

North Cumbria University Hospitals NHS Trust Cumberland Infirmary


Quality Report

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

Ratings

Overall rating for this hospital	Requires improvement	
Accident and emergency	Requires improvement	
Medical care	Requires improvement	
Surgery	Requires improvement	
Critical care	Good	
Maternity and family planning	Requires improvement	
Services for children and young people	Requires improvement	
End of life care	Requires improvement	
Outpatients	Requires improvement	

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out this comprehensive inspection because North Cumbria University Hospitals NHS Trust had been identified as a high risk trust on the Care Quality Commission's (CQC) Intelligent Monitoring system. The trust was also one of 11 trusts placed into special measures in July 2013 following Sir Bruce Keogh's review into hospitals with higher than average mortality (death) rates. At that time, there were concerns regarding inadequate governance, the pace and focus of change to improve overall safety, and patient experience, as well as slow and inadequate responses to serious incidents and a culture that did not support openness, transparency and learning. In addition, there were concerns regarding staffing shortfalls in a number of staff groups that may have been compromising patient safety, a lack of support for staff, a lack of effective, honest communication from middle and senior managers, failures in governance to ensure adequate maintenance of the estate and equipment and significant weaknesses in infection control practices.

We looked at how the trust had responded to the review as part of this inspection.

The announced inspection of the Cumberland Infirmary, Carlisle took place on 1 and 2 May 2014, and unannounced inspection visits took place between 8.30am and 4pm on 12 May 2014.

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

Our key findings were as follows:

Mortality rates

- Since our last inspection in October 2013 and the Keogh review in June 2013 there had been a significant improvement in mortality rates, which are now within expected limits.
- Patients whose condition might deteriorate were identified and escalated appropriately.

Infection control

- The hospital was clean throughout and staff generally adhered to good practice guidance in the prevention and control of infection. However, we noticed a build-up of refuse in dirty utility rooms at busy times, and that good practice guidance for infection control was not always adhered to in the special care baby unit in relation to the management of clean and dirty laundry.
- Infection rates were within expected limits.
- Deceased patients with infectious diseases were not always transferred to the mortuary with appropriate preventative measures in place.

Food and hydration

- Patients had a choice of nutritious food and an ample supply of drinks during their stay in hospital. Patients with specialist needs were supported by dietitians and the Speech and Language Therapy Team (SALT).
- The 'red tray' system was used to support patients who needed help to eat and drink.

Medicines management

- Medicines were provided, stored and administered in a safe and timely way.

Medical and nurse staffing

- Care and treatment was delivered by committed and caring staff who worked hard to provide patients with good services. However,
- There were numerous vacant consultant posts. This had an adverse effect on the timeliness of treatment for patients and meant support for junior doctors was ineffective in a number of core services.
- Nurse staffing levels, although improved, remained a concern and the hospital relied heavily on existing staff to cover extra shifts and on bank and agency staff to maintain adequate staffing levels. Adequate staffing levels were not consistently achieved in all core services.

Summary of findings

Importantly, the hospital MUST:

- Ensure that there are sufficient numbers of suitably qualified, skilled and experienced nurses to meet the needs of patients at all times.
- Ensure medical staffing is sufficient to provide appropriate and timely treatment to patients at all times.
- Ensure that all staff within departments in the hospital have the required skills to meet the needs of patients at all times.
- Take action to ensure that the planning and delivery of patient care and treatment is consistently carried out in accordance with published research and guidance issued by professional and expert bodies.
- Ensure that all equipment is stored safely.
- Ensure emergency equipment is complete and fit for purpose.
- Ensure that children are consistently risk assessed at the time of arrival into the paediatric department to meet national standards.
- Ensure triage services in A&E are always effectively staffed by appropriate personnel.
- Improve patient flow throughout the hospital to reduce waiting times in the A&E department.
- Develop a standard governance system across all surgical specialities to ensure surgical dashboard information is discussed, recorded and disseminated to all staff.
- Ensure that any children who are treated on the adult intensive care unit receive care that is appropriate for their age.
- Ensure that the maternity service reviews its identified risks and implements sufficient actions to mitigate them.
- Ensure that risk management processes in the maternity service are embedded to implement a robust quality assurance checking mechanism across the service to ensure an effective service.
- Ensure that the risk register for the hospital's children's ward accurately reflects the risks identified in the completed audits and reviews.
- Take action to protect the health and welfare of children and young people with mental health needs by ensuring that appropriate health and social care support is provided in collaboration with other providers.
- Ensure that good practice guidance in infection control is followed in the special care baby unit, particularly in relation to the management of clean and dirty laundry.
- Take action to prevent the build-up of refuse in dirty utility rooms at busy times.
- Develop a formal End of Life Care standard framework to assure safe, effective care at the end of life. Plans need to be in place to formally replace the Liverpool Care Pathway by July 2014.
- Address the problem caused by the downdraft air ventilation system in the mortuary, which was posing an infection risk.
- Improve how patient records are made available for outpatient appointments and clinics.
- Ensure that information about 'How to make a complaint' is accurate. We found that some complaint leaflets were available, but information for both the role and contact details for the Care Quality Commission was out of date and inaccurate and did not clearly direct people to the Public Health Service Ombudsman.

In addition the hospital should:

- Ensure effective patient flow through the A&E department to cope with its routine workload and reduce patient waiting times.
- Take action to prevent patients being moved between wards during the night.
- Ensure that a major incident plan for the surgical directorate is available and regularly tested.
- Ensure adequate services for patients who are accommodated in A&E overnight while waiting for a bed in the hospital.
- Make improvements to the major haemorrhage protocol to bring it into line with national standards.
- Ensure staff are aware of, and have access to, a robust policy for transferring sick children to tertiary children's hospitals.
- Continue to develop robust audit processes to verify staff adherence to the 'five steps to safer surgery' and World Health Organisation (WHO) procedures.

Summary of findings

- Ensure that the surgical service uses patient-reported outcome measures (PROMS) data effectively.
- Make sure that staff on the children's wards document whether children are able to be involved in making decisions about their care and treatment.
- Improve access to equipment and provide more suitable storage for larger pieces of equipment.
- Improve staff training with regard to all care bundles.
- Improve support given to junior medical staff.
- Improve the management of people with diabetes and stroke in line with national guidance.
- Improve the management of people living with dementia.
- Clarify a leadership role with a clear remit to promote 'normality' in child birth as supported by the Royal College of Midwives Campaign for Normal Birth and the National Childbirth Trust Birth Policy.
- Improve the use of information technology to improve the effectiveness of data flows. We were told that approval had just been given to introduce the IT data.
- Take the necessary action to ensure that staff have the opportunity to regularly discuss their personal development and any issues or concerns.
- Show how it has responded to information from patients, relatives and staff, and used this information to develop the service.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Accident and emergency

Requires improvement

Rating



Why have we given this rating?

