and reporting and suggested that there was no forum at which incidents were discussed and learning taken. We are aware from our other evidence evaluation that incidents were discussed and learning shared and so would expect the consultant for the day to be better informed and briefed concerning operational aspects of the service.

Culture within the service

- Staff were encouraged to report incidents and raise concerns.
- Staff were open, honest and happy to tell us what it was like to work in critical care.
- There was evidence of joint working and positive relationships with other departments within the hospital.

Public engagement

- The trust website had very little information about the critical care service.







Staff engagement

- The divisional strategy reported that under its 'people' principle it aimed to empower its staff. One of the ways in which it aimed to do this was by an on-going commitment to engagement and leadership development. The hope was that the initiatives planned would provide some career development opportunities and assist in staff retention.
- Some of the staff we spoke with told us that they felt better engaged with managers in the trust and that they had an opportunity to express their views.
- We saw examples of a number of 'Listening into Action' (Lia) projects. Lia is about re-engaging with staff and unlocking their potential so that they can really contribute to organisational success. For example, the whole issue of patient 'outliers' in critical care was part of a Lia scheme of work sponsored by the medical director. Several short term interventions, like education of recovery staff in step one critical care competencies, were taking place to help mitigate the risks whilst a wider review of critical care provision took place.

Innovation, improvement and sustainability

- The ICU was an active member of the Lancashire and South Cumbria Critical Care Network. Membership of the network enabled the unit to focus on making improvements where required through joint working with commissioners, providers and users of critical care.

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

Information about the service

Furness General Hospital offered midwife-led and obstetric consultant-led care for high risk and low risk women and a range of gynaecology services.

There were 22 maternity beds for antenatal and postnatal care; a day assessment unit and labour ward. The gynaecology ward had eight overnight beds with the flexibility to accommodate up to 12 if required.

Between June 2014 and June 2015, there were 1,129 births at Furness General Hospital. The percentage of births to mothers aged 20-34 was slightly higher than the England average. The percentage of births to mothers aged 20 and under was the same as the national average.

During our inspection, we visited the antenatal clinic, antenatal and postnatal ward, labour ward and gynaecology ward. We spoke with six patients and 40 staff, which included: midwives, ward sisters, matrons, doctors, consultants, senior managers and support staff. We observed care and treatment and looked at four care records. We also reviewed the trust's performance data.

Summary of findings

At the last inspection in February 2014, we rated maternity and gynaecology services as requiring improvement for being responsive and well led, this was in relation to patients' access and flow, governance and risk management arrangements and the vision and strategy for the service.

During this inspection, we found that although good progress had been made in the implementation of recommendations following the Morecambe Bay investigation, maternity services at Furness General Hospital required improvement for being safe and well-led.

Governance structures and processes were developing. There was a maternity dashboard (a clinical governance performance scorecard) however, this required further work to ensure that all risks were effectively identified, monitored and actioned in line with good practice guidelines. There was progress with the completion of actions against the Kirkup recommendations; this work was on going and a number of areas were yet to be implemented and fully embedded across the trust. There was multidisciplinary working amongst teams however collaborative working across sites could be improved. Midwifery supervision investigations were carried out separately to the trust's investigation process; it was therefore not clear how midwifery supervision investigations and the trust investigations would align.

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Audits showed that the 'five steps to safer surgery' procedures (World Health Organisation safety checklist) were not completed consistently and this level of practice was inadequate. Staff were aware of the procedures for safeguarding vulnerable adults and children, however the infant abduction policy had not been tested for some time.

Care and treatment was planned and delivered in a way to ensure women's safety and welfare. There were some incidents where the service had recognised there were opportunities where action could have been taken to recognise and assess risks more effectively.

The transfer of women to theatre could be improved. The trust had provided written assurance after the inspection that risks of transferring women were evaluated and action had been taken to mitigate the risk of any delays. Plans were also in place for a major refurbishment of the estate by December 2017, which included a dedicated obstetric theatre next to the labour ward.

There were items of equipment, which were out of date. The trust had addressed this and a process for checking and rotating stock was in place. Medicines were not being stored securely on the labour ward; following our inspection, we received assurance from the trust that all emergency drugs were going to be stored in tamper proof boxes.

Staffing levels were set and reviewed using a nationally recognised tool and guidance. Medical and midwifery staffing was in line with national recommendations for the number of babies delivered on the unit each year. Although there was no dedicated anaesthetic cover for obstetrics. The service felt the arrangements were sufficient for the intensity of the work although accepted that this fell short of national guidelines.

The service participated in local and national audits and external peer reviews to improve patient care. Processes were in place for infection prevention and control. Trust outcomes of care for women were meeting expectations in most areas and where areas required improvement, action was taken. Women were receiving care in line with current evidence-based guidance and standards.

Are maternity and gynaecology services safe?

Requires improvement



Care and treatment was planned and delivered in a way to ensure women's safety and welfare. However, we reviewed three incidents reported in June 2015 and a root cause analysis investigation relating to assessing and responding to patient risk, which recognised that there were opportunities where action could have been taken more effectively. The trust had taken action for learning from these events, including: information to staff about contacting paediatricians in a timely way, improved documentation, changes to guidelines and review of pathways for aspirin prophylaxis for women with pre-eclampsia.

Audits showed that the 'five steps to safer surgery' procedures (World Health Organisation safety checklist) were not completed consistently; this level of practice was inadequate. Staff were aware of the procedures for safeguarding vulnerable adults and children, however the infant abduction policy had not been tested for some time.

Concerns were raised at the 2014 inspection regarding the process of transfer of women from the labour ward to theatres; this issue remained at this inspection. The trust provided written assurance after the inspection that risks of transferring women were evaluated and action had been taken to mitigate the risk of any delays. Plans were also in place for a major refurbishment of the estate by December 2017, which included a dedicated obstetric theatre next to the labour ward.

There were items of equipment out of date. The trust had addressed this and a process for checking and rotating stock was in place. Medicines were not being stored securely on labour ward; following our inspection, we received assurance from the trust that all emergency drugs were going to be stored in sealed tamper proof boxes.

Medical and midwifery staffing levels were in line with national recommendations for the number of births on the unit each year. There was no dedicated anaesthetic cover for obstetrics. The service felt these arrangements were sufficient for the intensity of the work, although it was

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accepted that this fell short of national guidelines. There was no evidence to suggest there were any serious incidents or complaints relating to delays in obtaining an anaesthetist.

Incident reporting had improved since the last inspection. The trust had mechanisms in place to identify safety concerns and address themes. Information was collected and reviewed about standards of safety and shared with staff through safety briefings.

Incidents

- Staff we spoke with said they felt more confident to report incidents and were aware of the process to do so. Incidents were reported on the trust's electronic incident-reporting system. Staff told us they received feedback about incidents they had reported, with details of the outcomes of investigations.
- Results from the NHS Staff Survey 2014 showed that Furness General Hospital was within expectations with other trusts for fairness and effectiveness of procedures; reporting of errors; near misses and incidents.
- There were no 'Never Events' reported for maternity at Furness General Hospital in 2014/15. Never Events are serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken.
- There were six serious incidents reported for maternity across the trust, including a maternal death, intrapartum death and intrauterine death, between May 2014 and April 2015. We reviewed a root cause analysis investigation, which identified the care and service delivery problems, contributory factors and root causes. Action plans showed: changes had been made to clinical treatment; staff were reminded in a governance alert regarding aspirin prophylaxis for women with pre-eclampsia; there was training; revised documentation and changes to guidelines.
- There was a weekly senior manager review of all incidents causing moderate or greater harm; including near misses, and a rapid review process undertaken within 24 hours of the incident to identify themes and learning and decide if a comprehensive investigation should take place. The management of low and no harm incidents was undertaken at a local level by ward managers and matrons.

- A monthly 'Learning to Improve' bulletin was shared with staff electronically and in hard copy. A divisional bulletin was also available which reflected specific learning within divisions.
- Joint perinatal mortality and morbidity meetings were held quarterly across the three hospital sites. All serious cases, including stillbirths and neonatal deaths, were reviewed by a multi-disciplinary peer group which included obstetricians, paediatricians, midwives, medical students and risk management leads. Minutes for December 2014 to June 2015 showed that recommendations to improve practice had included changes to documentation and clinical practice and review of guidelines.
- An audit of compliance with Duty of Candour was in place following the change in legislation from October 2015, and was repeated for the period April to June 2015. The audit for women's and children's services showed that all incidents reported as moderate or above had received a duty of candour. We also saw examples of letters of apology and information from investigations had been sent to parents and duty of candour had been documented in the case notes.

Safety thermometer

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

Cleanliness, infection control and hygiene

- There were no cases of hospital-acquired Methicillin-Resistant Staphylococcus Aureus (MRSA) or Clostridium difficile (C. difficile) in 2014/15.

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- Areas we visited had antibacterial gel dispensers at the entrances. Appropriate signs were on display regarding hand washing for staff and visitors.
- Observations during the inspection confirmed that all staff wore appropriate, personal protective equipment when required, and they adhered to 'bare below the elbow' guidance in line with national good hygiene practice.
- The CQC Survey of Women's Experience of Maternity Services (2013) showed that the service scored 'about the same' as other trusts for cleanliness, infection control and hygiene.
- Environmental cleanliness audits showed between 98% and 100% compliance for maternity wards and delivery suite at Furness General Hospital.
- Women were screened for MRSA before undergoing elective caesarean sections.
- Data for April 2015 for aseptic non-touch techniques showed 90% of midwives and 94% of medical staff were compliant. Action included practice educators and education midwives to support managers in targeting staff who urgently needed to undertake an assessment.
- Failsafe systems were in place to identify women for Hepatitis B and HIV at booking, in order to ensure that relevant patients were managed on the correct care pathways. Data between January and March 2015 showed 100% of women had been screened for HIV and Hepatitis B.

Environment and equipment

- At the CQC inspection in February 2014, concerns were raised about the access and route used for transferring women from the labour ward to theatres. During this inspection, we found that the problem of getting women to theatre for an emergency caesarean section remained. Women were transferred to theatre through the medical assessment unit (MAU) using a connecting door which had to be unlocked. We followed the route and saw it took four minutes to find the key. We discussed this with the matron who said that risks were evaluated and no adverse incidents had been reported. Following our inspection, we requested the trust to provide additional information about access to theatres from the labour ward. The trust provided written information which indicated that staff risk assessed if it was appropriate to transfer a woman to theatre through the MAU and take the most appropriate route. The trust provided assurance that there had been no instances

where locating the key to the connecting door had caused delays in transferring women to theatre. However, an additional key has been placed in a digi-lock safe next to the connecting door to mitigate the potential risk of a delay in locating the key. Plans were also in place for a major refurbishment of the estate by December 2017, which included a dedicated obstetric theatre next to the labour ward.

- We found that processes for checking expiry dates of stock items were not consistent in all areas. For example, on the labour ward we found that both latex free gloves and the cord prolapse pack were out of date. There was also equipment that had expired in the caesarean section box. Following our inspection, the trust provided assurance that the out of date stock had been replaced and weekly checklists were in place to mitigate a recurrence.
- Adult and neonate resuscitation equipment was adequately checked, stocked and maintained. Records showed that checks were carried out daily.
- All delivery rooms had suction equipment with oxygen and ENTONOX® (nitrous oxide and oxygen) free standing cylinders.
- There were new Infant resuscitation cabinets in all delivery rooms; these were in use and connected to the walled oxygen.
- There was adequate equipment on the wards to ensure safe care, specifically cardiotocograph (CTG) and resuscitation equipment. Staff confirmed they had sufficient equipment to meet patients' needs.

Medicines

- On the labour ward, we found emergency medicines were not being stored securely and held in the emergency store room which could be accessed through two unlocked doors on either side of the ward. For example, we found unsealed boxes containing emergency drugs which stated that 'if the box seal was broken it should be returned to pharmacy.' One box contained diazepam which was a controlled drug. We discussed this with the matron on the labour ward who said she would address this. Following our inspection, we received assurance from the trust that all emergency drugs were going to be stored in tamper proof boxes. We were provided with information as to why these drugs were not locked away in the first instance, and this was due to situations in which these drugs were required in

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an emergency, however, until the tamper proof boxes arrived from pharmacy, we were informed the drugs were locked away and had been subsequently added to the risk register.

- Records showed medicine fridges were monitored in line with trust policy to ensure appropriate temperatures were maintained for the safe storage of medicines.

Records

- The service used the standardised maternity notes developed by the Perinatal Institute. We reviewed four records which were completed to a good standard. Each record contained a pathway of care that described what women should expect at each stage of their labour. Standard operating procedures and care pathways were included in records for care of women with diabetes, epilepsy, hypertension or a high body mass index (BMI) in pregnancy.
- Women carried their own records throughout their pregnancy and postnatal period of care. The personal child health record (also known as the PCHR or 'red' book) was given to parents before discharge and completed correctly.
- A venous thrombo-embolism risk assessment form was completed at booking with obstetric referral as indicated.
- Trust data showed 96% of staff had completed information governance training.

Safeguarding

- Staff demonstrated a good understanding of the need to ensure vulnerable adults and children were safeguarded and understood their responsibilities for identifying and reporting any concerns. There was a dedicated safeguarding midwife.
- Training figures for June 2015 showed 96% of staff at Furness General Hospital had received training at level 1 for safeguarding vulnerable adults; 96% of staff had completed training for safeguarding children level 1; and 90% for level 3.
- The trust had a child and infant abduction policy; however staff were unable to recall when the last time a practical test of the procedures had been carried out. This was not in line with trust policy which stated that: 'there is a need to do a physical test on a 12 month basis to ensure that the procedures work correctly and that staff understand how they work'.

- Children aged 13 to 16 were asked about their sexual activity and referred to the appropriate agencies where required. Girls under 13 years of age were automatically referred to the safeguarding team.
- The service was developing processes for reporting cases of female genital mutilation in response to the Department of Health's multi-agency guidance.
- There was a part-time specialist midwife for domestic violence and substance misuse. The midwife attended the Multi Agency Risk Assessment Conference (MARAC); a local meeting to share information on the highest risk cases of domestic violence and abuse between statutory and voluntary sector agencies.
- Women were asked about any abuse at booking and when they were alone. Midwives tried to see women alone at least once in their pregnancy.

Mandatory training

- Staffing rosters were arranged to allow staff time to attend mandatory training. The training covered a number of topics, which included obstetric emergency skills training, and adult and neonatal resuscitation.
- The service had introduced 'PROMPT' (Practical Obstetric Multi-Professional Training); an evidence based multi-professional training package for obstetric emergencies.
- There was a dedicated practice development midwife who monitored attendance and organised training sessions. Training records showed that staff had completed training in areas such as: infection control (level 1 96% and 98% level 2), fire safety (80%) and resuscitation (80%) against a year end trust target of 95%.

Assessing and responding to patient risk

- Midwifery staff used an early warning assessment tool known as the 'Maternity Early Obstetric Warning System' (MEOWS) to assess the health and wellbeing of women who were identified as being at risk. This assessment tool enabled staff to identify and respond with additional medical support if required. We reviewed three incidents reported in June 2015 and a root cause analysis investigation relating to assessing and responding to patient risk. The service recognised that there were opportunities where action could have been taken to recognise and assess risks more effectively. The trust had taken action for learning from these events, including: information to staff about contacting

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paediatricians in a timely way; improved documentation; changes to guidelines and review of pathways for aspirin prophylaxis for women with pre-eclampsia.

- A trust audit of ten sets of records of the WHO surgical safety checklist in June 2015 showed 70% had commenced appropriately and 40% were appropriately completed; this level of practice was inadequate. The service had escalated results to clinical leaders in theatres for further action.
- The service used the 'fresh eyes' approach; a programme of peer review of CTG readings for every birth. This meant the interpretation and accuracy of the tracing was enhanced.
- A clinical risk checklist was in place for suspected labour. Women with high risk factors presenting at home or in the midwifery led unit were transferred to the consultant led unit using the transfer guidelines.

Midwifery staffing

- The service met the national benchmark for midwifery staffing set out in the Royal College of Obstetricians and Gynaecologists (RCOG/RCM) guidance 'Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour' with a ratio of 1 midwife to 25 births, compared to the RCOG recommendation of 1 midwife to 28 births.
- The service had assessed staffing numbers and skill mix using the workforce planning tool 'Birthrate Plus' and was using a red flag system to identify when there were too few midwives on hand which impacted on care. The service was considering using the National Institute of Clinical Excellence (NICE) Guidelines on 'Safe Midwifery Staffing for Maternity Settings'.
- A total of 21 midwives had been appointed across the trust, with two starting in June 2015; a further two were awaiting a start date to be confirmed, and the remaining 17 were undergoing pre-employment checks. The residual midwifery vacancy rate was 6.1%.
- Daily safety huddles took place three times a day to monitor acuity against staffing levels and concerns were escalated to the matron, in line with the escalation policy. Staff were moved across sites to meet patients' needs where appropriate.

- There was a band 7 senior midwife on duty at all times on the labour ward. The planned and actual staffing levels were displayed on noticeboards on each ward. On the days we inspected the wards, there were no shortfalls in planned staffing levels.
- Figures showed 17% of whole time equivalent (WTE) staff were agency staff. The head of midwifery told us they used the same core team of agency staff who had been working at the unit for some time.
- We observed a handover on the labour ward, which was multi-disciplinary and comprehensive. In attendance were six doctors and three midwives. All women were discussed, including women under midwifery led care who may require obstetric input. There was good communication observed between midwives and medical staff.
- There was sufficient staffing on the gynaecology wards and two WTE staff were increasing ward support.
- Community midwives rotated on to the acute wards one to two days each month and were able to work in different areas. There were 4.86 vacancies in community midwifery of which 4.0 WTE had been recruited and would start in post in August 2015. Community caseload numbers was one midwife to 87 women. The service was looking to ensure caseloads to midwife ratios were fairly distributed, with additional investment and recruitment to community midwife posts.

Medical staffing

- Consultants provided 52 hours cover per week on the labour ward, which was in line with the recommended RCOG safer staffing standards for a service delivering fewer than 2,500 births per year. There were five consultants at Furness General Hospital.
- There were similar levels or better consultant-level and junior-level staffing compared to England, with the exception of registrars (STR 1-6) which was below the England average (37% compared to 50%). However, the increased consultant cover compensated for this.
- Locum usage between January and May 2015 was 9%. Long-term locums were commonly used to ensure consistency of care.
- There was no dedicated anaesthetic cover for non-elective care. In the regular working hours (9am – 5pm) first on-call senior anaesthetist or intensive care consultant provided cover for maternity.
- Between 5pm and 9.15am hours, a resident senior anaesthetist covered maternity, intensive care unit (ICU)

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and general emergencies. A non-resident consultant anaesthetist covered ICU and provided support for theatre and maternity services when the resident anaesthetist was busy. In March this year, a third on-call anaesthetic tier was put in place to mitigate the risk at the Furness General Hospital site. The clinical director felt this was sufficient for the intensity of workloads, although he acknowledged that this fell short of the RCOG guidelines to have a dedicated anaesthetist for obstetrics. There was no evidence to suggest there were any serious incidents or complaints relating to delays in obtaining an anaesthetist. All anaesthetic on-call staff were either resident in the hospital or lived in hospital accommodation. The most any staff had to travel was 12 minutes to reach the hospital if required.

- The General Medical Council national training scheme survey 2014 did not raise any concerns relating to junior doctor workload at this hospital.