The Government requires NHS trusts in England to admit, transfer or discharge 95% of patients within four hours of their arrival in the A&E department. The trust has struggled to meet this target, and its lowest performance was in January 2014 at 85.2%. However, it achieved 96.8% in February 2014 and 97% in March.

There was a reliance on locum doctors to cover substantial medical vacancies. Despite recent and ongoing recruitment, there were nursing vacancies in the department.

There were delays in triage due to staff vacancies. Children were not being consistently triaged by a specialist nurse as only one paediatric nurse was available for the entire department.

Because of a shortage of beds in the hospital, patients were sometimes accommodated in A&E overnight, with no standard operating procedures to support staff to manage their care.

Patients were involved in their care and treatment and were complimentary about the staff and service provided. However, waiting times and the management of the flow of patients through the department continued to cause patients concern. There were clear lines of accountability within the team structure. The team worked well together and there was good oversight for the department, including a medical lead (an A&E consultant), a nursing lead (a senior matron) and a unit manager (operations service manager).

Medical care

Requires improvement



The medical wards followed clinical pathways for care for a range of medical conditions, which were based on current legislation and national guidance. We found examples of good leadership by individual members of medical and nursing staff, although there was a lack of connection between the staff providing hands-on care and the Executive Team. Staff were hardworking, caring and compassionate. They treated patients with dignity and respect and planned and delivered care in a way that took patients' wishes into account.

Summary of findings

There were robust systems to report incidents and to manage risk within the service. Medical patients admitted to wards outside of the medical directorate were well managed and were seen regularly by appropriate medical staff.

Staff used the national early warning score (NEWS) system, to identify and escalate concerns in patients whose condition was deteriorating.

However, there were shortages of both nursing and medical staff throughout the medical directorate in the form of vacant posts, combined with high nursing sickness and absence rates. There was a heavy dependence on nurse bank and agency staff, high usage of locum doctors, plus a longstanding inability to staff wards to the agreed safe levels at all times. This meant that care and treatment posed a potential risk to patient safety.

Analysis of national audit data showed that improvement was needed in the management of patients with diabetes and those who had had a stroke. There were no clearly defined pathways for the care, treatment or support of patients once an initial diagnosis of dementia had been made.

Some patients were moved several times before being admitted to the most appropriate ward to treat their medical condition and some patients were moved after 11pm or in the early hours to make beds available to avoid breaching waiting times in the Accident and Emergency department.

Surgery

Requires improvement



Surgical services were delivered by a hardworking, caring and compassionate staff that treated patients with dignity and respect. Surgery was managed in accordance with national standards and guidance. The physical environment on the surgical wards and theatres were clean and safe.

There were shortages of both nursing and medical staff. Combined with bed pressures, this was having an adverse impact on the hospital's target of meeting the 18-week referral to treatment (RTT) times.

We saw evidence that learning from incidents and complaints and national audit of outcomes was disseminated and used to support improvement.

Summary of findings

However, there had been six surgical never events between November 2012 and April 2014. This is a higher number compared with similar trusts. Immediate response to the events was good but sustained review was not robust. Locally, the wards/departments were well-led, although there was a lack of connection between the staff providing hands-on care and the executive team.

Critical care

Good



Care and treatment was delivered in accordance with national guidance. We were concerned that the service had not submitted ICNARC data for the last year to support measuring the effectiveness of the service. The implementation of care bundles had not been supported by training for staff and they were not fully utilised. There were sufficient numbers of competent nursing staff to meet patients' needs at the time of our inspection. However, there were nurse vacancies within the service which had affected safe staffing levels in the recent past. Multi-disciplinary working was well established and staff worked well together as a team. There were daily consultant ward rounds and out-of-hours medical cover was provided by ACCS and anaesthetists in training with an on-call consultant. Staff were caring and compassionate, and patients and relatives spoke highly of their care and treatment. Staff were aware of current infection prevention and control guidelines, and applied them. Medicines, including controlled drugs, were safely and securely stored. Cleaning schedules were in place, and there were clearly defined roles and responsibilities for cleaning the environment, and cleaning and decontaminating equipment.

Maternity and family planning

Requires improvement



The maternity service at Cumberland Infirmary Carlisle was delivered by committed and compassionate staff that treated patients with dignity and respect. All the people we spoke with were positive about their care.

Summary of findings

The service had identified its risks and was monitoring its performance against national and local maternity indicators. However, we found that the identified actions that were needed to mitigate the risks had not yet been implemented.

The obstetrics and gynaecology service accounted for 29% of all incidents reported across the trust. The service did not provide a key option for pain relief as identified in the NICE quality statement that relates to the induction of labour. The rate of elective and emergency caesarean sections in the service was significantly higher than the national average. Surgical intervention in childbirth increases the risk to both mother and baby, which therefore reduces the overall safety of the service. We found no evidence of a clear strategy or plan for reducing the number of caesarean sections.

There was a lack of dedicated medical staff cover, no dedicated second theatre, pressure on space and a lack of compliance with key NICE guidance. This impacted on the ability of the service to respond in a timely manner and deliver a safe and effective service.

The service had the standard ratio of one midwife to 28 patient hospital births, one midwife to one woman in labour and the supervisor to midwife ratio was as expected. It had recently been part of a trust wide review of maternity services, which resulted in the introduction of a midwifery governance lead who had improved the approach to governance and monitoring of clinical practice. The specialist midwife roles had been welcomed, but staff felt that the roles were not yet fully embedded and they did not fully understand the roles of the clinical leads and the business manager.

The midwifery staff felt well-led locally. However, there was no evidence of an articulated strategic vision for the future of maternity and family planning services at the Cumberland Infirmary Carlisle location.

Services for children and young people

Requires improvement



Staff at the Cumberland Infirmary were caring and had the skills to provide effective and safe treatment to children who used the service. They understood the trust's policies and procedures. However, the hospital did not provide effective staff supervision.

Summary of findings

Safeguarding and child protection services were effective. Recent steps taken to ensure that staff followed the safeguarding children policy had resulted in positive outcomes. The medical staff, matron and ward staff demonstrated an open culture and were caring towards children and young people.