Major incident awareness and training

- A business continuity plan for safe staffing was in place. This included the risks specific to each clinical area and the actions and resources required to support recovery.
- There were escalation processes to activate plans during a major incident or internal critical incident.
- Multi-disciplinary team training days were in place which allowed the use of in-house and multi-professional obstetric emergency skills and drills using the trust's own policies and guidelines.

Are maternity and gynaecology services effective?

Good



Women's care and treatment was planned and delivered in line with current evidence-based practice, which was audited to ensure consistency of care and treatment pathways. The service participated in relevant local and national audits, including external reviews to improve patient care. Care outcomes were meeting expectations in most areas, and where improvements were required the service had taken action. Information about women's care and treatment, and their outcomes were routinely collected and monitored.

Learning needs of staff were identified and training was put in place. Multi-disciplinary team and professional training and development days had been introduced. Supervision processes were in place for midwives. Staff had received annual appraisals of their work. Progress was being made to ensure teams worked collaboratively across all hospital sites.

Consent practices were monitored and reviewed and women were involved in making decisions about their care and treatment. There was some awareness by staff of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, although this could be improved.

Evidence-based care and treatment

- There was evidence to demonstrate that women using maternity and gynaecology services were receiving care in line with national quality standards. The maternity guidelines group reviewed guidelines and staff were consulted on amended guidelines and procedures to reflect changes in practice. Guidelines were audited regularly after being introduced and action plans were implemented and monitored where required.
- There was a clinical audit programme 2015/16, which detailed plans for national audits, divisional priorities and educational audits. The plan included the audit supervisor, completion date and frequency.
- The maternity service had an audit midwife who worked closely with two clinical audit leads across hospital sites. Audits were discussed each month and included areas such as: emergency and elective caesarean section rates; third and fourth degree tears; pre-eclampsia and postpartum haemorrhage.
- Following the last CQC inspection, the trust commissioned an external provider to review its caesarean section rates. The recommendations included: improved documentation; CTG training; planning for pregnancy and review and learning from cases. The service had produced an action plan which included: correct filing of information within the notes, incorporating the WHO surgical safety checklist into record keeping audits; development and introduction of a standardised consent form for caesarean section; improving the documentation in maternal notes about the baby and completion of incident reports.
- The clinical audit midwife told us caesarean section rates were audited each month. Staff were documenting risks and benefits and referring women to the VBAC

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(vaginal birth after caesarean) clinic or women with a fear of birth were referred to a mental health midwife. Data from spreadsheets of caesarean sections were discussed at the quality committee. An audit of elective caesarean section rates showed a downward trend from 29% in April to 25% in May 2015. We reviewed a recent sample of caesarean section records and found that the management and justification for proceeding with this plan of treatment had been appropriate.

Pain relief

- Women were provided with information to make them aware of the pain relief options available to them.
- There was access to various types of pain relief for birthing women which included drug-free methods. There was also access to a birthing pool. Data showed there was a 3% water birth rate.

Nutrition and hydration

- Breastfeeding initiation rates for deliveries that took place in the hospital for February 2015 to June 2015 varied between 52% and 66% against a trust target of 60%.
- At the time of inspection, the trust had not registered intent to undertake the United Nations Children's Fund (UNICEF) Baby Friendly Initiative (BFI) Accreditation Scheme; the aim of this scheme is to train staff in supporting women to make an evidence based choice in how to feed their baby.

Patient outcomes

- There were no risks identified in: maternal readmissions; emergency caesarean section rates; elective caesarean sections; neonatal readmissions or puerperal sepsis and other puerperal infections (Hospital Episode Statistics January 2014 to December 2014).
- The normal vaginal delivery rate was 58%, which was slightly worse than the national average of 60%.
- The trusts elective caesarean section rates were higher (12.9%) than the national average of 10.9%.
- Emergency caesarean delivery rates at the trust was 13.6% which was better than the England average of 15.1%.
- The maternity performance dashboard for Furness General Hospital showed that between February and June 2015, there were three reported third and fourth degree tears which was better than the trust target of

five. There was a rolling audit programme for tears, which would be next presented in August 2015. Perineal suturing updates and starter workshops were regularly held for staff.

- There was one case of maternal sepsis reported at the hospital between February and June 2015, which was within the trust target of three cases.
- Forceps delivery rates were slightly higher (worse) than the England average, whilst ventouse deliveries (use of a suction cup) were slightly lower (better) than the England average.
- There were no stillbirths reported at Furness General Hospital between February and June 2015.
- There were four cases of post-partum haemorrhage reported between April and June 2015 against a threshold of two cases per month.
- Between 1 June 2014 and 31 May 2015 there were 118 admissions (all gestations) to the special care baby unit at Furness General Hospital, this included some babies admitted to the unit more than once due to transfer out and re-admission on return. The common primary diagnosis for admission for babies born at term was due to respiratory distress (11 cases) and infection (5 cases). Trust wide data showed there were 11 babies who experienced an unplanned admission to neonatal intensive care units outside of the trust. The reasons for transfer were within normal practice.
- The service participated in the 'UK National Screening Committee: antenatal and new-born screening education audit'. Trust data showed that the rates of avoidable repeat tests for new-born blood spot sampling showed improvements from 4% in April 2015 to 0.6% in May 2015; this was in line with national targets of no more than 0.5% and 2%.
- The 'National Neonatal Audit Programme 2014' showed improvements had been made compared to 2013 across the five domains with three out of the five indicators achieving national targets. The two areas requiring improvement were: babies with a gestational age of <32+0 weeks or <1501g at birth undergoing 1st Retinopathy of Prematurity (ROP) screening in accordance with the current national guideline recommendations and the proportion of babies <33+0 weeks gestation at birth are receiving any of their mother's milk when discharged from a neonatal unit. The trust was reviewing these areas and developing an action plan for improvement.

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Competent staff

- Newly qualified midwives completed a two year preceptorship programme which provided a framework to develop staff from a band 5 to a band 6 in maternity care. This included rotation across all sites.
- The 'North of England Local Supervising Authority's (LSA) annual report to the Nursing and Midwifery Council October 2014' showed the trust had met the domains relating to: statutory supervision of midwives and clinical governance; team working; leadership and development and supervision of midwives; and interface with users'. One domain was partially met, regarding the profile and effectiveness of statutory supervision of midwives. This was associated with timely inputting of information onto the LSA database and attendance at LSA events, both of which were underpinned by a lack of time. This would improve with the appointment of a full time dedicated supervisor of midwives (SoM).
- The range of caseloads held by supervisors of midwives (SoM) fluctuated from 12 to 15 midwives, which was in line with the recommended ratio of 15 midwives for each supervisor. All midwives had 24-hour access to supervisors. Some annual supervisory reviews were out of date because of workloads impacting on supervisory time, however a full time dedicated SoM had been appointed and an action plan was in place to ensure compliance.
- Staff told us they received a yearly appraisal. Trust data showed that 86% of medical and 84% of midwifery and gynaecology staff had received a yearly appraisal.
- Junior doctors attended protected weekly teaching sessions and participated in clinical audits. They told us they had good ward-based teaching and were well supported by the ward team and could approach their seniors if they had concerns.
- The results of the General Medical Council National Training Scheme Survey 2014 showed educational and clinical supervision. Induction and adequate experience for junior doctors was 'within expectations' for this trust, however access to educational resources and feedback was worse than expected.
- Skills passports had been developed and sent to all registered healthcare professionals. These documents

provided an outline of clinical skills development of all staff beyond the mandatory requirement and sat outside the training needs analysis. This was an example of good practice.

- The service had made some progress to meet the requirements of the new nursing and midwifery revalidation process which was to be launched in October 2015. The head of midwifery told us a trust wide approach was planned. Staff told us they had some awareness of the process and were beginning to develop their portfolios.

Multidisciplinary working

- Communication between medical, nursing and maternity care support workers was described as good on the unit.
- We found that specialist midwives worked closely with their colleagues across all hospital sites and had regular meetings to discuss practice issues.
- The postnatal ward had no formal transitional-care facility for babies requiring additional support; however, staff worked closely with the neonatal unit to care for babies who required additional clinical interventions.
- Multi-disciplinary team (MDT) and professional training and development days had been introduced which was currently a three-day mandatory study course.
- There was evidence of MDT meetings in place within the division, which included knowledge, information, decision and sharing days, ward rounds, audit meetings and morbidity and mortality meetings. Staff said they appreciated MDT working as this made them more aware of the skills and responsibilities of other staff groups.
- A daily safety huddle was held on the labour ward, which was multidisciplinary and included obstetricians, anaesthetists and midwives.

Seven-day services

- 'Out-of-hours' services were available in emergencies. All women could report to the hospital in an emergency either through A&E or maternity reception.
- There was seven-day medical cover provided with the minimum of a resident middle grade doctor, and at times a resident consultant.
- There was no dedicated team specifically for obstetric theatres overnight; cover was provided by a theatre team who responded to emergencies in the first instance, including obstetric emergencies. In support of

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the on-duty night team there was an on-call team available who would be called to manage a second and subsequent emergency. This team was only used if the second or subsequent emergency was an obstetric emergency; all members of this second team had to respond within 30 minutes of the call or be resident whilst on-call.

Access to information

- During the transfer of women between trust sites or to other hospitals, there were processes in place to ensure all appropriate documentation and case notes travelled with the woman, together with the results of the appropriate investigations carried out.
- There were effective processes in place to ensure that the results of the antenatal screening tests were followed up and actioned in a timely way and in line with protocols. The screening co-ordinator worked closely with the laboratory to ensure investigations were actioned. Results were checked and all high-risk women were given an appointment to be seen in clinic.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Women confirmed they had been given sufficient information to help in making decisions and choices about their care and the delivery of their babies.
- A divisional wide audit of records showed 100% notes had clear documentation of discussion regarding risks and benefits for any interventions.
- Staff were aware of Fraser guidelines for girls below the age of 16 to consent to their own medical treatment without the need for parental permission or knowledge.
- Staff had some awareness of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DOLS) and said they had attended a study day. However, we found there was limited knowledge when staff were asked what they would do if there were issues relating to capacity or when implementing a DOLS referral.

Are maternity and gynaecology services caring?

Good



Maternity and gynaecology services were caring. The NHS Friends and Family Test for May 2015 showed the majority of women would recommend the maternity and gynaecology service.

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

Compassionate care

- Feedback from the NHS Friends and Family Test showed 89% of women would recommend antenatal care in April 2015 and 95% in May 2015. The trust score was in line or better than the England average for the percentage of women who would recommend Furness General Hospital for birth and postnatal care (100%).
- Between April and May 2015, the scores for women who would recommend postnatal community provision was better than the England average with 98% and 100% against a target of 98%.
- The NHS Friends and Family test for June 2015 showed that 81% women would recommend gynaecology services to their family and friends.
- Women spoke positively about the standard of care they had received. Women told us they had a named midwife and received good continuity of care by the community midwives. They felt well supported and cared for by staff and that their care was delivered in a professional way.
- We observed staff interacted with women and their relatives in a polite, friendly and respectful manner. There were arrangements in place to ensure privacy and dignity in clinical areas.
- The trust scored about the same as other similar size trusts in all 17 indicators in the CQC Survey of Women's Experience of Maternity Care 2013.
- The trust was in line with the England average for the time taken to respond to the call bell.

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- The 'patient led assessments of the care environment' (known as PLACE) for 2014 showed that the trust was slightly better than the England average for privacy, dignity and wellbeing.

Understanding and involvement of patients and those close to them

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

Emotional support

- Bereavement policies and procedures were in place to support parents in cases of stillbirth or neonatal death; this was facilitated by two midwives with a special interest in the care of the bereaved. Information detailing various agencies that provided counselling support for women and their families was available. An annual memorial service was also held.
- The service had a 'Listen to Mother' birth afterthoughts service which provided women with an opportunity to have unresolved issues about their pregnancy or birth experience answered.

Are maternity and gynaecology services responsive?

Good



The service was aware of its risks and the need to ensure that services were planned and delivered to meet increasing demands. Waiting times and delays were appropriately managed.

There were a few occasions where capacity on the gynaecology ward meant the flow of patients was interrupted however, the service was responding to this and had introduced a number of measures to improve. Women were informed of any disruption to their care or treatment.

There were processes in place for women to make a complaint, comment or compliment. Improvements were made to the quality of care because of complaints and concerns.

Service planning and delivery to meet the needs of local people

- The service was working closely with commissioners and other stakeholders to ensure the recommendations from the Kirkup report were implemented across all trust sites.
- The service was working with its commissioners to develop a programme for a fully integrated maternity pathway, inclusive of public health and primary medical services, which set out what women had a right to expect. This included a more formalised transitional care pathway and midwifery led care.
- Senior managers planned for the risks associated with the increasing demands of the local and wider community. The service was looking to develop services to support the principles of the 'LDRP' (labour-delivery-postnatal-recovery); a model where women were admitted into labour in a single room and remained there throughout their stay until discharge. An estates strategy was in place to address the birth environment at Furness General Hospital with plans for completion of a new maternity unit by December 2017.
- There was a maternity public health strategy written in partnership with the trust's commissioners for the geographical areas of Morecambe Bay, which was refreshed for 2014/15. This was being considered through the commissioning group in how it could be delivered and linked into the work that was happening around 'Better Care Together'; the integrated maternity care pathway and the RCOG review.

Access and flow

- Maternity service bed occupancy rates were lower than the England average of 57% for all quarters, except quarter 4 2013/2014 where occupancy levels were approximately 5% (62%) higher than the national average.
- There were no closures of the maternity unit at Furness General Hospital in the last 18 months. There were contingency plans for the delivery suite in the event of the unit becoming full.
- There was no problem accessing the antenatal clinic at any of the sites. Women could be seen within 24 hours,

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either in clinic or in the maternity day assessment. The percentage of pregnant women accessing antenatal care across all hospital sites who were booked for delivery by 12 weeks and six days from March to May 2015 was between 92% and 96% which was better than the trust target of 90%.

- Most routine antenatal care was provided by community midwives. They completed risk assessments with women and gave advice and support with choice of place of delivery and birth plans. Women also attended the hospital for antenatal care. Those with high risk pregnancies attended consultant-led clinics.
- Midwives were available on call 24 hours a day for advice. Community midwives were integrated within the service.
- There were two triage rooms where women were assessed when they were admitted to the labour ward directly.
- The day assessment unit was open 8am to 6pm Monday to Friday; out of these hours, women would access the labour ward.
- Separate appointment times were available in the antenatal clinic for women who had suffered pregnancy loss.
- There was good access and flow in the antenatal clinic. We observed an afternoon clinic and saw that women did not have to wait long before being seen.
- On the gynaecology ward, there were eight overnight beds and two day case trolleys. Staff told us that due to capacity issues, patients from other specialities were cared for on the ward. If the ward was full, there were only two registered nurses on duty which meant the gynaecology assessment unit was closed. This had been identified on the divisional risk register and key controls and actions were in place.
- The 'new-born infant physical examination' (NIPE) was mostly paediatric led. There were three midwives who were NIPE trained. More midwives were being encouraged to complete training to ensure that the 72 hour target for NIPE was achieved. There were some delays on the neonatal unit for NIPE in achieving the 72 hours as this was not being seen as a priority. We were told that there were five babies on the system at the time of our inspection that had breached the 72 hour target.

Meeting people's individual needs

- There were effective and confidential processes for women attending the nurse led pregnancy advisory service. Standard operating procedures were in place for the sensitive disposal of fetal and placental tissue. There was evidence to show women were made aware of the options for disposal and given the opportunity to discuss them.
- Following a loss of pregnancy, support was provided to women. Memory boxes were available with items that could be kept, to serve as a memory of the baby.
- Women using the maternity services could access specialist midwives for the following aspects of care: diabetes; substance misuse; mental health and domestic violence.
- Women could access a joint consultant led diabetes clinic with support and advice being available from a diabetic nurse and dietician.
- Processes were in place to identify women with learning disabilities. Staff encouraged family and key workers to be involved in the care pathway and adjustments were made for women to have a single room and wear their own clothes rather than a hospital gown when going to theatre.
- A substance misuse midwife provided support and advice to women in their home or clinic. A drug and alcohol care pathway was followed and referral made to the consultant and anaesthetist for management of withdrawal. Information was shared with the named midwife, health visitor and social services.
- Women with a booking body mass index (BMI) of over 30 were referred to the anaesthetic clinic via the anaesthetic alert system and were seen by the anaesthetist on admission to the delivery suite.
- Women were routinely asked about current and previous mental illness at their antenatal booking. A maternal mental health risk assessment form was completed and women were offered review with the specialist mental health midwife to develop a plan for the perinatal period. There was on-going assessment of the woman's mental health during the antenatal and postnatal period. Referral could also be made to the crisis team and adult mental health team.
- There were a range of information leaflets in clinical areas, including: tests and screening, breastfeeding and other sources of support. The leaflets were available in different languages if required.
- Maternity services were working to an action plan developed by partners in public health to reduce the

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levels of maternal smoking. Women were offered Carbon Monoxide (CO) monitoring at booking and referred to smoking cessation services within GP surgeries and pharmacies. However, the performance dashboard showed the rates of CO2 screening offered, and the percentage of referrals offered for smoking cessation was below the trust target of 75% (April to June 2015 between 30% and 28%).

Learning from complaints and concerns

- Complaints were handled in line with the trust's policy. Information was given to women about how to make a comment, compliment or complaint. Matrons gave women contact cards so they could call if they had any worries or concerns during their stay.
- There were 10 complaints for maternity and gynaecology at Furness General Hospital between July 2014 and May 2015. The main themes related to care and treatment, staff attitude and discharge.
- Learning from complaints and concerns was discussed at monthly and weekly governance and risk management meetings.
- We reviewed a sample of complaints and found that apologies had been given and an action plan agreed. Learning from complaints included: ensuring privacy whilst communicating with women; sharing of best practice across sites; changes to visiting times; and improvements in referral to the bereavement midwife.

Are maternity and gynaecology services well-led?

Requires improvement



Governance processes and the management of risk were developing. There were processes in place to monitor risk. However, areas such as the maternity dashboard (a clinical governance performance scorecard), required further work to ensure that all risks, such as workforce, some clinical outcome indicators and complaints and incidents were effectively identified, monitored and actioned, in line with good practice guidelines.

There was progress made against the completion of actions against the Kirkup recommendations; this was

work in progress and a number of areas were yet to be implemented and fully embedded across the trust. Work was continuing to ensure collaborative working was strengthened across hospital sites.

Midwifery supervision investigations were carried out separately to the trust's investigation process. It was therefore not clear how the midwifery supervision investigation and the trust investigations were aligned. Summary reports of supervisory investigations, their findings and actions were shared with the trust. Where there had been a trust investigation and a supervisory investigation as a result of deficiencies in a midwives clinical practice, reports have been shared with parents where possible at the same time.

Staff said they were confident to challenge poor practice. User representatives and members of families affected by the events leading to the Kirkup Report participated on committees and working groups. The service took account of staff and public feedback and there were examples of service improvement.

Vision and strategy for this service

- The strategy for maternity services was aligned with the trust's operational development strategy 'Better Care Together'. The five year plan included a fully integrated maternity care pathway to meet the needs of women focussing on the provision of a midwife led service for birth and transitional care services for neonates. There were also plans for major refurbishment and building work of a new maternity unit on the Furness General Hospital site to be completed by December 2017. There were clear timescales for agreed actions and work streams assigned to project leads responsible for implementation.
- Most staff were aware of the vision and strategy for maternity services at Furness General Hospital. There was a service change plan which set out timescales for communication and engagement with staff during 2015/2017.