Locally, staff felt well supported by their managers. Although appropriate processes and facilities were in place to protect children from the risk of hospital acquired infections, high level infection control audits were not completed in full.

Environmental and care and treatment risk assessment had not been completed appropriately, which meant that the safety of children and young people was not always promoted. There were fewer nursing and medical staff at the weekend, so children and babies who attended the hospital were at risk of delayed or ineffective treatment over weekend periods. The information provided by the trust identified significant periods between when concerns were raised and when effective remedial action was taken.

A range of quality monitoring, management and departmental meeting reports confirmed that the senior management team were part way through developing a strategy to provide a safe and modern paediatric service.

End of life care

Requires improvement



End of life care was well supported on the wards through a dedicated specialist team. Patients received sensitive, individualised care and those close to them were also supported sensitively. The sharing of information was good and ensured that continuity of care was supported by robust record keeping. Pain and discomfort was managed well and medicines were readily available as required.

However, there were concerns about patients' dignity and respect after death when they were transferred to the mortuary. Some equipment was in need of replacement or upgrade.

The trust was developing an alternative pathway to use for people who were at the end of life to replace the 'Liverpool Care Pathway'. However, this was not in place at the time of our inspection.

Summary of findings

Outpatients

Requires improvement



The outpatient department was adequately staffed by a well-trained, professional and caring team. The outpatient areas were clean and well maintained and measures were taken to control and prevent infection.

There were delays to start and finish times in clinics because patient records were unavailable. This led to long waits for patients. We were informed that doctors would not see patients without their case notes and in some cases patients had not been seen on the day of their appointment. This issue has already been recorded as high risk on the trust's risk register.

People did not complain to us about the waiting times, although patients waiting at clinics said that they found it undignified for inpatients to be moved from wards through the main atrium area in their beds or wheelchairs while wearing bed clothes when attending for diagnostic imaging.

Although staff treated patients with dignity and respect, patients waiting for day surgery had limited privacy in the changing rooms, and the waiting area was cold and uncomfortable. We were informed by staff and patients that many people became distressed at having to walk through the public area to the theatre in a night gown. Others refused to change until they were in the theatre area.

Patients told us that they were very satisfied with the service they received. They were positive about staff attitudes and had confidence in the staff's ability to look after them well during a procedure. Staff were very committed and worked hard to achieve good outcomes for patients.

People were very complimentary about the service provided by the digital imaging team.

Outpatient clinics were generally comfortable and friendly, with suitable facilities. Oncology and digital imaging were meeting the two-week waiting targets for urgent patients but targets for six-week and 18-week appointments were not being met. Plans were in place to retrieve this situation by June 2014. The service was looking creatively at how to meet increased patient demand by best use of staff skills and by offering clinics at alternative locations to expand and develop capacity.

Performance was reported monthly and considered by the trust board. Plans for the service included

Summary of findings

addressing issues related to capacity. The board had ownership of the plans and there was a commitment at all levels to secure the required improvements. Staff overall were positive about the Chief Executive and the engagement and visibility of senior staff. Staff had confidence in their managers and felt there was a new, strong culture of leadership.

Requires improvement

Cumberland InfirmaryThe Cumberland Infirmary

Detailed findings

Services we looked at

Accident and emergency; Medical care (including older people's care); Surgery; Critical care; Maternity and family planning; Services for children and young people; End of life care; Outpatients

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Detailed findings from this inspection

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Detailed findings

Background to Cumberland Infirmary

The Cumberland Infirmary is a general hospital based in Carlisle. Along with the West Cumberland Hospital in Whitehaven, the hospital delivers acute care services as part of North Cumbria University Hospitals NHS Trust. We inspected the hospital as part of the comprehensive

inspection of North Cumbria University Hospitals NHS Trust. This inspection follows previous inspections, including the Keogh review in May 2013 and a CQC inspection in September 2013.

Our inspection team

Our inspection team was led by:

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

Head of Hospital Inspections: Ann Ford, Care Quality Commission

The team included an Inspection Manager, 10 CQC inspectors and a variety of specialists including a Surgical Operational Manager of Acute Trust Clinical Services; Director of Improvement, Quality and Nursing; Clinical governance expert; Consultant Physician and Gastroenterologist; Consultant Obstetrician &

Gynaecologist; Consultant Paediatrician & Honorary Senior Lecturer - Neonates/general paediatrics; Executive Director of Nursing with experience in Community Services, Service Transformation, Clinical Governance, Risk Management, Prevention & Control of Infection, Emergency Planning, Safeguarding of Children; Surgical Nurse; Paediatric Emergency Nurse Consultant; Head of Midwifery and Supervisor of Midwives; Lead Nurse for Critical Care and previous Head of Nursing Development and Quality; Student Nurse and two Experts by Experience.

How we carried out this inspection

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

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

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

We held a listening event in Carlisle on 29 April 2014 as well as one at Whitehaven and listened to people's experiences of the services at The Cumberland Infirmary,

West Cumberland Hospital and the Penrith Birthing Centre. Some people who were unable to attend the listening events shared their experiences by email or telephone.

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

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

Detailed findings

We carried out unannounced inspections between 8.30am and 4pm on 12 May 2014. We looked at the availability of beds on the medical wards as part of this visit.

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

Facts and data about Cumberland Infirmary

The Cumberland Infirmary, Carlisle provides a 24-hour A&E service with Trauma Unit status, a consultant-led maternity service and special care baby unit, a wide range of clinical services, including delivering complex vascular and general specialist services, and outpatient clinics.

The hospital has 412 inpatient beds and serves the local people around Carlisle and throughout North Cumbria. The North Cumbria University Hospitals NHS Trust serves a population of 340,000 who live in a largely rural area of Cumbria.

Detailed findings

Our ratings for this hospital



Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Accident and emergency	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Good	Requires improvement	Good	Good	Good	Good
Maternity and family planning	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Services for children and young people	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients	Inadequate	Not rated	Good	Requires improvement	Good	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

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

Accident and emergency

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

Information about the service

The A&E department at Cumberland Infirmary provided a consultant-led 24-hour service, seven days a week and is part of the Emergency Care and Medicines Business Unit (ECMBU) of the trust. The department is designated as a major trauma unit. Across the trust's two A&E departments, approximately 72,000 patients were seen every year.