Governance, risk management and quality measurement

- There was a 'Morecambe Bay Investigation Sub-Committee' which monitored and provided scrutiny of the recommendations and developments in relation to the governance, assurance and management arrangements, regarding the work being undertaken in

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response to the Kirkup report published on 3 March 2015. The sub-committee was chaired by a non-executive director with membership from service users' representation, a public governor and an external expert. The sub-committee reported monthly to the Board of Directors. The Sub-committee had met on 17 April and 11 May 2015. Minutes showed that good progress had been made since the trust received the report. The trust had met its deadlines in the report for achieving the recommendations to date. All of the projects were on track.

- A 'Kirkup Report Implementation Group' ('the KRIG') took the day to day responsibility to implement and deliver the agreed action plan and provided reports on progress to the sub-committee.
- The process for midwifery supervisory investigations was not clear. Investigations were carried out separately to the trust's investigation process and it was not clear how the supervision investigation and the trust investigation would align. The Head of Midwifery ('HOM') told us that summary reports of supervisory investigations, their findings and actions were would not be shared with the trust. For example, a summary report was sent to the Executive Chief Nurse as well as the HOM that provided a summary of findings, actions taken by supervision and or the midwife and any further actions required of the midwife. The full report was deemed confidential under section 4, rule 9 of the midwives rules and standards 2012 unless requested under the Data Protection Act. Where there had been a trust RCA investigation and a supervisory investigation as a result of deficiencies in a midwives clinical practice, reports have been shared with parents where possible at the same time. Parents may still receive two separate reports with different timelines and recommendations as the reports and investigations looked at different things. Factual information that supported these investigations was shared and discussed across supervision and risk management, and governance teams.
- The service had developed a maternity dashboard. The dashboard is a clinical performance and governance scorecard and helps to identify patient safety issues in advance. We observed that a number of areas such as: workforce, some clinical outcome indicators and risk incidents and complaints, were not included in the dashboard, as recommended by the RCOG good practice guidelines (No 7. January 2008). We discussed

assurance processes and monitoring against the dashboard with the senior team. The team acknowledged that further analysis and action planning was required to ensure all risks were captured and that the dashboard was being revised.

- The service had a maternity risk management strategy which set out guidance for reporting and managing risk. It detailed the roles and responsibilities of staff at all levels to prevent or minimise the possibility of the recurrence of risks and their consequences.
- Joint divisional weekly and monthly management team, management board and governance assurance meetings were attended by the obstetric and paediatric leads, nursing and midwifery staff, head of midwifery and matrons. Attendance trackers were reviewed at each meeting to monitor attendance in line with the meetings terms of reference.
- To support the governance process, there was a full time risk midwife, governance lead and quality and safety midwife. They were the interface between management and all other staff in maternity and gynaecology in sharing of risk management, lessons learned and changes made to practice. The minutes of the risk management group were presented to the divisional management team meeting and at the quality committee. The commissioners of service reviewed risks from serious incidents externally. The risk team said the chief nurse, head of midwifery and governance leads were aware of risks on the dashboard.
- The quality and safety midwife was new in post and provided cover across the women's and children's division regarding the review of incidents and monitoring progress of investigations and action plans. The risk team said there was joint working, for example, ward managers came across sites to attend root cause analysis investigations. Safety huddles occurred daily on the labour ward and reviewed incidents over the last 24 hours.
- Invites had been extended to all staff to shadow the maternity risk management team, in order to understand the process. Band 5 midwives and new starters were encouraged by the education team to spend a day with the governance team during their induction and supernumerary period.
- Supervisors of midwives attended governance and risk meetings. The maternity risk management strategy described the framework of statutory supervision and the role of a supervisor of midwives.

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- We saw that the majority of maternity and gynaecology policies and procedures were accessible to staff online and were in date and ratified.

Leadership of service

- The leadership structure in maternity and gynaecology was a Clinical Director, Deputy Director and Head of Midwifery (HOM) and Divisional General Manager.
- The HOM was responsible for maternity and gynaecology across the three trust sites. The HOM was the deputy director of nursing and reported to the chief nurse. There were three maternity matrons and a gynaecology matron who were accountable to the HOM. A deputy HOM had also been recently appointed.
- There was good matron support on the Furness General Hospital site and staff said they had regular access to the matron or a manager who was on site every day. Medical staff said they saw the clinical director every two weeks.
- Regular maternity and gynaecology ward meetings were held. Minutes showed areas discussed included: staffing; training; sickness absence; complaints and incidents.

Culture within the service

- Staff we spoke with were positive about the improvements and progress made against the Kirkup recommendations. One doctor said she felt women received a good standard of care and there was good team working on the unit.
- The focus group for midwives said they felt more empowered to put ideas forward and were supported to challenge poor practice. They said that 'things felt a lot better'. Staff were aware of how to access whistle blowing policies and felt concerns would be listened to.
- We observed willingness amongst midwives to integrate and work as one trust. They were aware of the challenges of the geographical area and acknowledged the need to rotate across the trust sites. This was already happening for newly qualified staff. However, there was some reluctance amongst medical staff who felt that there was no incentive to work across sites and would only go if there were staff shortages at Lancaster Royal Infirmary. The senior team told us that work was progressing on rotation to other units and tertiary centres. This included looking at a 'hub and spoke' model for practice learning opportunities to ensure staff had access to varied experience.

- Staff turnover rates showed 24% medical staff and 7% nursing staff. The medical workforce would start to stabilise once the new consultants currently undergoing pre-employment checks commenced in post. The cumulative sickness absence by whole time equivalent in the Women's and Children's Division between July 2014 and June 2015 was 6.31% against the NHS North West target of 4.3%.

Public and staff engagement

- The trust had resourced a communication and engagement project to ensure they were being fully open and honest in sharing the actions and progress with the public and wider stakeholders following the Kirkup report.
- A letter had been sent to all the families involved in the Morecambe Bay Investigation giving them the opportunity to be involved with the trust around recommendations.
- User representatives and members of families affected by the events leading to the Kirkup Report participated on committees and working groups, for example in designing the maternity 'end to end' care pathway.
- Examples were given where service users were members on panels for interviews for the recruitment of new staff, including midwives.
- The service took account of the views of women through the Maternity Services Liaison Committee, which was known as 'Maternity Matters in Furness'. The minutes from February and April 2015 showed areas such as breastfeeding and development of maternity welcome packs were discussed.
- The NHS Staff Survey 2014 showed the trust was within expectations for staff agreeing that feedback from patients was used to make informed decisions in their department.
- Work was progressing to improve cross-hospital site working. The senior management team told us from August 2015, a new video conferencing facility would be available for the women's division to increase MDT working.
- 'You said we did' boards showed improvements had been made to provide women with snacks between meals. Suggestions boxes were to be implemented by August 2015 and a year book of improvements produced.
- The service participated in the 15 Steps Challenge, designed by the NHS Institute; this encourages patients







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and staff to work together to identify improvements, which may enhance the patient experience. The challenge team consisted of: a service user; staff members; a trust governor; the acting chair and director of governance and other members of the corporate governance team, who walked the wards and took note of their first impressions. Action plans showed changes had been completed to the environment, signs were improved and information displays updated.

Innovation, improvement and sustainability

- There had been progress made against the completion of actions against the Kirkup recommendations, however this was work in progress and a number of areas were yet to be implemented and fully embedded across the trust.
- The Annual Local Supervisory Audit report October 2014 showed that the team of Supervisors of Midwives demonstrated great commitment to their statutory role and ensured that supervision was making a difference to the quality of service within the organisation.
- Some staff commented on the compatibility of IT systems in the community and GP surgeries with the trust systems, which led to duplication of information and was time consuming.
- Staff had made improvements within their areas through the Listening into Action programme. One midwife described how changes had been made to improving communication through texts and emails and how changes to clinic records for low risk women had reduced paperwork and duplication.
- The trust nursing and governance team had worked in partnership to develop a bid for 'Sign Up to Safety'. The bid was successful and focused on improving the assessment of fetal health through using antepartum cardiotocography (CTG); to support early appropriate interventions in the antenatal period and reduce complications. The bid enabled the trust to appoint band 7 midwife CTG champions at the Royal Lancaster Infirmary and Furness General Hospitals. Training programmes and assessment tools and 11 CTG viewing and archiving instruments with computerised analysis facilities would be provided.

Services for children and young people

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

Information about the service

The children and young people's service at the Furness General Hospital includes a 14 bedded inpatient ward, comprising five side rooms, one high dependency room and two bays of four beds each. There is a children's assessment unit which comprised of a four bedded bay and an eight bedded day case service.

There is a children's outpatient's department, a four-bedded tier one special care baby unit and two transitional cots. During the period 1st June 2014 to 31st May 2015, 6881 children and young people were seen in the emergency department, 1527 were seen in the children's assessment unit and 1527 children were admitted to the children's ward.

During our inspection, we spoke with six parents, carers and their children. We also spoke with a range of staff at different grades including nurses, student nurses, junior doctors, a play specialist, ward managers, matrons, the clinical director, the clinical lead, the assistant chief nurse, consultant paediatricians, domestic assistants, senior managers and support staff. We received comments from people who contacted us to tell us about their experiences and we reviewed performance information about the trust.

Summary of findings

Following our previous inspection in February 2014, we rated children and young people's services at this hospital as "Requires Improvement". We identified issues regarding staffing, resuscitation equipment, insufficient mental health support and mandatory training.

At this inspection we found that incidents were reported appropriately; however for patient safety incidents a rapid review was completed for incidents that were identified as moderate, major or catastrophic. Subsequently not all significant incidents were subject to a thorough investigation where lessons learned could be identified, potentially meaning that incidents could reoccur. For those incidents that did undergo an investigation, the lessons learned identified had been shared with staff by newsletters and within 'safety huddles'. The trust's abduction policy was not being adhered to as it stated a physical test should be carried out on the policy annually but this had not happened for a number of years.

Medical staffing was a concern, with consultant paediatrician vacancies ranging between 33% and 18%. Consultant paediatricians raised concerns around a lack of job plans and also the lack of junior and middle grade doctors. Concerns were raised to us from consultant paediatricians in that they felt when they raised concerns with senior leaders they were not acted upon or investigated appropriately. We were told of patient safety incidents of deteriorating patients that were not

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identified to a consultant paediatrician in a timely manner. When these incidents had been raised on the incident reporting system, they had not had a root cause analysis completed and were not dealt with as significant incidents.

At our inspection in February 2014 we identified that there was insufficient child and adolescent mental health services (CAHMS) to meet the needs of the children who required this service. However, the trust had completed work in this area. It had improved links with the service and had identified specific training to be undertaken by nursing staff to improve their knowledge with child and adolescent mental health issues.

Children and young people's needs were assessed appropriately with care and treatment delivered in line with current legislation and evidence based guidance. Policies and procedures were in place and staff were aware of how to access them.

Parents and children were generally satisfied with the care they received and felt they had been kept well informed. They told us staff were compassionate and caring.

The service met the needs of the children, young people and their families. The environment in each area of the service for children and young people was a child friendly environment. We saw numerous examples of the way the service was able to meet the needs of children and young people and parents could be with their child at all times. Interpreting services were available as required.

Are services for children and young people safe?

Requires improvement



At our last inspection in February 2014 it was identified that a recognised staffing assessment tool was not used. Work had been completed in this area and the service were using a staffing acuity tool based on the Nursing and Midwifery Council's (NMC) tool, which looked at staff to patient ratio on a shift by shift basis. There were nursing staff vacancies, with vacancies ranging between 15% and 8% vacancies for the 12 month period 1st June 2014 to 31st May 2015. For the same 12 month period consultant paediatrician vacancies ranged between 33% and 18%. The medical staff skill mix showed a higher proportion of consultant grades than the England average, but lower for registrars and junior doctors, with no registrars in post. Locum consultant paediatricians were used to cover for the vacancies. Consultants had expressed concern about medical staffing levels as there was a lack of middle grade and junior doctors. There were no registrars in post and 4 junior doctors at the time of our inspection. The trust's abduction policy was not being adhered to as it stated that a simulation test should be carried out on the policy annually but this had not happened for a number of years.

Incidents were reported within the children and young people's service and staff were knowledgeable about what types of incident they needed to report and could demonstrate how these would be recorded and escalated. Areas we visited were visibly clean and tidy. Good hand hygiene techniques were observed with hand wash audits being completed. Equipment was fit for purpose and a fully comprehensive medical devices register was in place within the division.

Incidents

- Incidents were reported using an electronic reporting system. Staff were knowledgeable about the types of incident they needed to report and could demonstrate how these would be recorded and escalated.
- There had been four serious incidents within the children and young people's service requiring investigation between 1st May 2014 and 31st June 2015, including a neonatal death, a delay in transfer of a child, medication incidents and a delayed diagnosis. These

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incidents had been investigated by the children and young people's divisional leads and lessons learned and recommendations had been identified and implemented.

- Lessons learned from incidents were shared within newsletters emailed to staff and also at staff safety huddles for a one week period. These were subsequently transferred to a communications folder that all staff had to sign to identify they had read them. Staff gave examples of incidents where lessons learned had been implemented in practice.
- Lessons learned were also shared from the North West Neonatal Network of Lancashire and South Cumbria and examples were given of this.
- Staff within all paediatric disciplines were familiar with the term 'Duty of Candour' (the regulation introduced for all NHS bodies in November 2014, meaning they should act in an open and transparent way in relation to care and treatment provided) and families had been informed of incidents involving their child.
- Perinatal mortality and morbidity meetings were held on a quarterly basis.

Cleanliness, infection control and hygiene

- All areas inspected were visibly clean and hygienic.
- We observed staff washing their hands and using hand gel according to the trust's policy. We observed the appropriate use of personal protective equipment such as aprons and gloves. Hand gel dispensers were in prominent positions with the exception of the children's assessment unit where there was no accessible hand gel dispenser on entry.
- Fully completed cleaning schedules were in place with clearly defined roles and responsibilities.
- Single occupancy rooms were available on the children's ward for children requiring barrier nursing but not on the special care baby unit. Barrier nursing is a set of stringent infection control techniques used in nursing. The aim of barrier nursing is to protect medical staff against infection by patients, particularly those with highly infectious diseases.
- Hand wash audits were completed weekly on the children's ward. These showed that staff were mostly compliant with trust policy. The results were displayed for staff to see the results.

Environment and equipment

- The medical devices register for the children and young people's service showed that all medical devices kept within the service were calibrated appropriately. The scales were seen to have had portable appliance testing (PAT). PAT is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use.
- We found some single use, sterile equipment past the expiry date on the children's ward such as a connector and syringe in the high dependency room which expired in December 2013. This was brought to the attention of the staff on duty who confirmed they would dispose of them.
- The children's ward, outpatient department and special care baby unit had resuscitation equipment appropriate for babies, children and young people. This equipment was checked daily. This was an area that had improved following our last inspection when we found the resuscitation trolleys had items on display which could be easily removed without being noticed.
- On the special care baby unit there was a stabilisation room where poorly babies were stabilised prior to being moved to another hospital or until their condition was stable enough for the main area on the unit. During our last CQC inspection we identified that this room was very cramped with insufficient room to allow for full access of a clinical team to give emergency attention if the baby's condition deteriorated. We found this still to be the case with no alterations having been made. This issue was on the departmental risk register.

Medicines

- Medicines, including controlled drugs, were stored securely and access was limited to qualified staff employed by the trust. The keys for the control drugs were kept separate for increased security.
- The controlled drugs were checked twice daily at shift change over. A register was kept and fully completed. All control drugs were in date and accurately recorded.
- Fridge temperatures were checked and recorded daily on the children's ward. However, it was noted that the maximum temperature of the fridge in May 2015 and July 2015 had been recorded up to 22 degree centigrade consistently over several days. This was above the National Patient Safety Agency recommended range of between 2 and 8 degrees Celsius. Staff were not familiar with the recommended range of temperatures or how to

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reset the fridge, although they had responsibility for checking it. The matron gave assurance that the fridge contents had been disposed of once she had become aware of the issue.

- On the special care baby unit and the paediatric outpatient's department the temperature ranges were not checked. Any change in temperature out of the recommended range could potentially affect the cold chain making medication in the fridge unfit for use.
- Trust data showed that prescription audits measuring accuracy of completion of prescriptions had been completed in February, March and May 2015. The results were 93%, 87% and 96% accuracy respectively.

Records

- Paediatric medical records were paper based and completed by each member of the multidisciplinary team which allowed continuity of care for each child. We reviewed twenty sets of records and on all the records reviewed we saw that each professional had recorded their entries appropriately: documentation was accurate, complete and legible and up to date.
- Records were stored in trolleys on the special care baby unit and in a storage unit adjacent to the nurse's station on the children's ward.
- On review of children's records, it was noted that the majority did not contain a growth chart to enable the paediatrician to establish whether the child was growing appropriately, including in the records of a young person admitted with an eating disorder. A neonatal growth chart audit was completed in January 2015 which identified that only 48% of records contained a growth chart and the recommendations from this were that a growth chart should be completed for each child. The action plan for this identified that there should be a further audit undertaken in this area in November 2015.

Safeguarding

- Policies and procedures were in place for safeguarding adults and children and staff were familiar with them. Staff understood their responsibilities in relation to protecting children from abuse and responding to concerns of a safeguarding nature.
- Staff confirmed they could contact the designated safeguarding lead, safeguarding link nurses, social workers or paediatric liaison if a patient was suspected of being at increased risk of abuse or neglect.

- The child or young person's records contained a safeguarding sheet which identified any safeguarding concerns in the family.
- There was a safeguarding folder kept on the children's ward that identified all babies up to 12 months of age where there were any safeguarding concerns. Staff were familiar with this folder and felt that the system worked well. There was no such system in place for children aged 12 months or over.
- The trust was completing audits on the use of the safeguarding trigger tool specific to children and young people within the emergency department. The results for December 2014 to March 2015 showed the trust was performing above the trust target. However, the audit was not completed between April 2015 and July 2015.
- The trust had an abduction policy which all staff were aware of and were observed to be monitoring all people entering and leaving the ward/unit. However, the policy states that a simulation test should be carried out to test the policy annually but this had not happened for a number of years.
- 99% of staff had completed level one safeguarding children training, which was higher than the trust target of 95%. However, the completion rates for levels two and three were lower than the trust target at 88% and 80% respectively.

Mandatory training

- Staff received training in: fire safety; conflict resolution; health, safety and welfare; equality and diversity; manual handling; information governance; infection prevention; information governance; resuscitation and safeguarding children levels one to three and safeguarding adults levels one and two.
- Staff reported that they were supported to complete their mandatory training and felt they had enough time to complete it.
- Records showed the training completion rate for all staff across the children and young people services ranged between 30% and 100%. The topics with the lowest completion rates were moving and handling Modules C to F (30%-35%) and conflict resolution (61%) which was significantly lower than the trust's target of 95% completion.
- Staff within the children and young people's service received profession specific training and development days referred to as 'PANDA' (paediatric and neonatal activity development activity).

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Assessing and responding to patient risk

- A paediatric early warning tool was used to aid recognition of sick and deteriorating children, which ensured children were seen urgently, if required. The tool used was the 'children's physiological observation track and trigger system' (CPOTTS) and we saw that this had been completed for each child.
- Staff told us that medical staff provided prompt support to children and young people in the special care baby unit and on the children's ward. This support was ordinarily from a consultant paediatrician due to the 24 hour consultant cover at the hospital.
- The hospital used the North West and North Wales Paediatric Transport services, a specialist transport service for critically ill children and neonates transferring from district general hospitals to one of the two paediatric intensive care units within the North West and North Wales area. The trust could also access clinical advice on the management of critically sick children before they required paediatric intensive care.
- Staff were aware of how to escalate key risks that could affect patient safety, such as staffing and bed capacity issues, and there was daily involvement by ward managers and the matron to address these issues.

Nursing staffing

- There were nursing staff vacancies ranging between 15% and 8% for the 12 month period 1st June 2014 to 31st May 2015 across children and young people's service at the hospital, including the children's ward, special care baby unit and outpatient's department.
- The children's ward used a staffing acuity tool based on the 'defining staffing levels for children's and young peoples services (2013)' as identified by the Royal College of Nursing, which looked at staff to patient ratio on a shift by shift basis. Staff reported this worked well in practice. The staffing establishment was also assessed across the trust and staff were moved according to need.
- We were told by nursing staff and managers that the trust had identified there should be a band six senior nurse on each night shift due to their increased skills and experience. However, staff raised concerns with us that night shifts were frequently led by band five nurses.

We reviewed staffing rotas for the month prior to the inspection and found that 16 out of 28 night shifts were covered by band five nurses and 12 covered by band six nurses.

- Nursing safety huddles occurred three times per day. Staff valued these safety huddles and felt it was a good method of updating them during their shift. We observed a safety huddle and found that it was very thorough.
- Staff on the special care baby unit were rotated onto the neonatal unit at Royal Lancaster Infirmary to ensure that they maintained their skills in each area. This had been implemented following our last inspection where it was noted that there was a high incidence of staff sickness with stress associated with working on the unit.
- The neonatal unit used the 'British Association of Perinatal Medicine' (BAPM) acuity tool. This equated to one to one nursing in the intensive care unit and one to two nursing in the high dependency unit. This acuity tool also takes into account skill mix. On the days of the inspection and on review of two months of duty rotas, we found that there was long term staff sickness on the special care baby unit.
- Agency staff were used on the neonatal unit. However, the unit made attempts to cover with agency staff who had experience of working on the unit. All agency staff were orientated to the unit and their training and competencies were managed by the relevant agency.

Medical staffing

- For the 12 month period June 2014 to May 2015 consultant paediatrician vacancies ranged between 33% and 18%. The medical staff skill mix showed a higher proportion of consultant grades than the England average, but lower for registrars and junior doctors, with no registrars in post. Locum consultant paediatricians were used to cover for the vacancies.
- The trust had plans in place to increase the number of consultant paediatricians from 10 to 11. However, at the time of the inspection no timescale had been identified for this.
- The service had 24 hour consultant paediatrician cover. There were 10 consultants working a 24 hour roster, which included a resident consultant and a second consultant on-call. This meant that children were reviewed by a consultant at whatever time they presented.

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- Consultants expressed concerns that they frequently worked through the night and subsequently worked through the following day without a break. They told us that they felt that a reason for this was due to the lack of middle grade and junior doctors.
- We were also told that paediatric clinics were frequently cancelled with less than six weeks' notice due to the consultant rota. Data provided by the trust identified that over the six month period, 1st January 2015 to 30th June 2015 there were a total of 33 outpatient's clinics cancelled (133 appointments), with 21 of these with less than six weeks' notice. The data provided by the trust was only available for trust wide figures and not for each hospital.

Major incident awareness and training

- There was a documented major incident plan within the children and young people's services listing key risks that could affect the provision of care and treatment. There were clear instructions for staff to follow in the event of a fire or other major incident. However, not all staff were aware of where they could locate this in the event of a major incident.
- Major incident awareness was not offered to staff as mandatory training. This was only offered as role specific training.

Are services for children and young people effective?

Good



Children and young people's needs were assessed appropriately with care and treatment delivered in line with current legislation and evidence based guidance. Policies and procedures were in place and staff were aware of how to access them.

Pain scores were completed in all the records that we reviewed but not all records contained the pain assessment tool. Nutrition and hydration were monitored and menus were child friendly and healthy foods were offered. The majority of services were offered seven days per week with the exception of the outpatient's department which was a Monday to Friday service.

Evidence-based care and treatment

- Policies and procedures were in place and could be accessed via the trust's intranet. Staff were aware of how they could access them.
- The service used a combination of National Institute for Health and Care Excellence (NICE), British Association of Perinatal Medicine (BAPM) and Royal College' guidelines to determine the care and treatment provided.
- Frequent audits were completed in paediatrics in areas such as paediatric records, epilepsy, diabetes and prescription completion. The results of these audits were largely positive. Subsequent action plans were implemented.
- All children had care plans within their medical records. However all the care plans that we reviewed were generic care plans and the individual issues section was not always completed. The impact of this is that children are not having a formal individualised plan of care.
- Appropriate care pathways were in use and were in keeping with the relevant NICE clinical or nursing guidance.
- The special care baby unit was part of the Lancashire and South Cumbria Neonatal Network and the ward manager attended quarterly meeting where best practice was discussed and lessons learned from incidents and complaints shared across the network.
- The special care baby unit was in the process of working towards the 'Bliss baby charter'. The Bliss baby charter is a guide to help hospitals provide the best possible family-centred care for premature and sick babies. This approach places parents at the centre of their baby's care.
- The trust was not working towards Unicef Baby Friendly status and there were no plans in place to do so. Research recommends Baby Friendly status as the best mechanism to raise breastfeeding rates (Department of Health guidance).

Pain relief

- Pain scores were completed within the records that we reviewed.
- Non-medication interventions for pain relief were also used, including comfort holding for babies and use of the play specialists for distraction techniques.

Nutrition and hydration

- On the special care baby unit and the children's ward there was a 'milk room' where there was a designated

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fridge for expressed breast milk. This was observed to be clean and well organised with trays that clearly identified each baby on the unit. However, the milk room or the fridge was not locked meaning that there was open access to anybody on the ward, with the potential of the milk being unknowingly tampered with.

- Breast pumps were available on the special care baby unit to loan to mothers who wished to express breast milk. Four new pumps had recently been purchased using charitable money.
- Children and young people were able to choose what they wanted for their meals from newly designed menus. The menus also had pictures of the meals to appeal to younger children and those children with learning difficulties.
- Meals were served by catering staff on the ward which ensured that correct portion sizes were offered.

Patient outcomes

- The rate of emergency re-admission within two days of discharge for non-elective paediatrics under one year of age was 3.8% and between 1-17 years was 3.3%. These were similar to the England average. However, for paediatric diabetes the re-admission rate was 14.9% which was higher than the England average.
- The rate of multiple (two or more) emergency admissions within 12 months among children and young people with asthma was 17.3% between January 2014 and December 2014 which was just above the England average.
- Data provided by the trust showed that the sub-speciality paediatric referral to treatment (RTT) performance for the trust's non-admitted patients ranged between 96.55% and 99.48% for the period January 2015 and June 2015, which was better than the trust threshold of 95%.
- The trust completed a paediatric asthma audit in November 2014 which showed that 61% of children presenting with asthma symptoms were managed in the children's assessment unit which was much higher than the national figures of 29%. This was subsequently better for children due to less children presenting with paediatric asthma being admitted to hospital as an inpatient. The audit also showed that of the 55% of children that required a follow up appointment, 40% were followed up by the hospital and only 15% of children were advised to see their GP compared to 40% nationally.

- The trust completed an audit looking at atopic eczema in children between February 2014 and August 2014. The NICE audit support document standards were used to completed this audit. The 100% standard required to meet the NICE guidelines for atopic eczema was not met. An action plan had been written to address this and the trust had identified that they will repeat the audit in March 2016 after the recommendations have been implemented.

Competent staff

- Trust data showed 75% of medical staff and 91% of nursing staff, bands one to seven, had received their appraisals. For medical staff this was lower than the trust target of 90%.
- Nursing staff working on the special care baby unit rotated onto the neonatal intensive care unit at the Royal Lancaster Infirmary Hospital to ensure they kept up to date with their practice.
- Student nurses told us that they were mentored by experienced staff and supervised in their practice. They said that they had received an orientation to the ward and had all received good support from the paediatric staff while on the wards and departments. The student nurses we spoke with told us they were enjoying their placement.
- No structured clinical supervision sessions were taking place at the time of the inspection. Staff or managers were not aware of any plans for this to be implemented. At the time of the inspection staff were doing informal supervision between their peers or with their manager.
- There was no rotation for medical staff to larger neonatal or paediatric units to ensure their skill base was kept up to date with procedures such as advanced paediatric life support. The trust had highlighted this as an area for improvement but due to the challenges of medical staffing this had not yet been implemented.

Multidisciplinary working

- Good multidisciplinary team (MDT) working was noted on every area visited. The ward rounds were attended by a multidisciplinary team and reviewed each child. Discussions were documented in the medical notes.
- There was one play specialist in post at the time of inspection with another one having been recruited and was due to commence in post. The play specialist worked over all children's service departments. However, this service was not available over weekends.

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Seven-day services

- There was consultant paediatrician cover at all times within the hospital with a second consultant on-call that could be called in if required.
- There were seven-day services within the paediatric services with the exception of day surgery and outpatient clinics. Ward clerks and play specialists were available five days per week. The paediatric outpatient department operated from Monday to Friday.

Access to information

- Policies and protocols were kept on the hospital's staff intranet so that all staff had access.
- Medical records were kept on the ward and were accessible to all staff that were involved in the child's care. All staff made notes in these records to ensure that they reflected the current care received.
- When children were discharged, health visitors were notified to ensure continuity of care.

Consent

- Consent was obtained from parents for each child or young person. Staff were aware of the appropriate procedures in obtaining consent. We saw staff talking to and explaining procedures to children in a way they could understand.
- During our last inspection it could not be established if Fraser guidelines (used to help assess whether a child has the maturity to make their own decisions and to understand the implications) were being followed. However, within this inspection, it was clear during discussions with staff that they used the principles of the Fraser guidelines when making decisions about young people's ability to consent to procedures.

Are services for children and young people caring?

Good



Parents, carers and children were positive about the care and treatment provided. They felt supported, involved in their child's healthcare and received information in a manner they understood. Staff were compassionate, kind and respectful whilst delivering care.

Staff were child and family-focused and they looked at the family unit when completing their assessments. Good interactions were observed between staff and children, young people and their families.

Compassionate care

- Children, young people, their families, relatives and representatives were positive about the care and treatment provided by staff. Patients and those close to them were happy and relaxed in the department and staff interacted well with them.
- During conversations with staff it was clear they were very sensitive to parents' needs and supportive when helping them come to terms with their current medical situation.
- The NHS friends and family test for children and young people's services showed 90% of parents and children were likely to recommend the services to their friends and family. The friends and family test was introduced in 2013 and asks patients whether they would recommend NHS services to their friends and family if they needed similar care or treatment.
- A '15 step challenge' had been completed which identified staff were very caring and positive with good communication.

Understanding and involvement of patients and those close to them

- Parents told us that staff listened to what they had to say and involved them and their children where possible, in the care and treatment of their baby/child. All parents said that they were kept well-informed by staff. We observed a clinical intervention on a child where a full explanation of the procedure was given to the child and parent in an age appropriate manner.
- We observed one child having a cannula inserted where we observed the staff involving the child and parent in the procedure and put the child at ease.
- Parents were encouraged to stay with their child on the children's ward. On the children's ward there was no room that parents could access to stay overnight but they were provided with a camp bed next to their child's bed/cot.

Emotional support

- The trust had developed better links between children and young people's services and the child and adolescent mental health services (CAMHS), which was

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an improvement from our last inspection. However, staff felt that due to the demands in this service there was sometimes a delay in children and young people being seen after being referred.

- There was a bereavement support link nurse that supported parents and families. There was also a midwifery bereavement co-ordinator who had close links with the special care baby unit.
- Parents were involved in developing an end of life care plan for their child where appropriate. We were told of instances where the parents have led on this for their child and had received a lead nurse to support them through this process.
- We saw that staff were able to build relationships very quickly with parents, children and young people. We saw evidence of this in all areas, including the ward, outpatients and special care baby unit. One example that we observed was the support a play specialist gave to a child and parent prior to them going to theatre.

Are services for children and young people responsive?

Good



The service met the needs of the children, young people and their families. The environment in each area of the service for children and young people was a child friendly environment. We saw numerous examples of the way the service was able to meet the needs of children and young people and parents could be with their child at all times. Interpreting services were available as required. The service received very few complaints but lessons learned from the complaints that they did receive were shared with staff.

At our last inspection it was identified that there was insufficient child and adolescent mental health services (CAMHS) to meet the needs of the children who required this service. However, the trust had completed work in this area and had improved links with the service and had identified learning needs with the nursing staff which was scheduled to be delivered later in the year.

Bed occupancy was 47% for the children's ward, 74% for special care baby unit and 30% for the children's assessment unit for the period 1st July 2014 to 15th July

2015 which were lower than the national paediatric bed occupancy of 75.9%. There was no neonatal outreach team due to the staffing shortages on the special care baby unit, which subsequently could delay discharge.

Service planning and delivery to meet the needs of local people

- The trust had achieved their local 'Commissioning for Quality Innovation' (CQUIN) target for 2014/15 which was for young people transitioning to adult services. This involved young people aged 14-18 with long term conditions, including diabetes, epilepsy and asthma and who were under the care of a paediatrician having transition care plans.
- Outpatient appointments took place in dedicated paediatric facilities. The environment of the outpatient's clinic was child friendly with toys available and access to a play specialist if required.
- Paediatric nurses rotated onto the emergency department every day covering between 9am and 10pm. This ensured that children were cared for by a paediatric nurse and they received child focused care. Band six staff from the children's ward rotated onto the emergency department once they had completed the emergency department triage course.
- The special care baby unit was a tier 1 tertiary unit (which is a neonatal unit that provides special care for babies within the local population) and part of the North West Neonatal Network of Lancashire and South Cumbria that included two tertiary units. Good working and transport arrangements were in place with neonatal intensive care and high dependency units across neighbouring counties as part of the regional transfer network.
- If there were male and female adolescents needing inpatient care on the children's ward, designated single rooms as well as bays were used. There were separate male and female toilet and bathroom facilities.

Access and flow

- There was no neonatal outreach team, although the commissioning agreement was being reviewed as part of a local initiative. Managers told us that there was concern around this service being staffed by current special care baby unit staff when there was already nursing shortages. Invariably this meant that the discharge of neonates could be delayed due to the lack of cover for this service.

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- Staff told us that there was often a delay in discharge medications arriving from pharmacy which subsequently delayed discharge. However, the matron informed us that if the child or young person was ready to be discharged in an evening, they would be given medication dispensed from ward stock to last overnight and they then asked the parents to return to the ward the following day to collect the discharge medication from pharmacy. This prevented a child staying in hospital overnight if there was no medical need.
- Patients could be referred to the children's assessment unit by GPs and the emergency department, and known patients could have direct access to the unit which allowed for a quicker assessment.
- Very small numbers of children were transferred out of the hospital with only 30 children being transferred to other hospitals between 1st July 2014 and 31st June 2015. However, when children were required to move to other hospitals for more specialised care staff told us that the process was very quick and efficient.
- For children and young people that attended the emergency department there were 18 children over a six month period between 1st January 2015 and 31st June 2015 that waited over the Department of Health's guidance of four hours.
- Bed occupancy for the children's ward was 47%, special care baby unit was 74% and children's assessment unit was 30% for the period 1st July 2014 to 15th July 2015 which were all lower than the national paediatric bed occupancy of 75.9%. The National Audit Office advises that hospitals with average bed occupancy levels above 85% can expect to have regular bed shortages, periodic bed crises and increased numbers of health care acquired infections.
- At the last inspection it was noted that there was insufficient CAHMS services to meet the needs of the children and young people who required this service. Although there were some improvements evident, there was still a shortage of mental health support available to young people who required it. The improvements included CAHMS contacting the ward on every week day to establish if any young people required their input and to offer support. Also the ward had arranged some training to take place on issues such as eating disorders, female genital mutilation and self-harm to enable staff to care for these young people more effectively. Also the staff utilised an agency to provide one to one support for young people who were at risk of self-harm when required.
- The children's ward had invited the autistic society and also special educational needs students to complete the 15 steps challenge to enable the ward to be more appealing to children and young people with learning difficulties. The ward had developed an action plan as a result of this and was in the process of completing the actions.
- There was access to a children's play area and also a youth room. There were many age appropriate toys, activities and games consoles.
- The ward had access to a school service providing access to relevant children on the paediatric ward. Children who were in hospital longer term had access to a teacher. Where the child was able to, they could attend the school/youth room to make sure they did not fall too far behind in their learning.
- The postnatal ward provided transitional care and support to mums and babies with a mix of post natal staff from the maternity services to care for mum and neonatal staff that provided care to babies and advice and support to mums. Transitional care was for babies who may have been admitted straight from the delivery suite or from the special care baby unit when they no longer required close monitoring, so Mothers could get to know their baby and establish feeding routines before being discharged home.
- The play specialists were responsive to the needs of children within different paediatric areas of the hospital. They told us they frequently were asked to support children and young people in the emergency department, outpatient clinics and theatres. Children and parents were very complementary about this service.

Meeting people's individual needs

- The children's ward had a mixture of four-bedded bays and single rooms. Separate toilet facilities were available for children, parents and staff. The ward had a parents' room that offered a sitting area, shower, toilet and kitchen facilities. There were transitional rooms available on the postnatal ward for mothers' babies that required additional support.
- Translation services were available if required. There were posters displayed in prominent areas around the children's areas to notify parents and carers of the service.

Services for children and young people

- All areas of the hospital that children visit were child friendly, including the outpatient's department, children's ward and the emergency department.
- The ward housed both a youth room and a play area. The youth room was in the process of being updated following feedback from young people.

Learning from complaints and concerns

- Information was displayed in all wards and departments explaining how parents, children and young people could raise their concerns or complaints.
- Out of a total of 319 complaints received by the trust 1st June 2014 to 31st May 2015 only six related to the children and young people's division.
- Lessons learned from complaints were shared at safety huddles and then stored in a folder where each staff member was expected to sign to identify that they had read it.
- Staff were all aware of the complaints process. Staff told us that they would always try to resolve any issues immediately. If issues could not be resolved, the family was directed to the complaints process. Staff were aware of any complaints that had been made about their own ward or department and any learning that had resulted from them.

Are services for children and young people well-led?

Requires improvement



Consultant paediatricians raised concerns around a lack of job plans and also the lack of junior and middle grade doctors. Concerns were raised to us from consultant paediatricians in that they felt when they raised concerns with senior leaders they were not acted upon or investigated appropriately. Examples given included concerns raised under bullying and harassment, lack of junior doctors and also patient safety incidents. We were told of patient safety incidents of deteriorating patients that were not identified to a consultant paediatrician in a timely manner. When these incidents had been raised on the incident reporting system, they had not had a root cause analysis completed and were not dealt with as significant incidents.

There was a departmental risk register in place and staff were aware of the identified risks. This was up to date and reviewed regularly. However, for patient safety incidents a rapid review was completed for incidents that were identified as moderate, major or catastrophic. Subsequently root cause analysis were not completed for all significant incidents.

There was a clear vision for the service and for the trust. Staff that we spoke with were knowledgeable about this. Nursing staff felt that the board were aware of the service they provided and were aware of the trust's vision and values.

Vision and strategy for this service

- The trust values were displayed in a number of areas that we visited which were the special care baby unit and the children's ward. There was a clear vision for the service and for the trust and staff that we spoke with were knowledgeable about this.
- There was a vision within children and young people's service to train three advanced nurse practitioners to assist in the junior doctor rota.