There were separate walk-in and ambulance entrances to the department. Main reception is staffed 24 hours a day. Within the main department there were 20 clinical assessment spaces: a three-bed resuscitation area and three-bed monitored step down/majors treatment area; 11 trolley cubicles; one psychiatric, one eye/ENT, one triage assessment rooms; and one dedicated decontamination room. The department had a separate children's waiting area and one dedicated room for paediatrics. On average the department sees around 140 patients each day (approximately 50,000 patients each year).

We spoke with 16 patients, one relative and 10 staff – including consultants, middle grade doctors, an operations manager, chief matron, matron, sister, staff nurses and ambulance staff. We observed care and treatment and looked at treatment records. We also reviewed many items of the trust's own quality monitoring information and data.

Summary of findings

Trusts in England are tasked by the Government to admit, transfer or discharge 95% of patients within four hours of their arrival in the A&E department. The trust has struggled to meet this target consistently; its lowest performance was in January 2014 at 85.2%. However, it achieved 96.8% in February 2014 and 97% in March.

There was a continued reliance on locum doctors to cover medical vacancies in the department. Nursing vacancies were affecting the roles undertaken by triage nurses, which risked adversely affecting patient safety.

Care and treatment was evidence-based. Four care bundles were available in the department for use in relation to acute chronic obstructive pulmonary disease (COPD), sepsis, community acquired pneumonia and unexplained diarrhoea and/or vomiting. However, the protocol for massive haemorrhage needed to be updated to bring it into line with current standards.

The department needed to improve how it used national outcome and audit data to improve patient treatment outcomes. The Trauma Audit & Research Network (TARN) data collection and submission rates also needed to improve, as the data available was not current.

The findings of the Northern Trauma Service review team in February 2014 supported the trust's plan to have a CT radiographer on site overnight and stated that out-of-hours CT reporting needed to be reviewed.

Accident and emergency

Access to the service and patient flow continued to be challenging. There had been occasions when patients had to be accommodated in A&E overnight because of a lack of beds in the hospital, and there were no standard operating procedures in place for staff to follow on how to provide the accommodation.

There were delays in triaging patients as triage staff were expected to cover other duties because of the shortage of nurses. Children were not being consistently triaged by a specialist nurse as there was only one paediatric nurse available for the entire department.

Patients were involved in their care and treatment. Staff spent time explaining treatment options to allow patients to make an informed choice. Overall, patients and relatives were complimentary of the staff and of their treatment. However, some remained concerned about waiting times and the transfer times from A&E to an appropriate ward.

There were clear lines of accountability within the team structure. The local management team worked well together and there was good oversight for the department that included a medical lead (an A&E consultant), a nursing lead (a senior matron) and a unit manager (operations service manager).

Both medical and nursing staff expressed their views about the service openly and constructively. The staff were caring and passionate about the department and about the care they provided to patients.

Are accident and emergency services safe?

Requires improvement



There was a continued reliance on locum doctors to cover medical vacancies. There were also nursing vacancies, which were affecting roles undertaken by nurses within the department and adversely affecting patient safety. We noted that the draft version 1 of the 'Accident and Emergency Department Operational Policy' did not include reference to the MAJAX and CBRN and the protocol for massive haemorrhage required immediate up dating to bring it in line with current standards.

Incidents

- No never events were reported in A&E within the previous 12 months.
- The trust reported six serious incidents requiring investigation (SIRIs) relating to the A&E department to the Strategic Executive Information System (STEIS) between December 2012 and January 2014. We looked at the serious investigation report for one of the most recent SIs reported and saw an action plan had been developed to improve practice from lessons learned, with further follow-up actions agreed. The learning from the incident had been fed back to the A&E team to prevent it happening again.
- The trust provided a copy of the A&E department's incident management report from September 2013 to February 2014, which showed that a total of 204 incidents were reported during this period. These incidents had been categorised appropriately and the majority were assessed as not resulting in harm to patients.
- Staff reported incidents of concern electronically, and they were competent and confident when reporting incidents. Notes from the clinical governance meetings included reviews of SIs and incident reports and indicated that lessons learned were shared and discussed. Outcomes from lessons learned were displayed on the notice in the staff base.

Safety thermometer

- Clinical practice was monitored through a monthly audit and the safety data was visibly displayed on notice boards in the department. This provided up-to-date

Accident and emergency

information on performance in areas such as hand hygiene, environment and equipment cleanliness, falls, pressure ulcers and other incidents. There were no current concerns identified.

Cleanliness, infection control and hygiene

- The department was clean and staff were aware of the current infection prevention and control guidelines. We saw adequate hand washing facilities and alcohol hand gel available throughout the department.
- During our inspection we saw that hand gel was not used frequently as staff and visitors moved about the department.
- Staff observed guidance on 'bare below the elbow' and wearing personal protective equipment, such as gloves and aprons, while delivering care in accordance with good practice.
- Staff handled and disposed of clinical waste safely, including sharps.

Environment and equipment

- The public areas and clinical environments were modern, well maintained and in a good state of repair. There were ample supplies of suitable equipment. Appropriate life support and associated monitoring equipment and resuscitation equipment was accessible and available in the department.
- The emergency equipment checks in the paediatric cubicle of the resuscitation room were not being checked daily in line with recommended best practice.

Medicines

- Policies and procedures were accessible to staff on the trust's electronic shared drive and staff were aware of the procedures to follow. Medicines were stored, managed, administered and recorded safely.

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

- Policies and procedures were accessible to staff on the trust's electronic shared drive and staff were aware of the procedures to follow. We observed staff discussing care and treatment options with patients and /or their relatives to enable them to make informed choices. Where patients lacked capacity to make their own choices staff consulted with appropriate professionals and others as appropriate, so that decisions were made in the best interests of the patient.

- Patients and/or their relatives confirmed that staff had provided clear explanations for them to make informed decisions. We witnessed staff seeking verbal consent before undertaking treatments for example, prior to cannulation and taking specimens.

Safeguarding

- Policies and procedures were accessible to staff on the trust's electronic shared drive and staff were aware of the procedures to follow on how to escalate safeguarding concerns.
- Senior medical staff were responsible for ensuring patient discharge arrangements. Internal and external patient transfer arrangements were safe and appropriate to meet the needs of the patient.

Mandatory training

- Staff received mandatory training that covered a wide range of subjects under a number of domains for example, health and safety, safeguarding, moving and handling, resuscitation and medicines management.
- We looked at the department's nursing training records up to the end of January 2014. We saw variable completion rates reported across all of the domains. For example, 100% completion was reported for safeguarding children and young people level 1 and 82% at level 3; 90% for adult safeguarding at level 1 and 24% at level 2; 79% for training in learning disabilities, 91% for Mental Capacity Act level 1 and 53% for fire safety.
- Training reports for medical staff also showed variable completion rates across all domains. For example, 100% completion for safeguarding children and young people level 1; 18% for adult safeguarding at level 1 and 4% at level 2; 43% for fire safety and 46% for basic life support.
- The ECMBU quality and safety report for quarter 3 noted that improving completion rates was a key priority and operations managers were issued with monthly updates for action.

Management of deteriorating patients

- We looked at five national early warning score (NEWS) records and saw they contained internal escalation clinical response triggers to senior medical staff if a patient had a high NEWS score. Pain scores and fluid output was included within NEWS assessments.

Accident and emergency

- Walk-in patients were registered at main reception and asked to wait in the waiting area before being triaged by the nurse. If there were any immediate concerns about a walk-in patients' health the receptionist would contact the nursing staff to ask for immediate assistance.
- Ambulance crews confirmed their arrival by using the electronic arrival (HAS) screen, whilst at the same time notifying the A&E team of their arrival. Systems and processes were in place to receive ambulance pre-alerts for major emergency cases.
- Ambulance patients were brought directly to the nurse's station in the main department where a very brief history was given to enable the nurse to determine the most suitable location to treat the patient. A full handover from the ambulance staff was then given to the nurse within that particular area.

Nursing staffing

- Recruitment to fill existing nursing vacancies was ongoing. All of the six band 7 qualified nurse posts had been filled and all six new staff were now working in the department.
- The daily nursing staffing establishment for the department was 7am to 9am three qualified/one health care assistant (HCA) increasing to five qualified/one HCA from 9am to 1.30pm. From 1.30pm to 9.30pm six qualified and one HCA from 5pm to 1am. Overnight from 9.15pm to 7.15am there were four qualified nurses.
- During discussions with senior staff it was apparent that the day shift was short of one whole time equivalent (WTE) qualified nurse every day.
- Patients were not always triaged in a timely way as there were times when triage was unavailable due to staffing pressures.
- The triage nurse was expected to care for patients in other parts of the department. During our inspection we saw the triage nurse working in the resuscitation area, leaving triage unmanned.
- Staffing rotas indicated that two (WTE) agency nurses were working to cover staffing vacancies. There was appropriate use of an orientation pack for agency staff and induction packs for new nurses.
- The service only had one (WTE) qualified paediatric nurse to cover the entire department. This was not conducive to delivering consistent, specialised care for children in A&E. We also looked at two sets of children's notes and saw that the children had not been triaged on admission. The Royal College of Paediatrics and Child

Health (2012) Standards for children and young people in emergency care settings states that children should be triaged within 15 minutes. The department did not always comply with this. This can put children at risk, as signs of serious illness may not be identified if they are not assessed quickly on arrival.

- Risks in relation to insufficient nursing numbers across the entire ECMBU had been escalated onto the risk register. We saw from the register assurance that control measures were in place to manage the risk and these controls were reviewed monthly.

Medical staffing

- There was a consultant presence in the department from 8am to 11pm on weekdays and from 9am to 5pm at weekends. Consultant on-call cover was provided 24 hours, seven days a week. Middle grade doctors along with junior doctors were on duty 24 hours a day, seven days a week for 365 days a year.
- We spoke with two consultants who told us the medical staffing establishment included six whole time equivalent (WTE) consultants. At the time of our inspection, there were three vacant WTE consultant posts, which were covered by long term locum doctors.
- Risks regarding the reliance of locum doctors to bridge vacancies across the ECMBU had been escalated onto the risk register. We saw from the register assurance control that measures were in place to manage the risk and these controls were reviewed monthly.

Major incident awareness and training

- Security arrangements were in place in the department to cover the weekends. The door from the main reception into the main department was electronically controlled.
- A new decontamination tent for use in handling hazardous waste incidents had been ordered, but training in this was not frequent.
- We noted that the draft version 1 of the 'Accident and Emergency Department Operational Policy' did not include reference to the MAJAX and CBRN (major incident/accident plan and chemical biological radiological and nuclear exposure) plans.

Are accident and emergency services effective?

(for example, treatment is effective)

Accident and emergency

Not sufficient evidence to rate

Care and treatment was evidence-based. Four care bundles were available in the department for use in relation to acute chronic obstructive pulmonary disease (COPD), sepsis, community acquired pneumonia and unexplained diarrhoea and/or vomiting.

We did not witness comprehensive multidisciplinary team (MDT) working within the department. Nursing and medical handovers were undertaken separately.

Improvement is required in response to utilising national outcome audit data to improve patient treatment outcomes. TARN data collection and submission rates require improvement.

The Northern Trauma Service review team in February 2014 had recommended support to the trust's plan for a CT radiographer on site overnight, along with a review of out-of-hours CT reporting.

Evidence-based care and treatment

- Care and treatment in A&E was evidence-based and followed recognisable and approved guidelines such as those from the National Institute for Health and Care Excellence (NICE) and nationally recognised assessment tools. It was managed in accordance with the principles in 'Clinical Standards for Emergency Departments' (CEM).
- Clinical guidelines were developed and referenced with NICE guidance and/or other nationally recognised standards. Guidelines were approved through the trust's clinical guideline committee.
- Guidelines were available and accessible to staff electronically. There were visual prompts relayed on the trust's electronic systems to inform staff of any new guidelines released.
- Data from the Trauma Audit and Research Network (TARN) is used to promote improvements in care through national clinical audit and to show performance comparison information on survival rates of patients with major injury who have been admitted to hospital. The department's data was nine months old and needed to be updated. In February 2014, the Northern Trauma Service review team reported that they would expect to see the department's

completeness score increase to 50% within six months, and to achieve the desired 80% within 12 months. The trust had provided extra administration support to help to improve TARN data completion.

- The Northern Trauma Service review team had also recommended that the massive haemorrhage protocol should be updated to bring it into line with national standards, but this was not yet in place.
- We looked at three College of Emergency Medicine (CEM) audits. These had been reviewed and the trust had reviewed the priorities for improvement and subsequent action planning.

Patient outcomes

- Care bundles are a set of interventions which, when used together, significantly improve patient outcomes. Four care bundles were available in the department for use in relation to acute chronic obstructive pulmonary disease (COPD), sepsis, community acquired pneumonia and unexplained diarrhoea and/or vomiting. Staff were aware how to access and activate the bundles.