Governance, risk management and quality measurement

- The children and young people's service had a departmental risk register and staff were very aware of what the identified risks were. This was up to date and reviewed regularly.
- Within incident management the children and young people's division undertook a 'rapid review' for all incidents classed as moderate, major or catastrophic. This involved the ward manager or matron reviewing the case notes and feeding this into a weekly governance meeting. A decision was made at this meeting whether a root cause analysis was required. Subsequently not all significant incidents were subject to a thorough investigation where lessons learned could be identified.
- There was a monthly paediatrics divisional audit progress report and a divisional and governance assurance report, that reported issues such as sickness and absence, patient safety incidents, training and development, risk register and root cause analysis to the trust's board.

Leadership of service

Services for children and young people

- Nursing staff felt that their managers and matrons were visible and approachable.
- There was a weekly nurse management meeting attended by matrons, ward manager and senior leadership where agenda items included sickness, audit, training and governance. This meeting was rotated between Royal Lancaster Infirmary and Furness General Hospital.
- Concerns were raised to us from consultant paediatricians that they felt when they raised concerns with senior leaders they were not acted upon or investigated appropriately. Examples given included concerns raised under bullying and harassment, lack of junior doctors and also patient safety incidents.
- Several consultant paediatricians raised concerns around the lack of a job plan and also the lack of junior and middle grade doctors. The reason staff gave for this was that their understanding was a job plan had been written but this had not been approved by the Royal College of Paediatrics and Child Health (RCPCH), due to the lack of junior and middle grade doctors. These consultants raised concerns that they felt the current working patterns were 'unsafe'. Each of the consultants advised that they had raised their concerns to senior management but had not received a response and felt that no subsequent changes had taken place.
- Information supplied by the trust showed that there were no current job plans that reflected the current working pattern of the consultants. The trust advised that this was mainly due to getting additional resource for staffing levels and they were in the process of constructing formal job plans.
- Consultant paediatricians raised concerns that they felt there was a 'bullying' culture within their team. They reported they had raised concerns to their clinical lead but reported they felt they had not received the necessary level of support.
- We found there was low staff morale amongst the team of consultant paediatricians; this was a particular concern in the neonatal service. They raised concerns to us in relation to them not working well as a team and difficulties with providing cover for each other in relation to sickness or in unforeseen circumstances. Concerns were also raised to us in relation to bullying and harassment issues within the team. Consultants told us they had raised concerns with senior management but felt that no action had been taken as a result of the concerns being made and they had not received any response. When we raised these issues to the senior managers it was clear that a clear process had not been identified to address the concerns.
- We found there was a lack of morale amongst the medical team.

Public engagement

- Food menus had been changed with the input from children, young people and their families. The need for change had been identified on patient feedback in that it had previously not been child friendly or particularly healthy.
- There was an annual ward 'take over day', where young people were invited to come in and be involved in how the ward was run and provide suggestions for improvement. On the last 'take over day' one of the issues that was identified was that young people did not always want to talk in front of their parents and they would value being able to have private discussions with staff. This resulted in posters being developed and put round the wall to advise young people that this option is available if required.
- The ward had completed the '15 steps' challenge with various groups of stakeholders. They had subsequently made changes to the ward following the feedback from this, including changes to the youth room, displays on the ward and also having pictures on the menus to appeal to autistic children. The 15 Steps Challenge is a tool to help staff, patients and others to work together to identify improvements that will enhance the patient experience. The challenge is a ward walk around, seeing the ward through a patient's eyes.

Culture within the service

- All nursing staff spoke positively about the care that they were providing to the children and young people.
- We saw how staff placed the child and the family at the centre of care delivery, and how this was seen as a priority and everyone's responsibility. We observed that staff were respectful towards each other, not only in their specialities, but also across disciplines.
- We were told that four consultant paediatricians had left the service within the 12 month period prior to the inspection, three of which were substantive posts and one was a locum post.

Services for children and young people

- The patient experience link nurse goes into local schools to engage young people and to receive information about what suggestions young people may have and what they might want in a hospital.

Staff engagement

- Some staff on the children's ward raised concerns to us that they felt that when they had made suggestions for improvement on the ward, they were not always listened to, examples included delays in discharge medication and concerns around not always having a senior nurse on the night shift. Nursing staff were also concerned that they were frequently moved to the Royal Lancaster Infirmary without any prior notice. Also they felt concerned that they were expected to work in an unfamiliar environment and they were a significant distance from home.

- Staff received a regular newsletter which they told us they valued. The newsletter kept them informed of governance issues and trust strategy.

Innovation, improvement and sustainability

- The children's division had recently secured funding to train three paediatric advanced nurse practitioners. The training was due to commence in September 2015 and will last two years with a further year consolidation. The trust had no paediatric advanced nurse practitioners in post at the time of the inspection.
- Frequent audits took place within the children and young people's service which were evaluated and plans put into place to enhance service improvement.

End of life care

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

Information about the service

End of life care services at Furness General Hospital (FGH) for the purposes of governance reported through the medicine division. At Furness General Hospital patients with end of life (EOL) care needs were nursed on the general wards. There were 1,261 deaths across the three hospital sites in 2014. From April 2014 -January 2015, 896 patients had been referred to the specialist palliative care team (SPC).

The hospital consultant-led Macmillan SPC nurses are ward based and developed treatment plans and symptom control for patients which the general nursing teams delivered. The Macmillan SPC lead nurse took the lead role at FGH as there was no palliative care consultant for this site.

The trust has a bereavement team who provide care and support to relatives and there are well established links with voluntary and charitable organisations providing hospice care, counselling and bereavement support.

During this inspection we visited five inpatient wards; wards 6 (stroke/elderly care), 7 (respiratory/general medicine), 9 Coniston suite cardiology/gastroenterology/ oncology) and 5 (general surgery) and the acute medical unit (AMU). In addition we visited the spiritual centre, bereavement office, hospital mortuary and the viewing room.

We observed care, looked at nine care records and spoke with nine patients and seven relatives. We also spoke with staff across all disciplines, including doctors, nurses, health

care professionals, members of the management team, porters, chaplains, bereavement team, engagement officer, Patient Advice and Liaison Service (PALS) and mortuary staff.

We also spoke with the three SPC nurses, the clinical lead for palliative care and the palliative care consultant. In addition we 'shadowed' a SPC nurse who provided treatment and symptom control for patients, and support and advice for staff, patients and their relatives at the hospital.

We looked at policies and procedures. We received comments from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

End of life care

Summary of findings

At the last inspection in February 2014, we rated end of life care as good overall, with safe as required improvement. This was in relation to the variation in the standard of DNACPR records and documentation.

During this inspection, we found that improvements in a number of areas had been made. A replacement advanced care plan had been piloted across two wards and was now fully implemented across the trust following a programme of staff training. An audit was completed in January 2015 by the trust to check DNACPR documentation. Following the findings of the audit, training had been provided and staff were working on the actions, however there were some shortfalls in records particularly around staff understanding and awareness of how to assess people's capacity to make decisions. There had been an increase in palliative care consultant cover however there remained insufficient palliative care consultants to cover FGH. This post had been vacant for eight years and the service was currently managed with the existing palliative care consultants.

Processes for incident reporting and learning were in place. Some wards had received Gold Standard Framework (GSF) accreditation. Arrangements for medications were well planned and managed including the prescription of anticipatory medication.

There were effective processes for rapid discharge that enabled patients to be discharged from hospital to home in the last hours or days of their lives. There was currently no joined up system for information sharing however there were plans to introduce the 'electronic palliative care co-ordination systems' (EPACCS) from July 2015.

The trust had plans in place to integrate end of life care services into the 'Better Care Together' strategy.

The nursing and medical staff were working with primary and secondary health care professionals to adopt nationally recognised best practice tools, including the GSF, preferred place of care, priorities for care for the dying person and the advanced care plan. It was clear the trust were working hard to embrace partnership working. The timeline for implementation

was slow. Two fixed term nursing band 6 educator posts had come to an end as well as the end of life nursing lead and there was concern regarding the impact this would have on the provision of end of life care services.

End of life care

Are end of life care services safe?

Good



Procedures were in place to support staff in reporting incidents. Learning from incidents took place within the SPC team at meetings and for staff at ward level. Anticipatory end of life care medication was prescribed appropriately. Since the last inspection there was now consistency in using the same equipment to minimise the risk of errors. Training for equipment used specifically by the SPC team; such as syringe drivers had been rolled out to staff across the trust. Staff were clearly aware of their role and responsibilities in relation to safeguarding.

Staffing levels for the SPC team was generally sufficient to meet the needs of patients however, if the service was to become a seven-day service additional staffing would be required. Medical cover had increased since the last inspection however there was a palliative consultant medical staffing vacancy which was recorded on the risk register. Despite the post being at FGH this had an impact on the provision of the service overall.

Out of the seven DNACPR forms reviewed at FGH, three had been completed appropriately. Although we found shortfalls, the forms were generally well completed, legibly signed and counter signed appropriately. We saw some clear record keeping on the forms and in patients' notes of the reason why the decisions were made, with involvement of the patient or a family member and the involvement of an appropriate clinician. Some of the minor shortfalls we noted included: gaps in timing between junior doctor and consultant's signature, no use of the junior doctors GMC number and no use of an identity stamp.

Incidents

- Staff confirmed they were encouraged to report incidents and they were knowledgeable about the incident reporting process. Staff could recall incidents they had reported with reference to end of life care issues. One example was in relation to poor communication with a patient's relative regarding resuscitation. Staff had since attended the 'Sage and Thyme' study day to improve their communication skills. SPC staff told us of a monthly newsletter, which outlined lessons learnt from incidents.

- Mortuary staff completed an incident form if they had any concerns regarding the moving and handling or presentation of a deceased patient or regarding correct identification procedures.
- Staff reported they received feedback and were alerted to any themes from incidents. Minutes from the End Of Life (EOL) operational group showed staff were encouraged to report a clinical incident where a patient was unable to be discharged due to unavailability of nursing home beds.
- Staff confirmed they attended ward meetings and multi-disciplinary meetings where issues relating to incidents were reported. Staff on ward 6 explained they used reflective practice to think about what they could have done differently in the event of an incident to improve the outcome for a patient. In addition they used a communication book to share any information with each other.
- Medical staff we spoke with demonstrated an understanding of their individual responsibilities in relation to the duty of candour. Medical staff were supported to be open and honest with patients and apologise when things go wrong. Incident reports included a prompt to remind staff to send a duty of candour letter where appropriate. The Duty of Candour is a regulatory requirement. The aim of the regulation is to ensure trusts are open and transparent with people who use services and inform and apologise to them when things go wrong with their care and treatment.
- SPC staff attended mortality reviews and despite the target for reviews being 50% the team tried to review every patient to establish any learning.

Medicines

- Anticipatory end of life care medication was prescribed appropriately. We reviewed seven medication administration record (MAR) charts on the wards we visited and saw appropriate prescribing. We saw that staff followed the policy and managed controlled drugs in accordance with the Controlled Drugs Regulations 2013.
- Medical staff said they followed the trust's clinical guidelines on anticipatory medication prescribing. In addition they were provided with advice and support from specialist nurses.

End of life care

- Nursing staff said they felt EOL medication was well managed and patients received effective symptom control. Staff confirmed there was access to an on-call pharmacist for 'out of hours' medication requests.
- In 2011, the National Patient Safety Agency recommended that all Graseby syringe drivers should be removed by the end of 2015. Since January 2015 new syringe drivers were available to deliver subcutaneous medication. Staff said each ward was assigned two syringe drivers and they could access a syringe driver when prescribed. This included for those patients who were being discharged home.
- Training for the use of the McKinley syringe drivers had been rolled out to staff across the trust and advice from the SPCT was provided as required.
- One of the specialist nurses was a nurse prescriber due to complete this training. Ward nurses discussed medication changes with doctors when advice was not sought from a specialist nurse.
- On ward 6 we saw anticipatory medication was prescribed in a timely manner, leading to relief for a patient who was in pain. Staff told us they sought advice from the specialist nurse if they had any concerns that a patient was not being kept pain free.

Records

- Work has been undertaken by the trust following the review of the 'Liverpool Care Pathway' (LCP) and the decision to withdraw it in July 2014. Guidance was available for staff for 'Best Care for the Dying Patient' until all wards and clinical areas were using the new care of the dying patient (CDP care plan introduced by the trust). The hospital used paper-based and electronic records. We were unable to locate any patients who were using the new CDP during this inspection. Staff spoken with were aware of the new care plan but not all staff had completed the training.
- We saw clearly documented care of the dying pathway care plans for two patients. The assessments and entry onto the pathway were comprehensive. Breaking bad news was included in the notes and subsequent medical and clinical notes were well documented to show these patients journeys.
- Care plans we looked at on the wards to assess and record patients' EOL care reflected national guidance.

These records provided sufficient information for staff to provide safe, effective care. Records included completed risk assessments for example, falls, nutrition and pressure relief.

- We saw evidence of use of an orange sticker system in place which highlighted when the SPC nurses had recorded in patients notes to minimise the risk of information not being seen by staff.
- In January 2014 the trust introduced the 'Deciding Right' DNACPR (do not attempt cardio-pulmonary resuscitation) form which was being used across North Lancashire and Cumbria in line with guidance published by the General Medical Council (GMC). A case note audit of the decision making and documentation was completed in February 2015. Out of 132 patients with a DNACPR in place, only 50 patients had information recorded on 'Lorenzo' relating to EOL care. This audit highlighted the need to improve the electronic information recording and sharing, which was starting to be addressed. Improvements to the clinical note recording on 'Lorenzo' would enable the information to be shared with the GP's palliative care register.
- At FGH we found some minor shortfalls in three out of seven DNACPR forms. The DNACPR forms and the medical notes we reviewed highlighted clear records in patients' notes of the reason why the decisions were made, with involvement of the patient or a family member. Some of the shortfalls we noted included: gaps in timing between junior doctor and consultant's signature, no use of the junior doctors GMC number and no use of an identity stamp.
- Medical staff were able to describe the procedures for DNACPR forms and told us they had received 'refresher' legal training in December 2014. Relatives of end of life patients told us their relatives' resuscitation status had been explained to them prior to completion. The trust acknowledged the need to ensure training was ongoing to ensure staff were consistent in completing these forms.
- We saw patients' records were stored securely on wards to ensure access was appropriate.
- Recording systems were in place in the mortuary to ensure patients were admitted and kept appropriately.

Safeguarding

End of life care

- There were adult safeguarding policies and procedures in place. Staff knew how to report and escalate concerns regarding patients who were at risk of neglect and abuse.
- All staff in the SPC had attended mandatory safeguarding training for both vulnerable adults and children.

Mandatory training

- All staff in the SPC team were up to date with their mandatory training. Mandatory staff training currently included a care of the dying study day which included a bereavement section and a one hour session on an 'Overview of Care of the Dying'.
- Staff training and education for managing the care of patients at the end of life had been provided on an ongoing basis by the SPC team and currently by the Gold Standards Framework (GSF) and the bereavement co-ordinators who were rolling this out to all staff.
- Electronic educational packages with learning on DNACPR, advanced communication skills, palliative care and oncology were readily available. This training was mandatory for junior doctors and band 5 nurses caring for oncology patients. Senior staff were able to monitor the staff who had completed this training to ensure learning was being implemented. There was some concern raised by the SPC team, doctors and ward staff that this training should be mandatory throughout the trust and was not.
- The trust was undertaking the Gold Standards Framework (GSF) for acute hospitals training and a training programme was in place to provide ward staff with training in the principles and practice of GSF. This was national accredited training aimed at enabling frontline staff to provide a gold standard of care for people nearing the EOL.
- All staff we spoke with raised concerns that both co-ordinator posts were being phased out and the training role was now being taken on by the local hospice.

Assessing and responding to patient risk

- Staff used an early warning scoring system to alert nursing and medical staff that the patients' condition had deteriorated. Patients' documentation was transferred to a care of the dying care plan when the recognition was the patient was expected to die within hours or a few days.

- A system was in place to identify patients by use of a discreet symbol on the electronic board who were for example, EOL. Staff showed a mixed understanding about these symbols on the wards we visited.
- Ward staff had contact details for the SPC team and confirmed the team responded promptly when needed.

Nursing staffing

- Staffing for EOL care was the responsibility of all the staff and not restricted to the Macmillan SPC team. The SPC team included a lead nurse, two clinical nurse specialists and a Band 6 nurse, specialist development post. Staff told us their workload was manageable.
- Ward staff we spoke with told us they always prioritised care for a patient who was EOL and did what they could to ensure a staff member was with them.
- The wards lacked link nurses for EOL care which may impact on the trust's ability to ensure staff received up to date information. Staff in this role would have training and development links with the SPC team. This role had ceased due to lack of continuity in staff on the wards.
- Handovers to discuss patients and caseloads were held twice a day involving two Macmillan SPC nurses and the consultant when possible. Other staff who attended regularly included the GSF co-ordinator, bereavement officer, physiotherapist and nurses. Handovers included regular meetings with the oncology staff team to discuss patients.
- Staff confirmed medical and nursing handovers were effective.

Medical staffing

- There was no palliative care consultant for this site. This post had been vacant for eight years and the service was currently supported by palliative care consultants at the Royal Lancaster Infirmary (RLI). The trust identified on their risk register concerns regarding their inability to recruit a palliative care consultant in South Cumbria which had an impact on the progress of improving the quality of EOL care at FGH. However, any queries were responded to by one of the consultants as they had a 24 hour response time to referrals and provided advice by phone as required.
- Specialist consultant palliative care advice and support at RLI was available from a full time consultant who covered five sessions per week and a part time consultant for two sessions per week. In addition both

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roles included cover at St John's hospice but cover for FGH was 'not always sufficient'. The recent appointment of a medical director at St John's hospice had enabled the full time consultant to spend more time at RLI.

- The SPC medical and nursing team had a daily update whereby patients who were referred to the SPC team were given a plan which could be communicated to patients. A good level of support was provided by the SPC team at RLI and at FGH and the service had good links with the palliative medical staff and support from the local hospice.
- In July 2015 the consultant planned to present a 'Case for Change' in response to the National Care of the Dying Audit in Acute Hospitals (NCDAH) published in May 2014 regarding the provision of specialist palliative care advice and support being available at least 9am to 5pm, 7 days per week.
- The specialist consultant team operated a 1:3 on-call cover service offering specialist advice and treatment plans. A specialist palliative care telephone advice line for 'out of hours' was provided by the local hospices.

Major incident awareness and training

- There was a trust major incident plan which listed key risks that could affect the provision of care and treatment.
- There were clear instructions in place for staff to follow in the event of a major incident.
- Staff we spoke with were aware of the plans and described the action they would take in the event of a major incident.
- In the event of a major incident, the mortuary had a policy for staff to consult.

Are end of life care services effective?

Good



Interim guidance had been in place following the removal of the Liverpool Care Pathway nationally in 2014 and a replacement care plan had recently been agreed through a cross-organisational group. Training was being delivered across the trust. This meant work was being done to look at a multi-disciplinary approach to EOL care in all settings. Ward 9 was accredited and a further ward was being assessed for GSF accreditation, and plans were in place for GSF to be embedded in the organisation, with

accreditation to be achieved on another three inpatient wards over the next two years. The trust supported patients to be discharged to their preferred place of care either through fast track discharges to their home, a nursing home or hospice.

The trust contributed to the National Care Dying Audit Hospitals (NCDAH) to compare end of life care provision with that of other healthcare providers. In 2013/14 the trust did not achieve 6 of the 7 organisational KPIs in the NCDAH and the trust performed worse than the England average in the NCDAH for 7 of the 10 clinical indicators. However, there was evidence to show that actions for improvement had been undertaken. Concern was raised that the SPC team would struggle to meet the response times to patients if they were stretched further to seven days a week, particularly due to the increasing number of patients now identified as being palliative or end of life. Following an audit of the DNACPR forms we found staffs' understanding of assessing people's capacity to make decisions about their care and treatment varied.

Evidence-based care and treatment

- The trust had responded to the withdrawal of the LCP with the 'Best Care of the Dying' guidance as an interim position. A replacement tool was agreed across the trust and training was being delivered.
- The trust had been piloting two versions of the 'caring for the dying patient' care plan since January 2015. The current version had been condensed by the strategic clinical network development team and adapted for use. There were plans for this to be audited during 2015-16.
- The SPC team were working in line with National Institute for Health and Care Excellence (NICE) to provide its EOL service.
- The new care plan included a section to ensure patients' spiritual needs were assessed and recorded in line with NICE guidance for EOL care.
- Policies and procedures were available for staff on the intranet including guidance on best care for the dying patient, GSF and links to hospices.
- The Macmillan palliative care clinical nurse specialists had access to current, relevant literature and used evidence-based research to underpin their clinical

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practice. Two of the nurses explained they were actively involved in EOL research and were looking at palliative skills around communication and mindfulness for patients recently diagnosed with cancer.

- All staff in the SPC team undertook within their role the responsibility for training and the development of staff.
- We saw clear guidance displayed on the notice board of ward 9; this included an explanation of the GSF and what this meant in practice for patients and relatives. Information was included about 'dementia awareness' and the butterfly scheme. Staff were familiar with the GSF EOL pathway to guide them through the process and use as a reminder to take appropriate action for patients.
- The service did not currently audit the preferred place of care.

Pain relief

- Providing effective pain relief for patients receiving EOL care was a critical part of the SPCT. In 2013-14 SPC staff had attended courses in advanced pain, symptom control and non-medical prescribing to ensure patients' received appropriate advice.
- Appropriate medication was available for ward staff to use and we saw that anticipatory prescribing was managed well. With a patient's permission we sat in on a consultation. The patient was asked about any pain. The SPC nurse increased the patient's opiate medication and sought medical advice. This was then clearly recorded in the notes and on the medication chart.
- During the period from 16 April to 2 July 2015, 19 of the new care plans had been used for patients at the EOL at FGH. A current report on the 'Introduction of the care for the dying patient' showed all the doctors who completed these confirmed they had prescribed the 'just in case' drugs for symptom management. This demonstrated this aspect of patient care was well embedded in practice.
- The NCDHA in 2014 showed that 58% of patients at the trust had medication prescribed 'as required' for the five key symptoms that may develop at the end of life. This was in keeping with the national average for England which was 51%.
- Doctors we spoke with confirmed they were aware of the guidance available to them and were familiar with contacting the SPCT for advice.

- Following a pharmacy department Opioid audit in 2013-14, an update was made to the trust standard operating procedure, a patient information leaflet and an audit of opioid prescribing was carried out. This showed how the trust was looking to improve and develop.
- The care plan included a 'pain core care plan' which prompted staff to seek medical or specialist palliative care if a patient's pain remained uncontrolled or side effects were problematic.

Nutrition and hydration

- Care plans included an assessment for oral nutrition and hydration and indicated patients should eat and drink normally for as long as possible despite this need reducing as people approached the end of their life. A mandatory core care plan was included with interventions for staff to appropriately support patients with eating and drinking.
- The 2013/14 trusts score in the NCDHA for assessment of a review of the patients' nutritional requirements were 34% which was worse than the England average of 41%. In the last 12 months the CDP document included clear guidance that patients should not be denied food and oral fluids. Staff found using a nutrition and hydration plan for patients improved multidisciplinary communication between doctors and nurses. Two of the doctors we spoke with confirmed they felt this record was positive.
- The care plan included principles to guide the staff in their ongoing assessment; including ensuring regular mouth care was given, considering thickened fluids and involving the family as necessary.
- Patients we spoke with were positive about the availability and choice of suitable and nutritious food and drink and access to regular hot and cold drinks. We looked at the record chart for a patient in receipt of artificial nutrition (a form of life-sustaining treatment whereby nutrients and fluids are provided by placing a tube directly into the stomach, the intestine or a vein.) Staff were able to explain how they managed the patient's artificial nutritional support and they had been assessed as being competent.

Patient outcomes

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- UHMB had participated in the National Care of the Dying Audit of Hospitals (NCADH) 2013/14. The trust did not achieve six of the seven organisational targets in the audit and performed worse than the England average for seven of the ten clinical indicators.
- We saw evidence of the action plan that had been developed to detail the recommendations made. Considerable work was being done where shortfalls had been identified including: provision of the specialist palliative care service, staff training, and patients' nutritional and hydration status, symptom management and patients' spiritual needs being incorporated in the new care planning system.
- The SPC team explained a new audit was currently in progress and the previous one was at the time when the LCP had just been withdrawn. They were contributing to this audit at the time of our inspection. The SPC team believed the results would be more favourable than the 2013-14 audits.
- A new 'care of the dying patient' care plan had been introduced in a phased approach to replace the LCP with effect from January 2015. In the weeks of its availability 48 care plans had been used at RLI and 15 at FGH. A future audit of its use was planned to assess its effectiveness.
- The trust supported patients to be discharged to their preferred place of care either through fast track discharges to their home, a nursing home or hospice. Two revised discharge pathways were implemented late in 2014: red for patients whose condition is rapidly deteriorating and the patient has a preference for care outside the acute hospital and amber for patients whose increasing decline is recognised. The patient and family were involved in the full process to facilitate a reduced length of stay and enable care in the place of their choice; ensuring discharge was supported and safe. The SPC team provided guidance and support as required.
- Monitoring of the discharge pathways since January 2015 was undertaken to evaluate the effectiveness of fast track discharging of patients known to the specialist palliative care team to their preferred place of care.
- Since January 2015 there had been 41 discharges using the fast track process, 20 of which were at Furness General Hospital. An action plan had been developed to address issues affecting the timeliness of these discharges. Examples included: care agencies being unable to provide required domiciliary care suitable

adjustments to the home environment and provision of equipment. Positive results included: a fast track at a weekend, good support from Hospice at Home who sourced Marie Curie sitting services and improved documentation accompanying the patient.

Competent staff

- The SPC team were well qualified and attended relevant courses to extend and update their knowledge and skills; one example was the lead nurse had recently attended a palliative care nurse's conference.
- The SPC team confirmed they received monthly clinical supervision to support them in their role and they had received an appraisal in the last 12 months.
- We spoke with two EOL GSF co-ordinators who had rolled out the training for the new end of life care plan to ward staff. These posts were due to end in July due to the funding for the project coming to an end. Feedback had shown the training provided by co-ordinators empowered staff to be more confident with communication skills when a patient was identified as being at or nearing the end of their life.
- All fourth year medical students gained experience through the palliative care service. This involved 12 students three times a year.
- Ward staff confirmed the SPC nurses came to the wards upon request and provided support as necessary to EOL patients.
- The palliative medicine consultants had been appraised and were completing their revalidation in line with General Medical Council guidance.
- Between the three hospital sites 125 nurses had been trained in the verification of expected death. This reduced some work from the medical staff.
- We saw the trust training management system which enabled staff to carry out on line training. A new staff member in the mortuary explained how the local training they completed then fed into a national training programme to develop their career path.
- SPC staff attended mortality reviews and despite the target for reviews being 50% the team tried to review every patient to establish any learning.

Multidisciplinary working

- The multi-disciplinary team worked well together to co-ordinate and plan the care for patients at the end of

End of life care

life. The hospital palliative care team held weekly MDTs on both trust sites. Attendance consisted of nursing and medical staff from the hospital, community and hospices. Minutes confirmed this.

- In addition daily MDT meetings were held on the medical wards to discuss and manage patient risks and concerns. Patients at the EOL were included in this discussion so all disciplines could contribute to effective and consistent care for patients at the EOL.
- There was access to non-specialist physiotherapy and occupational therapy at both hospital sites.
- The speech and language therapist did not attend MDT meetings routinely however they were in frequent contact with the nurses to provide guidance and advice.
- Requests for input from the SPC team were made by the staff. Patients' records we looked at showed evidence of input from regular multi-disciplinary team meetings.
- The chaplains visited the wards daily and received referrals from staff for any specific requests. The chaplain provided spiritual or general support as requested from the patient.
- The palliative care team worked closely with respiratory, breast, cardiology and stroke specialities. The team have strong relationships with cancer and non-cancer specialists and the acute oncology team.
- There was currently an 'electronic palliative care co-ordination system' (EPAACS) available but this was not implemented properly with all potential users and across all sites.

Seven-day services

- The team offered a five day Monday-Friday 8am -6pm service on the acute sites. 'Out of hours' there was a hospice hotline provided by nurses with access to advice from consultants on a 1:5 rota 24 hours a day seven days a week. The consultant worked across boundaries and was part of a seven day rota. Concern was raised that the service would struggle if they were stretched further to seven days a week.
- Staff reported there were no issues in accessing diagnostic services which were available 24 hours a day, seven days a week.
- Plans for the future included a business plan to access a seven day specialist palliative care face to face consultation and 24 hour SPC advice.

Access to information

- The SPC team had provided 'care of the dying patient study days' and included a bereavement section on this course.
- The palliative care website provided information and guidance for staff on the intranet. Information included guidance on referring patients, including those requiring symptom control, links to hospices, medical and nursing assessments, and 'just in case drugs'. Staff we spoke with felt this was a useful resource that was easy to access.

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

- The trust had a consent policy in place. The policy included advanced decisions, lasting power of attorney, mental capacity guidance and the use of Independent Mental Capacity Advocates where necessary.
- Two DNACPR forms showed a mental capacity decision was recorded on the form and in the notes. This included family involvement. In addition, a copy had been forwarded to the patients' GP.
- Training around the Mental Capacity Act including DoLs and best interest decisions had just been delivered to five case workers, safeguarding and discharge leads and two hospital social workers.
- Evidence of training dates were available for nurses and support staff to attend a training day on 'care of the dying patient in the last days and hours of life'. This programme included Mental Capacity Act, recognising dying communication and advanced care planning.

Are end of life care services caring?

Good



End of life care was provided by caring staff. Staff were sensitive to the needs of patients who were seriously ill. Feedback from patients about the care and treatment they had received was mostly positive. Patients received compassionate care and their privacy and dignity was maintained.

Patients and those close to them were positive about their interactions with the committed palliative care team.

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Patients felt their individual needs were met in a professional, sensitive way. Staff were observed spending time talking with patients and relatives and people were encouraged to be involved in their relatives care.

Staff recognised the importance of identifying patients nearing the end of their life to ensure they received a positive experience.

Compassionate care

- Staff were caring and compassionate and understood the need for sensitive communication for patients who were approaching the EOL. We observed patients on wards who looked well cared for and interactions between staff and patients were caring and respectful. We heard from people who wanted to share their experiences with CQC and we spoke with relatives of patients during this inspection. One example included where the bereavement nurse had provided some appropriately written children's books for children following the loss of their relative. A number of patients felt their experience could have been made better by improved communication between staff and relatives. One of the recommendations following the 2014 'hospital bereavement experience survey' was the importance of including families in decision making and ensuring regular, clear communication. There were plans to send the survey this year.
- Training in communication skills was provided to staff through the 'Sage and Thyme' programme. A foundation level communication skills workshop developed in response to NICE guidance. The palliative care team had attended advanced communications training.
- On the wards we visited we saw families were encouraged to participate in aspects of care of their relative, for example, wiping their face and mouth care.
- Patients' records showed discussions of sensitive conversations that had been held with patients and relatives.
- The bereavement nurses were hospital based roles that supported families and carers at the time of death. Bereavement staff had introduced canvas bags that included the dragonfly dignity symbol. The dragonfly 'dignity symbol' logo enabled staff within the hospital to identify the person carrying the bag as newly bereaved; and therefore may need extra care and support as they leave the hospital.

- The bereavement office staff told us they contacted each bereaved family and met them when they collected the cause of death certificate and their loved ones possessions from the office. Families were offered the choice of specialist nursing support at this time. A dedicated bereavement office was opened at FGH in March 2015 which had enabled the move away from the service being in the general office to improve the family's experience at such a distressing time.
- Ward staff reported to us how respectful hospital porters were when caring for deceased patients before they were transferred to the mortuary. Staff treated patients with dignity and respect after their death. We saw that mortuary staff referred to deceased people in a respectful manner.
- Normal visiting times were waived and car parking permits were available for relatives of patients who were at the end of their lives.
- Where possible patients at EOL were provided with a side room; staff confirmed this was normal practice and we observed this during the inspection.
- There was a quiet room on most wards where sensitive conversations could be held. On ward 9 a room was being made into a palliative care room so patients could have time away from their bedroom in a pleasant environment.

Understanding and involvement of patients and those close to them

- Patients and their relatives felt involved in their care. The named consultant and nurse was written above patients' beds and relatives told us they had been given an opportunity to speak with the medical staff.
- We saw a section in the new advanced care plan where there was a record of family involvement and where staff could record on the communication sheet.
- We observed staff speaking with patients living with dementia in a kind and sensitive way. We were aware medical and nursing staff were consulting with a patient and their relatives to discuss their preferred place of care. Staff spoke of this patient with compassion and sensitivity when describing how they were planning to make this discharge. Patients were aware of the plans in place for them and if they were being discharged to an alternative place of care.

End of life care

- A policy was in place to ensure potential tissue donors were identified and referred to the national referral centre. As part of EOL care, healthcare professionals were identified as the point of contact for bereaved relatives about donation.

Emotional support

- In 2013/14 the hospital's score in the NCDH for assessment of the spiritual needs of a patient and their nominated relatives or friends was 20%. This was worse than the England average of 37%. In the last 12 months the trust chaplaincy service had become more established and was seen as an integral part of the service provided to patients, relatives and staff.
- We spoke with the respiratory specialist in the outpatient department about breaking bad news to patients. A nurse would always sit in with a consultant when bad news was shared with a patient.
- The hospital had a Christian chaplaincy service that provided spiritual support to patients and those close to them. Staff were also able to obtain the services of ministers from other faith groups if patients wished to see them. The chaplain service has increased from one to three chaplains, providing a chaplain on each hospital site.
- The chaplaincy at FGH was introducing a service of remembrance every two months starting from October 2015.
- Some contract funerals have been held for those people with no close family or who could not afford the cost of a funeral. We were told of an occasion where the chaplain held a funeral service to replicate the funeral a relative was too unwell to attend for their deceased loved one.
- We spoke with the volunteer engagement officer. The service had expanded to 140 volunteers across the three hospital sites. This service included specific volunteers to support the emotional needs of patients. Two patients we spoke with spoke favourably of the service provided.
- The 'National Care of the Dying' audit (2014) reported that the trust was below the English average in access to information relating to death and dying. There were bereavement booklets for relatives. Signposting for people to contact other support agencies was available on wards throughout the hospital, for example information about local hospices, cancer information guide, Marie Curie and hospice at home service.

- We spoke with two bereavement officers who advised us part of their role was speaking with relatives about tissue donation.
- At FGH there was access to a specialist palliative care psychology service.

Are end of life care services responsive?

Good



End of life care services were responsive to the needs of the local population. The trust had a new strategic plan in place which aimed to improve and connect services to prevent patients having their care compromised with admissions and re-admissions to hospital. The SPC team had a flexible referral process. Ward staff told us the SPC team responded promptly to referrals, usually within 24 hours.

Services were planned to take account of the needs of different people, including people living with dementia. The trust had a rapid discharge service for discharge to a preferred place of care (PPC). There was open access for relatives to visit patients who were at the end of life, and free car parking for those visiting. Access to side rooms was provided whenever possible. Facilities to meet the multi-faith needs of people had improved since the last inspection and the chaplaincy service had expanded. Bereavement services were well organised and responsive to people's needs. The skills and commitment of the SPC teams provided support to ward staff in a responsive and timely way that met the individual needs of patients.

Service planning and delivery to meet the needs of local people

- There was a three year EOL CQUIN (a payment framework which enables commissioners to reward excellence) the aims of which were to improve quality of care for people with life limiting conditions and the bereaved. One element of the CQUIN was to implement GSF to co-ordinate care across boundaries, ensuring consistent use of good practice. The aim of this was for non-specialist staff to identify patients who may be in the last years of life, and assess their needs, both clinical and personal with the SPC team, as necessary.
- To support this GSF training had been available: for example an overview to all staff, identifying GSF,

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advanced care planning and bereavement. Significant improvement had been made in generalist palliative and EOL care during this time, however staff recognised further and continued training and development was required to embed the cultural change. The team had worked hard with GP's and most were GSF accredited.

- The membership of the existing EOL group has been reviewed to include UHMB, North Lancashire and Cumbria provider services and local hospices to create an overarching group. The specialist palliative care 'cross bay' meetings involved the deputy chief nurse and a representative from general medicine, in order to ensure EOL care was important for all staff and not just the palliative care team.

Meeting people's individual needs

- A holistic assessment or advanced care plan was used to identify patients who were in the last days or hours of life.
- The SPC team had a flexible referral process. Ward staff told us the SPC team responded promptly to referrals, usually on the same day.
- There was a good pathway for respiratory patients. An advanced nurse practitioner took referrals from GP's and oncologists and had carried out 150 pleural aspirations in two years. This was managed as a day case service in order to make the experience more patient friendly, rapid and cost effective.
- Up to this inspection 15 of the new individualised advanced care for the dying patient documents had been completed from April-July 2015 at FGH. Results to date showed that all doctors prescribed anticipatory medication for symptom management in the dying phase.
- Information about the dementia 'butterfly scheme' was displayed on the notice board to alert staff to patients who may require more support and time due to their illness.
- We listened to a board round on one ward where the staff reviewed the complex planning for discharge for patients. Staff confirmed this was effective communication and enabled them to respond to the needs of individual patients. The 'hospice at home' visited wards each week where there were patients who were due to be discharged and they would speak with them on the ward if required.
- Mortuary staff demonstrated their awareness of and sensitivity to cultural and faith practices.

- The chaplaincy had engaged with a local mosque to better understand their needs and what the chaplaincy and bereavement service could deliver to support Muslim families. In addition the chaplains had organised deceased patients to be repatriated to countries of origin, for example Pakistan.
- A version of the bereavement booklet had been translated to polish to meet the needs of local people. This was awaiting final print.

Access and flow

- The SPC team told us their referrals were promoted through them visiting the wards. Staff told us the team always responded in a timely way to requests for advice or to visit the patient.
- GSF was noted on the inter-ward transfer information which highlighted to staff that a patient may be in their last year of life.
- Two doctors told us they made referrals to the SPC team however they were not aware of a referral protocol. Despite this their patients were seen and their judgements appeared satisfactory.
- In total the SPC team showed 4128 patient contacts recorded in 2013-14. The 65% of hospital patients seen by the SPC team were coded on the GSF, whereby patients identified as likely to be in the last year of life have a holistic needs assessment and are offered an opportunity to plan for their future.
- The specialist palliative care team received referrals from 896 patients from April 2014 to January 2015. Of these the majority (67%) of new patients referred to the service in 2014/15 had a diagnosis of metastatic cancer. However the referrals from non-cancer patients had increased by 8%. This showed the specialist services of the palliative care team were provided mainly to an increasing number of non- cancer patients.
- The trust had a rapid discharge service for discharge to a preferred place of care (PPC). Following on from NICE guidance, the EOL Strategy (2008) was clear that people at the end of life should be able to make choices about their place of death. The rapid discharge pathway was to support patients to be discharged from hospital in the last hours /days of life. The discharge team had successfully discharged 81 patients on fast tracked continuing health care from July 2015 which demonstrated responsiveness to patients' needs.