Competent staff

- Appraisals and supervision of medical and nursing staff were undertaken and recorded. An appraisal gives staff an opportunity to discuss their work progress and future aspirations with their manager. Information from the quarter 3 ESMBU safety and quality report showed an appraisal rate of 48.77% for doctors and 69% for consultants.
- The ESMBU risk register showed that action to improve its appraisal rates had been recorded and assurance control measures were in place to manage the required improvement, which were reviewed monthly.
- Weekly clinical and business leadership meetings were established to monitor progress on clinical and operational workforce governance.

Multidisciplinary working

- We did not witness comprehensive multidisciplinary team (MDT) working within the department. Nursing and medical handovers were undertaken separately. On the day of our inspection, no occupational therapy or physiotherapy presence had been requested in the department.

Accident and emergency

- Staff worked well together as a local management team. There were clear lines of accountability, cohesive working and good local leadership, which contributed to planning and delivering patient care.

Seven-day services

- Consultant presence in the department was from 8am to 11pm on weekdays and from 9am to 5pm at weekends. Consultant on-call cover was provided 24 hours, seven days a week.
- Middle grade doctors along with junior doctors were on duty 24 hours a day, seven days a week for 365 days a year.
- The visit by the Northern Trauma Service review team in February 2014 had recommended supporting the trust's plan for a CT radiographer to be on site overnight. It also noted that out-of-hours CT reporting needed to be reviewed to ensure timely turnaround of imaging reporting.
- Other services such as radiology and pathology were also available seven days a week.

Are accident and emergency services caring?

Good



Patients were involved in their care and treatment, staff spent time explaining treatment options to allow patients and relatives to make an informed choice. Patients and relatives overall were complimentary of the staff and of the treatment they had received.

Compassionate care

- We observed positive interactions between staff, patients and /or their relatives. Staff consistently demonstrated caring attitudes towards patients throughout the inspection. We spoke with 16 patients and one relative. The majority spoke positively about their care and treatment. They felt that they had been treated with dignity and respect.
- We observed staff drawing curtains around each patient's bed and individual cubicles to maintain their privacy and dignity. We heard staff using appropriate speech and tone when talking with patients.

- The A&E Friends and Family Test results show that the trust was performing better than the England average for three of the four months, with December and January scoring the highest at 67. It also reflects that the most responses received were 1,538 in December 2013.

Patient understanding and involvement

- Most patients reported positively about how they had been involved in making decisions about their care and treatment.

Emotional support

- We saw staff spending appropriate time talking to patients and/or their relatives and responding to their questions in an appropriate manner. Most members of staff provided the appropriate emotional support, reassurance and comfort to patients and relatives who were anxious or worried. But we did observe a member of staff who escorted an extremely distressed patient to the imaging department and then left them to wait in the department on their own.

Are accident and emergency services responsive to people's needs? (for example, to feedback?)

Requires improvement



Access and flow continued to be challenging. Patients were accommodated in A&E overnight due to bed pressures in the hospital, but there were no standard operating procedures in place for staff to follow on how the accommodation should be provided. There were delays in triage as triage staff were expected to cover other areas due to staff vacancies. Children were not being consistently triaged as there was only one paediatric nurse available for the entire department.

Service planning and delivery to meet the needs of local people

- Communication between staff was effective. Shift handovers involved staff providing detailed information on the risks, treatment and care for each patient, the staffing requirements and patient flow through the department.

Accident and emergency

- We attended the daily morning staff meeting and observed the team planning for the day, discussing concerns or incidents from the previous day and receiving feedback from other incidents along with any lessons learned.
- Handovers between ambulance and nursing staff were conducted sensitively, safely and efficiently. The department's operations policy gave staff guidance on how to escalate patient pathway delays to enable them to meet the needs of the patients.

Access and flow

- The trust has struggled to maintain the target of admitting, transferring or discharging 95% of patients within four hours of their arrival in the A&E department. Its performance has been below the England average many times, with the lowest being 85.2% in January 2014. However in February 96.8% of patients were seen within the four hours and in March this rose to 97%.
- Time to triage for patients attending by ambulance should be 15 minutes, but the department was not consistently meeting this target. Ambulance staff confirmed handover times can vary and said some waiting times were over half an hour.
- The number of patients leaving the department before being treated is consistently better than the England average, but it meant patients were waiting longer to be treated. A number of the patients we spoke with were concerned about the long waiting time. Staff reported that the frequent delays in patient flow through the department were due to beds not being available on the wards. This was a particular issue in medical wards.
- There had been occasions when patients had to be accommodated overnight in a bed in the A&E department because beds were unavailable on wards. We raised this issue directly with the Chief Matron and Operations Service Manager for the unit, and they confirmed this had happened on rare occasions.
- There were no standard operating procedures developed for providing care and treatment for patients who needed an overnight stay in A&E while waiting for a bed in the hospital. Both managers agreed to undertake a full review of this issue following our inspection.
- On the day of inspection access and flow through the department was managed effectively.

Meeting people's individual needs

- We reviewed the notes for five patients and saw care and treatment was carried out in accordance with the

assessed needs of each patient. The integrated electronic care record tracked a patient's movement through the department. These records included triage times.

- A psychiatric liaison nurse worked within the department and provided specialist support for people presenting with mental health problems throughout the working day. Outside normal working hours, the out-of-hours (OOH) crisis team provided cover. Staff in the team reported that because the OOH crisis team had to cover a large geographical area, this resulted in slower response times and increased patient waiting times.
- Translation/interpreter services were available at the hospital.
- Staff were familiar with the guidelines on same-sex accommodation and designated patients to treatment areas accordingly.

Learning from complaints and concerns

- The ECMBU monitors and tracks complaints and identified themes. The chief matron is delegated to monitor complaints at a local level and discuss these at the weekly leadership meetings. Lessons learned from complaints were applied within the department to improve patient experiences.
- Reviews of complaints and lessons learned were discussed at monthly governance and departmental meetings. Systems and processes were in place to advise patients and relatives on how to make a complaint.

Are accident and emergency services well-led?

Requires improvement



There were clear lines of accountability within the team structure. The team worked well together and there was good oversight for the department, including a medical lead (an A&E consultant), a nursing lead (a senior matron) and a unit manager (operations service manager).

Both medical and nursing staff expressed their views about the service openly and constructively. The staff were caring and passionate about the department and about the care they provided to patients.