Learning from complaints and concerns

End of life care

- Complaints were handled in line with trust policy. Information was available to inform patients and relatives about how to make a complaint.
- Informal complaints were dealt with on the wards. If necessary people would be advised to use the patient advice and liaison service (PALS). There were few complaints relating specifically to EOL care. The team leader for EOL care would be made aware of any complaints about the specialist palliative care service. Complaints relating to EOL were discussed at the strategy group and were used for multi-disciplinary teaching.
- One aspect of the bereavement nurses role was to identify family concerns and ensure these are resolved in a prompt and timely manner by the most appropriate professional.
- We saw evidence where a complaint had been responded to and where learning was put in place to improve practice. For example, action had been taken to ensure care plans were held at the front of the notes and a sticker was placed on patients' notes to show they are EOL.

Are end of life care services well-led?

Good



The service was well-led. The EOL lead had a clear vision as to the way forward for palliative medicine with a stable EOL Macmillan SPC nursing team. The service strived to improve the quality of life of patients and their families who face life threatening illness, by providing pain and symptom relief, and spiritual and psychosocial support from diagnosis to the end of life into bereavement. The staff we spoke with were clear they were advised in EOL or palliative care by people who were approachable, responsive and supportive. It was acknowledged the improved service would require an additional consultant to provide seven-day cover 24 hours a day and a manageable on-call rota.

Clinical governance arrangements that involved EOL care was well managed. The service was responding effectively to national initiatives and local demand in a prompt and timely manner. Staff were clear about their commitment to

providing care that ensured patients ended their life in a dignified way in their preferred place of care. Care was guided by a knowledgeable team who were supportive and provided good leadership.

EOL care service leaders were clear on the key risks within the service but the service did not have a specific risk register. This meant that, unlike other services in the hospital, there was no clear, easily accessible overview of the ongoing risks within end of life care services. Information provided by the trust included the issue of no palliative care consultant at FGH.

Vision and strategy for this service

- The clinical director with responsibility for EOL care and the SPC team leader spoke to us passionately about the vision for the service. In 2013 the SPC team developed a comprehensive clinical strategy. This included a five year plan. We were told how the five year strategy was developed and the SPC team had a clear vision how to develop palliative and EOL care across specialisms. The consultant spoke of how the current service was fragmented with several providers of palliative and EOL care across Morecambe Bay and the plans to move to a more community based, palliative service which have been proposed in a business case based on the 'Better care together model'. This would link care between the acute, voluntary and community sectors.
- The new strategic plan aimed to improve and connect services to prevent patients having their care compromised with admissions and re-admissions to hospital. It was acknowledged that the new service would require an additional consultant to provide seven-day cover 24 hours a day and a manageable on-call rota.
- Following the NCDAAH audit the trust developed an action plan that included identifying a board member with specific responsibility for care of the dying. The trust has addressed this and somebody was now taking on this role.
- Significant improvement had been made in generalist palliative and EOL care, however further work was required to embed the cultural change of linking care between the acute, voluntary and community sectors.

Governance, risk management and quality measurement

End of life care

- We saw local and service leadership whereby the SPC team attended 'cross bay' governance meetings twice-monthly that encouraged collaborative working and information sharing to the benefit of dying patients and their relatives.
- EOL care leaders were clear on the ongoing risks within the service but the service did not have a specific risk register. The trust stated this was because it did not have a division or department that had, as its primary purpose, palliative end of life care, which would enable easy identification of such risks. This meant that, unlike other services in the hospital, there was no clear, easily accessible overview of the ongoing risks within end of life care services.
- However, the trust did provide a 'risk register' document which identified the concerns related to palliative and end of life care when requested. However, it was not clear whether the actions detailed had reduced the on-going risk rating. The risks were not dated so it was not clear how long they had been on the risk register.
- There were systems in place to audit the quality of end of life services that were regularly reported and monitored from the ward to the board. The monitoring of complaints, incidents, audits and quality improvement projects were raised at board level.
- The trust had been implementing the GSF over the last two years. Staff at all levels spoke of their anxieties the impact on the demand for the service this may have on the EOL team and training provision. A goal was for GSF to be embedded in the organisation, with GSF accreditation to be achieved on all adult inpatient areas. Plans were in place for a further three wards over the next two years to achieve GSF accreditation.
- An action plan was developed as a result of the NCDHA and identified areas that remained ongoing including: provision of an additional consultant, communication skills and education and training in care of the dying being mandatory.
- The SPC team had developed clinical and educational strategies to aid them to remain clear about their objectives.
- The UHMBFT SPC/EOL team, including bereavement services, were employed within the medicine division of the trust. The consultant was the trust clinical lead and worked with Lancashire North CCG and there was an appointed nursing lead. The team held operational meetings and reported through the elective medicine division.
- Ward staff felt that the SPCT were visible, approachable and supported staff to care for patients at the end of life.
- Chaplaincy services were well-led. An annual report reviewed the service from 1 April 2014 to 31 March 2015 which highlighted the achievements and service developments for the year.
- The service was well supported by specialist nurses; there was limited medical input to the SPC team. However there were now three part time consultants, in palliative medicine. We were told this paved the way for the possibility of a specialist registrar training post.
- The SPC team were encouraged to take up learning and development opportunities to expand their knowledge and skills to improve and enhance the service provided to patients.
- There was a clear line of reporting to the trust's chief executive and board members so issues could be dealt with effectively.

Culture within the service

- The SPC nurses were passionate about their roles. The service was focused on positive outcomes in terms of patient care and experience. Staff were proud of the work they did and were committed to doing the best for patients.
- Staff reported positive working relationships across all disciplines. There was a culture of sharing knowledge and expertise demonstrated through formal training and informal teaching opportunities.
- All staff we spoke with showed a positive attitude towards caring for dying patients.

Public engagement

- The bereavement officer gave out information packs to families when they came in to pick up death certificates.
- Patient surveys had been sent out for those who had been identified as being in the last twelve months of life. The service had not yet analysed the results from this.
- The service had been part of the National Care of the Dying Audit of Hospitals (NCDHA).

Leadership of service

- The SPC team demonstrated effective leadership and the leaders understood the challenges to provide good quality palliative and EOL care services across Morecambe Bay.

End of life care

Staff engagement

- The service had made improvements with education and communication skills. Staff completed an evaluation following a bereavement care study day and responses were analysed to drive improvement.
- Ward staff told us they felt listened to and the intranet was a useful resource for information.
- Staff in the SPC team had an annual appraisal which they told us worked well and as a small team they had the opportunity to raise and discuss any problems.
- The trust were proud of the UHMB bereavement team who accepted an award at the 2015 'Your health heroes' awards ceremony in February, where the hard work of the team were recognised including the mortuary and chaplaincy departments.







Innovation, improvement and sustainability

- The staff shared a number of innovative practices. One example included the new draft EOL stroke pathway.
- The trust were taking on board caring for non-malignant palliative care patients and had been implementing the GSF through the EOL network as part of a two year funded project (2013-15). During this time significant improvement had been made in generalist palliative and EOL care however the team acknowledged further

work was required to embed the cultural change needed. The SPC team supported wards to achieve the GSF accreditation and wanted to expand on the success of the trust achieving GSF accreditation.

- Improvements have been made to the discharge summaries. Other innovation has been the development of the SPC team sending discharge summaries to patients seen by the SPC team.
- The SALT (speech and language therapist) were doing innovative work with food thickener and designing a document around feeding and the risk of choking with EOL patients. A plan to have this information held at the front of the patients' notes for ease of access for staff was being developed.
- Improvement has been made for the provision for transferring bariatric patients to the mortuary on both sites and work was being done with the learning disability specialist nurse to support bereaved people.
- The SPC team told us the introduction of a designated MDT to include occupational therapists, physiotherapists and social workers would further develop the service.
- A fully functional electronic palliative care co-ordinating System (EPACCS) across all relevant sites would enable service providers across boundaries to share information.

Outpatients and diagnostic imaging

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

Information about the service

For the period 2013/14 the trust had 512, 694 outpatient attendances (185,788 of these were at the Furness General Hospital). In the period 2104/15 this had increased to 520, 602 attendances trust wide. Records we reviewed confirmed that there had been a steady increase in required diagnostic services appointments over the last three years.

The radiology service includes: Diagnostic imaging and reporting across a variety of modalities including CT/MR imaging, Nuclear medicine, Fluoroscopy, Mammography, Ultrasound and General Radiography. The pathology service provided a full range of patient diagnostic and reporting services to support effective patient diagnosis and treatment plans. Blood and analysis services were provided to emergency and theatre areas. The service had a Community Patient Contact Centre (CPCC) which acted as the patient focal point for correspondence, discussions and planning around bookings for their elective appointments. The outpatient service was responsible for the management of room scheduling and staff support to clinicians to enable the running of outpatient based treatment functions within UHMB.

We inspected a number of the outpatient clinics at this hospital including ophthalmology, orthopaedics, ENT, Renal and respiratory, physiotherapy and diagnostic services. We spoke with ten patients and 12 staff including nursing, medical allied health professionals and support

staff some who worked across the 3 hospital sites. We received comments from people who contacted us about their experiences. We also reviewed the trust's performance data and looked at individual care records and images.

Outpatients and diagnostic imaging

Summary of findings

Since our last inspection, there had been improvements to the service such as in the provision of records.

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

During our last inspection we noted that there was no information available in the departments for patients who have a learning disability or written information in formats suitable for patients who had a visual impairment. During this inspection we noted that this was not the case. Main outpatients have specific information /leaflets for patients with learning disabilities. Main outpatients and the Ophthalmic department have information/ leaflets in easy read formats; or written in formats suitable for those patients who have a visual impairment. However, staff we spoke with in outpatient departments across the site were not able to tell us how written information in an ‘easy read’ format could be accessed..

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

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

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good



Since our last inspection, there had been improvements to the service such as in the provision of records.

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The OPD/Diagnostic services were housed in the main hospital building on the site. We noted that space was limited in some areas and some areas were carpeted such as in the main outpatient area which may impact on the ability of the provider to maintain adequate infection prevention control measures. The trust managers told us that there was an “I’ve been cleaned” sticker system in operation to inform staff at a glance as to the cleanliness of equipment and furniture.

At our last inspection we had told the trust that it should review its staffing investment to ensure that the allied health professional workforce is developed at the same pace as the nursing and medical workforce to meet the growing demand for services. At this inspection we found there was a shortage of permanent occupational therapists as well as radiologists and staffing shortages in pathology. At the time of the visit there were just 0.6 WTE Occupational Therapists posts vacant Trust-wide. The need for additional occupational therapists had been identified and was on the divisional risk register. This had been reviewed on 24 July 2015 and still showed a high risk rating for therapy staff vacancies. The trust had employed temporary staff to fill the allied health professional staffing vacancies.

Incidents

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

Cleanliness, infection control and hygiene

- The outpatient and diagnostic imaging settings were visibly clean overall and regularly maintained. The cleaning records for the departments confirmed that the environment was cleaned regularly and this was displayed publicly for patients to see.

Outpatients and diagnostic imaging

- The trust managers told us that there was an “I’ve been cleaned” sticker system in operation to inform staff at a glance as to the cleanliness of equipment and furniture. We visited the therapy department and found that none of the walking frames in the department had the “I’ve been cleaned” stickers. This was not in line with the trust policy. We brought this to the attention of the senior manager in the department who assured us that the frames had been checked and the policy would be adhered to immediately.
- Regular hand hygiene audits demonstrated compliance rates in line with trust targets throughout the departments.
- Staff in the outpatients and diagnostic imaging departments complied with the trusts policies and guidance on the use of personal protective equipment and adhered to “bare below the elbow” guidance.

Environment and equipment

- We noted that space was limited in some areas and the service provision was physically constrained by the existing environment. The lack of sufficient growth space for the future development of outpatient service was acknowledged by the trust and was identified on the identified on the divisional risk register.
- We found two clinical rooms in the ENT department were crowded and contained a number of filing cabinets containing records. The lack of space and multiple uses of rooms may impact on the ability to provide the appropriate clinical setting for the provision of care.
- Equipment within the departments had been portable appliance tested for electrical safety. Our checks of equipment revealed that the equipment was well maintained and ready for use. All the staff we spoke with said that space was limited for the suitable storage of equipment. This was acknowledged by the trust as well as the lack of sufficient growth space for the future development of outpatient service. This was identified on the divisional risk register
- We examined the resuscitation trolleys located throughout the departments. The trolleys were secure and sealed. We found evidence that regular checks had been completed. However we noted that all the record logs were new and had commenced in June 2015 so we were not able to check on practice prior to this date.

- The hospital had two CT scanners and one MRI scanner. The department had a radiation protection ‘local rules’ policy in place to support the safe use of equipment.
- Radiological/hazard signage was displayed throughout the department.
- There systems and processes in place to ensure maintenance and servicing of imaging equipment.

Medicines

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

Records

- At our last inspection we told the provider they must ensure the timely availability of case notes and test results in the outpatients department. We found that the outpatient departments were experiencing difficulties in obtaining patient records in time for clinic appointments. At this inspection we met with staff and managers who confirmed that the provider had invested heavily in the medical records storage and provision on the site. At the time of our inspection the latest data provided by the trust for Furness General Hospital was 99% availability for outpatient records and 98% for elective inpatients. The staff we met were very proud of the improvements they had achieved since our last inspection. They carried out a system of cold audits to monitor the improvements.
- The trust had continued to roll out its “Paper Lite” project which ensured that electronic information was available for patients. This project was not yet fully implemented but staff were positive about the improvements in efficiency and effectiveness for outpatient services such as the availability of test results and timely access to information.

Safeguarding

Outpatients and diagnostic imaging

- Safeguarding policies and procedures were in place across the hospital. These were available electronically for staff to refer to.
- There was a safeguarding lead at the hospital and radiology/diagnostic staff told us they were encouraged to contact the safeguarding lead if they had any concerns about patients. Staff were aware of their roles and responsibilities and knew how to raise matters of concern appropriately. Audits provided by the trust showed that the staff had followed the correct safeguarding process.
- The trust target for safeguarding training was 80%. Records showed that the outpatient service had achieved 99% compliance with the relevant safeguarding training. We found 98% of staff working in the radiology/diagnostic department had completed mandatory safeguarding training to level 2, and child protection training to level 2.

Mandatory training

- The majority of staff received access to training in a range of subjects including health and safety, infection prevention control and manual handling. Mandatory training was delivered as a mix of e-learning and face to face training which staff said was adequate to meet their needs. Some staff told us accessing e-learning had practical difficulties as it was located on the intranet. Staff needed to access it through computers in the department, which was not always possible.
- The trust target for mandatory training was 80%. Records showed a mixed result in the numbers of staff who had completed their mandatory training. At the time of our inspection records showed that the Furness General Hospital site had met the trust targets for equality & diversity, and resuscitation and infection prevention control. However we found that for fire safety and welfare training the figures were well below the trust target at 39% for outpatient and diagnostic imaging.

Assessing and responding to patient risk

- At our last inspection we found that the trust previously had issues with the implementation of an electronic appointment booking system prior to 2011. At this inspection we found that patients' safety was being monitored on a regular basis in relation to delays in accessing appointments. An outpatient improvement group was in place to monitor and implement

improvements in the management of patient appointments, in order to ensure care was provided in a safe and timely manner and to reduce risks such as delays in appointments (which in turn could cause delays in diagnosis and treatment).

- Policies and procedures were in place should a patient deteriorate or have an adverse reaction to drugs and preparations in the diagnostic and imaging department.
- If a patient became unwell in the outpatients department the service had a clear protocol to follow. Staff were able to talk about and demonstrate a good knowledge of emergency procedures.
- There were policies and procedures in the imaging department to ensure risks to patients from exposure to harmful substances were managed and minimised.
- WHO checklists were completed for non-surgical interventional radiology which audits showed were being completed in line with trust policies and procedures.

Nursing staffing

- At our last inspection we told the provider that they must ensure staffing levels and skill mix in all clinical areas were appropriate for the level of care provided.
- The trust did not have a formal tool for calculating the number of nurses required in outpatients; however staff told us that they tried to ensure enough staff to provide chaperones for all patients in clinic. Managers determined the number of nursing staff required by the number of clinics running at any particular time but also the nature of the clinics.
- Staff told us they were able to plan rotas in advance to manage the workload. Staff felt that nursing numbers and skill mix overall met the needs of their patients.
- We found that the outpatient staff had to access to agency staff to ensure adequate staffing levels were available to support the needs of patients.
- The sickness rate at Furness General Hospital for outpatient services of 4.7 % was lower than the trust overall sickness rates with exception of the ENT department with a rate of 16%. As of May 2015 there was no sickness reported in the radiology department in May 2015. Managers were aware of the staffing levels and absence rates which were monitored monthly.

Medical staffing

- At our last inspection we told the trust they should consider its investment into the diagnostic and imaging

Outpatients and diagnostic imaging

services to respond to increased demand. Staffing concerns were identified in radiology and dermatology, where there was a shortage of specialist staff. The trust was told they must continue to actively recruit medical and specialist staff in areas with identified shortfalls.

- At this inspection we found that the radiologist vacancies were identified on the divisional risk register as a high risk. There were vacancies within the radiology service. Managers told us that they were actively out to recruitment and had introduced the use of extended roles for advanced practitioners to help manage the case load. We did not see evidence of any sharing of staff with other trusts. The service leads felt that there had been some improvements in staffing but the recruitment of experienced radiology staff remained a challenge. Records provided by the trust showed that the vacancy rates as of May 2015 for medical staff were 27.8%.
- Breast screening was managed in a small, self-contained unit. Staff here told us they had been through a particularly difficult time due to staff issues. However, the three members of staff we spoke with all told us that they felt supported.
- There was a sufficient number of medical staff to support outpatient services. We found that the majority of clinics were covered by specialist consultants and their medical teams.

Allied Health Professionals

- At our last inspection we had told the trust that it should review its staffing investment to ensure that the allied health professional workforce is developed at the same pace as the nursing and medical workforce to meet the growing demand for services. At this inspection there was a shortage of occupational therapists. We found that the sickness rate for occupational therapy was 16.5% as of May 2015 and 5.8% in Physiotherapy.
- The need for additional occupational therapists had been identified and was on the divisional risk register. This had been reviewed on 24 July 2015 and still showed a high risk rating for therapy staff vacancies. We saw evidence that the trust had put in two temporary band six grade occupational therapy staff at the Furness General Hospital site to ensure that patients had access to specialist occupational therapy staff on the acute and

short stay wards. The lack of appropriate temporary therapy staff may impact on the safe and timely care for patients and have a potential impact on their rehabilitation and length of stay.

Major incident awareness and training

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

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Patients attending the outpatient and diagnostic imaging departments received effective care and treatment. Care and treatment was evidence based and followed national guidance. Radiology staff were able to explain their safety protocols and the local rules for use of equipment and practice within the area were displayed in all the rooms. Double reporting of scans was in place to ensure their accuracy. Audits showed that 96% of records were available for outpatients and 98% were available for elective inpatients.

Overall staff were competent and supported to provide a good quality service to patients. Competency assessments were in place for staff working in the radiology department along with temporary staff to the department. The majority of staff we spoke with confirmed that they received one-to-one meetings with their managers on a monthly basis, which they found beneficial.

The outpatient service operated six days a week and had extended normal working hours. However, most activity happened between Monday and Friday 9am-5pm.