Accident and emergency

Vision and strategy for this service

- The trust's values, vision and improvement priorities were clearly displayed throughout the hospital. The ethos of the emergency department was clearly stated in its operational policy. The department was consultant-led and the whole team worked well in the interests of patients.

Governance, risk management and quality measurement

- The medical lead and one other consultant told us departmental meetings and clinical governance meetings were held monthly. We looked at the last clinical governance meeting notes from April 2014 and saw these included discussions on patient care, safety, risks and quality of the service. Actions were agreed for follow-up and these were assigned to key personnel within the department.
- The department's operations policy version 1 had recently been revised and was still draft at the time of inspection. The policy clearly sets out the scope, duties and responsibilities of clinicians, nursing, managers and responsibility of the Emergency Care Sub Unit Board (ECSUB).
- The ECSUB committee is responsible for monitoring progress, reviewing risks in relation to emergency care and business continuity. This committee reports directly to the Emergency Care and Medicine Operational Board.
- The department is a major trauma unit. The trust's trauma guideline identified the trauma team along with the criteria for responding to and managing patients arriving with major trauma injuries. Both the guideline and trauma treatment record (Trauma Document) had been developed in accordance with national and regional trauma standards. We did note that the trauma guidelines did not include any details of document controls.

Leadership of service

- Oversight for the department included a medical lead (an A&E consultant), a nursing lead (a senior matron) and a unit manager (operations service manager).
- Weekly clinical and operational leadership meetings were established and we heard from staff who attended that their purpose was to monitor clinical and operational workforce governance.
- Regular monthly staff meetings gave staff an opportunity to receive trust wide updates; share lessons learned from incidents and complaints, and contribute to improving the quality and development of the A&E service.

Culture within the service

- We spoke with a number of the medical and nursing staff and they expressed their views about the service openly and constructively. The staff were caring and passionate about the department and about the care they provided to patients. Staff felt they worked well together as a team. It was reported that band 7 qualified nurses were not allocated management time, which consequently reduced opportunities to support and develop the staff team.







Public and staff engagement

- Since April 2013, patients have been asked whether they would recommend hospital wards to their friends and family if they required similar care or treatment, the results of which have been used to formulate NHS Friends and Family Tests for Accident & Emergency and Inpatient admissions.

Innovation, improvement and sustainability

- The department is recognised as a trauma centre and is part of the North East Regional Trauma Network.

Medical care (including older people's care)

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

Information about the service

The acute medical care services at Cumberland Infirmary provided care and treatment for a wide range of medical conditions. We visited Willow, Maple, Larch, Beech and Elm wards and the discharge lounge over the course of our inspection. The stroke unit was located within Elm ward. We observed care, looked at records for 12 people and spoke with 18 patients, seven relatives and 29 staff across all disciplines.

We also visited the coronary care unit and heart centre located within Willow ward, where we observed care and treatment and reviewed a sample of care records. We talked with two patients and six members of the nursing and medical staff.

Summary of findings

The medical wards had clinical pathways for care in place for a range of medical conditions, which were based on current legislation and guidance. We found examples of good leadership by individual members of medical and nursing staff, although there was a lack of connection between the staff providing hands-on care and the executive team. Staff were hardworking, caring and compassionate. We saw that staff treated patients with dignity and respect and planned and delivered care in a way that took their wishes into account. There were robust systems for reporting incidents and managing risk within the service. Medical patients admitted to wards outside of the medical directorate were well managed and were seen regularly by appropriate medical staff.

However, there were shortages of both nursing and medical staff throughout the medical directorate as a result of vacant posts, combined with high nursing sickness and absence rates. There was a heavy dependence on nursing bank and agency staff, a high usage of locum doctors, plus an ongoing inability to staff wards to the agreed safe levels at all times. This meant that care and treatment was not being provided safely. Analysis of SSNAP and NADIA data demonstrated that improvements were needed in the management of patients with diabetes and those who had had a stroke. There were no clearly defined pathways of care in place for the care, treatment or support of patients once an initial diagnosis of dementia had been made.

Medical care (including older people's care)

Some patients were moved between wards several times before being admitted to the most appropriate ward to treat their medical condition and some patients were moved after 11pm or in the early hours to avoid breaches of waiting times in the Accident and Emergency department.

Are medical care services safe?

Requires improvement



There were robust systems for the reporting of incidents and the management of risk within the hospital. However, there were chronic shortages of both nursing and medical staff throughout the medical directorate in the form of vacant posts. These shortages, when combined with high nursing sickness absence rates, heavy dependence on nursing bank and agency staff, high usage of locum doctors, plus an ongoing inability to staff wards within the medical directorate to the agreed safe levels at all times, meant that care and treatment was not being provided safely.

Incidents

- There were robust systems for reporting incidents and near misses across the medical directorate. Staff were confident in reporting incidents and near misses and were supported by managers to do so. Our review of incidents reported by the trust showed that between December 2012 and January 2014, the number was acceptable when compared with other trusts. This showed a healthy reporting culture. Feedback was given and we saw examples of learning from incidents being applied and evaluated.
- Mortality and morbidity meetings were held monthly and were attended by ward managers. These meetings discussed any deaths that had occurred in the medical directorate and any learning from the deaths. Ward managers then took the learning points back to their individual teams.

Safety thermometer

- The department was managing patient risks such as falls, pressure ulcers, bloods clots, catheter and urinary infections, that are highlighted by the NHS Safety Thermometer assessment tool. This is a tool designed to be used by frontline healthcare professionals to measure a snapshot of these harms once a month. The trust monitored these indicators and displayed information on the ward performance boards. The hospital has performed well against the England average for all the indicators measured.

Medical care (including older people's care)

Cleanliness, infection control and hygiene

- The hospital's infection rates for C.difficile and MRSA infections lie within an acceptable range for a hospital of this size. Antibiotic prescribing guidance was available on the trust's intranet, which medical and nursing staff said they found comprehensive and useful. The wards we inspected were clean, well-organised and well maintained. Staff were aware of current infection prevention and control guidelines. There was a sufficient number of hand wash sinks and hand gels. Hand towel and soap dispensers were adequately stocked. We observed staff following hand hygiene practice and 'bare below the elbow' guidance.
- On the wards with small dirty utility rooms, bags of domestic waste were stored on the floor and in some cases there were so many that they blocked staff access to hand washing facilities in the dirty utility area, despite being collected regularly throughout the day. Staff informed us that if they noticed a build-up of domestic refuse bags they could ring for an additional collection and that the response to these requests was good.