There was evidence of good multidisciplinary working in the outpatient and diagnostic imaging departments. Doctors, nurses and allied health professionals worked well together.

Evidence-based care and treatment

Outpatients and diagnostic imaging

- Care and treatment followed evidence based national guidance. For example NICE guideline 101: management of chronic obstructive pulmonary disease (COPD). We also found that services were following royal college guidance such as the Royal College of pathologists' clinical guidelines for the management of abnormal blood results.
- NICE and best practice guidance was available to staff via the trusts intranet.
- Radiotherapy's guidance was condensed national guidance and was easily accessible on the departments own database.
- Radiology staff were able to explain their safety protocols and the local rules were displayed in all the rooms. Double reporting of scans was in place to ensure their accuracy.
- Diagnostic reference levels (DRLs) audits took place to ensure patients were being exposed to the correct amount of radiation for an effective but safe scan for each body part and these showed appropriate exposure levels.
- Radiotherapy undertook both internal and external audits, which were mostly positive. These included system audits, such as equipment calibration, image review processes and British Standards Institute (BSI) assessment.

Pain relief

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

Patient outcomes

- We were told that Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER 2000) audits were conducted which showed that the service was compliant.
- The outpatient departments participated in audits such as hand hygiene, cleanliness and record keeping. We also saw evidence of staff using the electronic patient record system to carry out electronic clinical audits such as for waiting times in clinic.
- The day before our inspection we had observed at the sister site a trust wide audit day was in action when staff from the three trust locations met together to take part

in clinical audit presentations and learning. We were told by staff on the Furness General Hospital site and records showed that this was a regular diary commitment to ensure that opportunities for audit were in place across all the trust locations.

- Records of local audit demonstrated a high rate of compliance with good practice across the service including IRMER audits in the imaging dept.
- The pathology service was compliant with the national clinical pathology accreditation scheme.

Competent staff

- Competency assessments were in place for staff working in the radiology department along with temporary staff to the department. However, staff raised concerns about their competencies in CT scanning, due to their rotation into this area being stopped by staff shortages.
- We saw copies of competences for support staff to ensure that they competent to carry out specific procedures within the outpatient department such as the administering of eye drops.
- The majority of staff we spoke with confirmed that they received one-to-one meetings with their managers on a monthly basis, which they found beneficial. Data provided by the trust showed that 92% of outpatient staff at band 7 and below and 98% of radiology staff had received an appraisal in the last twelve months. The use of appraisals is important to ensure staff have the opportunity to discuss their work load and any development needs or support required to help them carry out their job role.
- Staff were also trained in meeting the needs of patients living with dementia.

Multidisciplinary working

- There was evidence of good multidisciplinary working in the outpatient and diagnostic imaging departments. Doctors, nurses and allied health professionals worked well together.
- Radiology and Diagnostic services offered one-stop clinics in some specialties, such as those provided by the Breast Screening Unit (BSU). Patients attending the BSU could receive an ultrasound, mammogram, and aspiration, dependant on clinical need. The clinic was staffed by specialist radiographers alongside a consultant. Specialist nurses offered a support service for patients.

Outpatients and diagnostic imaging

- Letters were sent out by the outpatients department to people's GPs to provide a summary of the consultation and any relevant treatment management plans.

Seven-day services

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

Access to information

- Medical and nursing staff said they had access to the information they required. They told us the notes were almost always available for clinics and always for surgical procedures. Audits showed that 96% of records were available for outpatients and 98% were available for elective inpatients.
- Staff had access to trust intranet to access policies, procedures and NICE guidance.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Although the staff that told us they had received training in the Mental Capacity Act 2005, we found during our discussions with staff their knowledge was variable. The compliance rate with the basic safeguarding training was 99% for Furness General Hospital outpatient and imaging services. Some of the staff we spoke with could not demonstrate a sound knowledge of the principles inherent within the legislation.
- We found a varied level of understanding of the implications on their role and responsibilities that would result from patients' lack of mental capacity. Most staff could not explain when an assessment might be indicated, how it would be requested or who would complete it. This meant a patient may not receive an appropriate assessment of their mental capacity or the support which may be indicated as a result.
- We looked at four consent forms for surgical procedures. All the records were completed and scanned onto the electronic patient record.

Are outpatient and diagnostic imaging services caring?

Good



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

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

Compassionate care

- The patients we spoke with said that staff had been polite and caring. Staff spoke with patients in a respectful manner and was open and friendly in their approach. We witnessed patients being treated with courtesy and dignity by reception staff, who showed patients to side waiting areas when required. We found copies of a "Dignity and Respect Policy" in each clinic room.
- We observed that a confused person had attended the outpatient department without an appointment. The staff were able to identify the patient and contacted their relatives. We observed that the person was well supported including being provided with a meal and drinks whilst they were in the department.
- We observed some instances where patients that attended clinic regularly had built relationships with the staff that worked there.
- Staff could describe examples of how difficult messages were given to patients and those close to them both sensitively and privately. However, we observed, and the trust data confirmed, that some patients were told to expect results by telephone. Our specialist advisors felt that this was not good practice as patients should receive bad news face to face so that they could access emotional support in a timely manner. We noted that a complaint had been received from a patient with a concern about this practice.

Outpatients and diagnostic imaging

- The service operated a continuous patient experience survey which patients were encouraged to complete, either during or following their visit to the department. We saw examples of completed surveys which were all positive.
- We observed some instances where patients that attended clinic regularly had built relationships with the staff that worked there.
- The Friends and Family Test, which assesses whether patients would recommend a service to their friends or family, showed that 93% of patients would recommend the service to family and friends. This was slightly lower than the other sister sites.

Understanding and involvement of patients and those close to them

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

Emotional support

- The trust had a number of clinical nurse specialists and lead nurses available for patients to talk about their condition. For example respiratory nurses to talk with patients who had been referred for oxygen therapy.
- We saw examples of access to local advisory groups to offer both practical advisory and emotional support to both patients and carers.
- We observed a patient with mobility issues attending the outpatient department and being supported with the automatic check in process. There was a strong visible presence of volunteers available to support patients on arrival in the outpatient department.

- Three records we looked at showed completed assessments for anxiety and depression appropriate to the clinical needs of the patients.

Are outpatient and diagnostic imaging services responsive?

Good



We found that some improvements had been made to the outpatient and diagnostic service but some areas for improvement had not been implemented. Overall access to appointments had improved but performance was variable. The percentage of people waiting less than 31 days and 62 days from diagnosis to first definitive treatment for all cancers varied. From quarter 1 to quarter 3 of 2013/2014 the trust performed in line with the England average. In quarter 4 of 2013/2014 the trust performed worse than the national average but from quarter 1 to quarter 3 2014/2015 the trust performance improved and they performed slightly better than the England average.

The environment and ability to ensure privacy and dignity for patients impacted on the service delivery. We observed that patients returning from theatre were transported through some parts of the outpatient department. During our last inspection we noted that there was no information available in the departments for patients who have a learning disability or written information in formats suitable for patients who had a visual impairment. During this inspection we noted that this was not the case. Main outpatients have specific information /leaflets for patients with learning disabilities. Main outpatients and the Ophthalmic department have information/ leaflets in easy read formats; or written in formats suitable for those patients who have a visual impairment. However, staff we spoke with in outpatient departments across the site were not able to tell us how written information in an 'easy read' format could be accessed.

The outpatient and radiology/diagnostic departments were able to access telephone translation services for patients.

Service planning and delivery to meet the needs of local people

Outpatients and diagnostic imaging

- The trust served a geographical area of 1000 square miles. The trust outpatient and diagnostic imaging services were located through the geographical area to facilitate access to clinics and reduce travel times for people using the services.
- Extra clinics were held at weekends to reduce waiting times for patients.
- Some services such as dietetics were piloting telephone clinics to reduce the need for patients to travel. We noted that this was not always suitable for each patient and this was being monitored for efficacy.
- Some staff felt that although they were encouraged to work as one trust there were still issues in inequalities of service delivery on each site. Staff reported that if they rotated to a different hospital site the policies and procedures were not always the same in a similar department. The lack of streamline provision may impact on the effectiveness and appropriateness of service delivery.
- We found that the follow up to new appointment rates for the Furness General Hospital site were the same as the England average.
- During our last inspection we noted that the trust needed to improve the waiting times for patients once they arrived in the department. Staff were able to describe how they had responded to an identified delay in ENT clinics and how they had put systems in place to reduce the waiting times for patients. Data provided by the trust showed that 1% of patients waited up to 30 minutes for their appointment in the last four months and only 1 % of patients waited over 60 minutes. The Furness General Hospital site had the best waiting times of all three sites across the trust.
- We also noted at our last inspection that there were a number of incidents regarding the transport for patients. We spoke with patients and external staff who confirmed that this had improved over the last twelve months. The location had not reported any incidents in the last six months regarding transport issues for the Furness General Hospital site. Patients we spoke with told us that things seemed to have improved recently.

Access and flow

- The outpatient department undertook 520,602 outpatient appointments during 2014/15.
- The referral to treatment percentage score within 18 weeks for non-admitted and incomplete pathways were better than the standard from April 2013 to February 2014. From March 2014 the trust was similar to the England average and fell lower than the standard in January 2015.
- Trust wide data showed diagnostic waiting times were generally lower than the England average with the exceptions of April, October 2014 and January 2015.
- All three cancer wait measures performed similar to the England average from 2013/14 and 2014/15.
- Changes to the management of the waiting list meant those that had been waiting longest were now being offered the quickest appointments. This meant fewer patients were waiting extended periods. The average percentage of clinics cancelled from January to April 2015 was 0.6%.
- The trust had a number of patients who failed to attend for their appointments. The Did Not Attend rates were consistently lower than the England average with an average of 6% for the hospital compared to 7.2% nationally. This was continually monitored to enable adaptations to be made to meet the needs and demand of the population.

Meeting people's individual needs

- The Outpatient and Diagnostic imaging departments were able to access telephone translation services for patients. We were told by staff that this could be arranged without notice when patients who required the service presented themselves in clinic. However, we did not see any information in any format explaining this to patients who may need translation services.
- During our last inspection we noted that there was no information available in the departments for patients who have a learning disability or in easy to read formats. Main outpatients now had specific information and leaflets for patients with learning disabilities. Main outpatients and the Ophthalmic department had information and leaflets in easy read formats; or written in formats suitable for those patients who have a visual impairment. However, staff we spoke with in outpatient departments across the site were not able to tell us how written information in an 'easy read' format could be accessed.
- The service used the "Blue daisy" scheme. This was a discreet trust wide system for the identification of patients to help identify people who were living with dementia who may require extra support when they were attending the service.

Outpatients and diagnostic imaging

- We inspected the therapy department and found that there were no call bells in the disabled toilets. We brought this to the attention of the manager who referred the issue to the estates department for immediate action. The lack of call bells for disabled people to call for help if needed was not in line with national standards for the provision of disabled toilet facilities.

Learning from complaints and concerns

- Trust data for the time period 1st June 2014 – 31st May 2015 showed that 21 complaints had been received which were related to the outpatient service.
- We found concerns or complaints leaflets and Patient Advise Liaison Service leaflets were available throughout the departments. The response target for complaints is 35 working days from receipt of the complaint which data showed was currently being met.
- We saw copies of the latest “Learning to improve” bulletin. This bulletin highlighted the ways the organisation had considered complaints and changed or improved things. One area highlighted in the bulletin related to the outpatient department reminding all staff about the importance of informing patients of any delays during clinic.

Are outpatient and diagnostic imaging services well-led?

Good



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

The service held monthly core clinical governance and assurance meetings with standard agenda items such as incident reporting, complaints, training and lessons

learned. The outpatient service reported risks through the core clinical services division. Senior staff were aware of the risk register and were actively engaged in monitoring the risks. The executive were more visible and showed examples of regular communication and feedback. Overall staff felt more engaged with the trust and felt that there had been some improvements in service delivery.

Vision and strategy for this service

- The trusts vision of “better care for the future together” across the region were displayed through the trust. All of the staff we spoke with were aware of the trust’s vision and values. Service leads told us that there was an operational plan for the outpatient and diagnostic services but we did not see evidence of this being shared with staff.

Governance, risk management and quality measurement

- At our last inspection we found that the trust’s governance and management systems were not fully embedded in all parts of the service and not all services were following trust policies and procedures. At this inspection we found that improvements had been made.
- There were systems to report and manage risks. Staff were encouraged to participate in changes within the department and there was departmental monitoring at both consultant and board level in relation to patient safety. The service held monthly core clinical governance and assurance meetings with standard agenda items such as incident reporting, complaints, training and lessons learned.
- The outpatient service reported risks through the core clinical services division. Senior staff were aware of the risk register and were actively engaged in monitoring the risks.
- The need for additional occupational therapists had been identified and was on the divisional risk register. This had been reviewed on 24 July 2015 and still showed a high risk rating for therapy staff vacancies.
- Radiology consultants attended monthly directorate clinical governance and risk meetings to review the quality of service provision and ensure that the standard of clinical care was effective and in line with national standards.

Leadership of service

Outpatients and diagnostic imaging

- Staff told us that the executive were more visible and showed examples of regular communication and feedback.
- However we had both positive and negative feedback about the visibility of middle managers. The recent reorganisation across therapy service had caused some uncertainty and staff felt they did not know their new managers.

Culture within the service

- Staff were candid throughout our inspection about both the good parts of their service and the areas that required improvement.
- We noted that staff evaded answering questions relating to how systems worked across the three sites we visited during our inspection. One member of staff we spoke with in the Breast Screening Unit told us they did not know their colleagues on other sites. During our conversation, the staff member was unable to tell us the surname of a colleague in an equivalent role on another site.

Public engagement

- The trust was proactive in seeking patient feedback within the outpatient services. We found feedback forms available in all the departments we visited with post boxes for patients and visitors to leave completed forms.

Patients told us they were actively encouraged to complete these. We looked at a sample of five completed cards which were all overwhelmingly positive about care people had received.

- Information was displayed on message boards throughout the outpatient services to engage the public in messages about the service and to seek feedback.

Staff engagement

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

Innovation, improvement and sustainability

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

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

- Ensure that all premises used by the service provider are clean, secure, suitable for the purpose for which they are being used, properly used, properly maintained and appropriately located for the purpose for which they are being used. This is particularly in relation to services provided from critical care and outpatients.
- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed in order to meet the needs of the patients. This is particularly in relation to medical care, children and young people services, and radiology, dermatology and allied health professionals.
- Ensure that staff receive appropriate support, training, supervision and appraisal to enable them to carry out the duties they are employed to perform, particularly in Accident and Emergency, medical and surgical services and Children and Young People services.
- Ensure referral to treatment times in surgical specialities improve.
- Ensure that staff understand and act in accordance with the requirements of the Mental Capacity Act 2005 and associated codes of practice.
- The provider must ensure that staff follow policies and procedures around managing medicines, including intravenous fluids particularly in children and young people's and critical care, services.
- Maintain securely an accurate, complete and contemporaneous record in respect of each service user, including medical and nursing, and food and fluid charts, particularly in medical and surgical services.

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

In urgent and emergency services:

- Take action to improve waiting times and ambulance handovers.
- Ensure action plans following CEM audits clearly state the steps required to secure improvement.
- Improve staff engagement, knowledge and awareness of the strategy for the service.

In medical care services:

- Ensure there are clear plans in place to reduce the number of falls occurring within the service.
- Improve the management of people with a stroke in line with national guidance.
- Consider improving arrangements for clinical supervision to ensure they are appropriate and support staff to effectively carry out their responsibilities, offer relevant development opportunities and enable staff to deliver care safely and to an appropriate standard.
- Take action to reduce the number of patients staying on medical wards that are not best suited to their needs and to reduce the number of moves between wards.

In surgical services:

- Ensure there are systems in place to identify themes from incidents and near miss events to promote safe care.
- Ensure all staff understand the process for raising safeguarding referrals in the absence of the safeguarding lead.
- Reduce and improve re-admission rates.
- Ensure all procedures are performed in line with best practice guidance. Where practice deviates from the guidance, a clear risk assessment should be in place.

In critical care services:

- Ensure that there is timely access to medical care for patients out of hours and that any delays do not result in patient harm.

Outstanding practice and areas for improvement

- Consider how it is going to improve performance in reducing the number of delayed and 'out of hours' discharges of patients from critical care.
- Ensure that any delayed discharges from critical care do not result in a breach of the government's single sex standard.
- Ensure that all entries in patient records are appropriately signed and dated.
- Consider the provision of a supernumerary clinical co-ordinator on duty 24/7.
- Consider how it intends to respond to the latest Health Building Notes guidance for critical care units in planning its vision and strategy for the service.

In maternity and gynaecology services:

- Ensure that the actions of the Kirkup recommendations are implemented within timescales and embedded across the trust.
- Ensure there are clear lines of responsibility and accountability at ward manager and matron level within maternity so that staff feel supported and barriers to communication and change are removed.
- Implement the recommendations of and monitor compliance with the PHSO Report 'Midwifery supervision and regulation: recommendations for change' (2013) with regard to Trust/Midwifery Supervisory investigations, so that parent(s) receive a joint set of recommendations and a single timeframe resulting from the investigation.
- Ensure that the 'Five steps to safer surgery' (World Health Organisation) is embedded in obstetric theatre practice.

- Ensure that a physical test is carried out in line with trust policy to ensure that the infant abduction procedures work correctly and that staff understand how they work.
- Monitor effectiveness for joint working between obstetrics.

In children and young people's services:

- Ensure that there are clearly defined and formalised job plans in place for consultant paediatricians.
- Consider reviewing the investigation process of patient safety incidents with full consideration given to the reporting professional's account of events and concerns.
- Ensure that there are measures in place to monitor the effectiveness of joint working within medical staff teams.

In end of life care services:

- Ensure there is a clear and accessible system in place to identify and monitor risks within end of life care services.
- Continue to take action to improve those areas identified by the NCDAAH.
- Ensure all DNACPR forms are completed to the appropriate standard.

In outpatients and diagnostic imaging:

- Continue to build relationships and develop closer team working to develop a one trust culture.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 18 HSCA (RA) Regulations 2014 Staffing</p> <p>Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)</p> <p>Regulation 18(1)(2) Staffing</p> <p>The provider must ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed in order to meet the needs of the patients. This is particularly in relation to medical care, children and young people services, and radiology, dermatology and allied health professionals.</p> <p>The provider must ensure that staff receive appropriate support, training, supervision and appraisal to enable them to carry out the duties they are employed to perform, particularly in Accident and Emergency, medical and surgical services and Children and Young People services.</p>
Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment</p> <p>Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)</p> <p>Regulation 15 (1) Premises and equipment</p> <p>The provider must ensure that all premises used by the service provider are clean, secure, suitable for the</p>

This section is primarily information for the provider

Requirement notices

purpose for which they are being used, properly used, properly maintained and appropriately located for the purpose for which they are being used. This is particularly in relation to services provided in critical care and outpatients.

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

Regulation 12 (2)(a)(g) Safe care and treatment

The provider must ensure that staff act in accordance with the requirements of the Mental Capacity Act 2005 and associated codes of practice.

The provider must ensure that staff follow policies and procedures around managing medicines, including intravenous fluids particularly in children and young people's and critical care, services.

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

Regulation 17 (2)(b)(c) Good governance

This section is primarily information for the provider

Requirement notices

The provider must maintain securely an accurate, complete and contemporaneous record in respect of each service user, including medical and nursing, and food and fluid charts, particularly in medical and surgical services.

Ensure referral to treatment times in surgical specialities improve.