Environment and equipment

- The hospital did not have an equipment library and most equipment was stored on wards. Staff told us they found this frustrating, particularly when the equipment was needed urgently, as they had to contact other wards to find the equipment if it was not available on the ward. Electrical connection leads for some equipment were frequently missing and nursing staff felt they had an additional task, once equipment had been located, to ensure that it was clean and fit for use. Large pieces of furniture, such as stroke chairs, hoists and electric wheelchairs were stored mostly in bathrooms. In one case equipment was stored in a therapy room, which meant the therapists had to move it into corridors so they could use the room to deliver the therapy to patients.
- We checked the resuscitation equipment on all of the wards we visited and found it had been checked regularly by a designated nurse. On all these wards, there were new boxes containing emergency drugs, which were too large to fit inside the resuscitation trolleys. Staff were concerned about the risk that these boxes could easily be stolen or that patients who were cognitively impaired could open them without difficulty and access the contents. Their concerns had been escalated to the senior management team, and we were

informed that new containers had been ordered that were small enough to fit inside the resuscitation trolleys. No action had been taken to reduce the risks associated with access to the emergency drugs in the meantime.

Medicines

- All ward-based staff reported a good service from the pharmacy staff, including the timely dispensing of medicines for patients on discharge.
- Patient who had the capacity to self-medicate were supported to do so following a risk assessment undertaken by a member of the pharmacy team.

Records

- During our inspection we reviewed nine sets of patient records on four wards. In all these records, documentation was accurate, legible, signed and dated, easy to follow and gave a clear plan and record of the patient's care and treatment. Risk assessments such as the waterlow score (a tool for assessing patients at risk of pressure ulcers) and falls risk assessments were well documented and regularly reviewed. Care plans contained clear accounts of actions in place to reduce and manage risks to patient safety.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated a good knowledge of the Mental Capacity Act 2005 and how it protects patients' rights. Through a review of patient records, we saw that staff had assessed patients' mental capacity to make a decision and when patients lacked capacity staff sought advice from appropriate professionals, and others as appropriate, so a decision could be made in the patient's best interest.

Safeguarding

- There was a system for raising safeguarding concerns. Staff were aware of the process and could explain what was meant by abuse and neglect. This process was supported by training and all of the staff we spoke with about safeguarding had undertaken safeguarding training.

Mandatory training

- The records we saw at ward level were in the form of training matrices. They indicated that compliance with mandatory training was over 80%, although staff informed us that this was not reflected on the trust wide electronic training recording system. This was because

Medical care (including older people's care)

some ward managers had not been able to input the training information into the electronic system as they were awaiting the relevant training. Others told us they had input the information but were unsure whether they had completed the process correctly. Therefore it was not possible to assess the actual percentage of staff that had completed required mandatory training.

Management of deteriorating patients

- The trust used the National Early Warning Score (NEWS), which was designed to identify patients whose condition was deteriorating. Staff were prompted when to call for appropriate support. The chart incorporated a clear escalation policy and gave guidance about ensuring timely intervention by appropriately trained personnel. We found that this tool was in use and steps had been taken to ensure staff understood how to use it and escalate concerns about a patient's condition appropriately.

Nursing staffing

- We found nurse staffing levels were calculated using a recognised dependency tool. Managers on all the wards we inspected, except the coronary care unit and heart centre, reported vacancies for trained nurses that had not been filled and many reported long term sickness and absence. Copies of duty rotas confirmed this. The trust had a system in place for escalating staffing shortages. However, ward managers informed us that they often did not get the trained nursing staff they needed, or they would be allocated a healthcare assistant when they had asked for a trained nurse. Most wards relied heavily on bank and agency nursing staff, which meant that, although some bank and agency staff worked regularly on the same wards, continuity of care was affected.
- We observed several nursing and medical staff handovers during our inspection. Communication between staff was effective, with staff handover meetings held during daily shift changes. We heard handover discussions that included information regarding risks and concerns relating to each patient. Discharge plans were also discussed as well as any issues that required follow-up.

Medical staffing

- Throughout the trust there were numerous vacant consultant posts. All the wards we inspected in the medical directorate had vacant consultant posts, most

of which had been filled with locums, who were sometimes employed for short periods and could leave with very little notice. Most of the junior medical staff we spoke with in the directorate told us there were times when they felt unsupported, and those who received good support had witnessed colleagues struggling from a lack of consistent support from senior and middle grade medical staff. One junior doctor told us, "I've been OK because I have some experience, but I feel sorry for some colleagues who are finding it really hard to cope." We spoke with medical staff at all levels throughout the hospital who were working many additional hours voluntarily each week in order to provide safe and effective patient care.

- Staff told us about the many ways in which the shortages of consultants affected patient care. One example given was the delay in routine liaison with families that required a consultant presence.
- There was no oncology consultant presence in the hospital out of hours and there was no on-call rota for oncology. Staff expressed concern that the medical staff providing cover out of hours did not always have the specialist oncology skills, knowledge and experience to provide the most effective medical care to oncology patients out of hours. The consultant would receive telephone calls and give advice and support when off duty, but this was done on a voluntarily basis.

Are medical care services effective?

Requires improvement



The medical wards had clinical pathways for care in place for a range of medical conditions based on current legislation and guidance. However, analysis of Sentinel Stroke National Audit Programme (SSNAP) and NADIA data demonstrated that improvements are needed in the management of patients with diabetes and those who had had a stroke.

Evidence-based care and treatment

- The medical wards had clinical pathways for care in place for a range of medical conditions, based on current legislation and guidance. Clinical guidelines were available and accessible on the trust's intranet. Many had been recently introduced or updated and included 'care bundles' for the care and treatment of

Medical care (including older people's care)

pneumonia, sepsis, and stroke care. Staff on some wards told us they had not received any training in using the new clinical pathways. There was evidence that the stroke pathway had recently been evaluated and a revised pathway was being piloted so that the documentation used was common throughout all the trust's hospitals.

- The Cumberland Infirmary provided 20 hours of diabetes specialist nurse time a week. Good practice suggests that the ratio of diabetes specialist nurses to hospital inpatients should be 1:300, as recommended in the report Commissioning Specialist Diabetes Services for Adults with Diabetes (Diabetes UK, 2010). This meant that the hospital was providing less than half of the recommended diabetes specialist nurse expertise to patients.

Pain relief

- The effectiveness of pain relief was audited for individual patients as part of their plan of care. The medical directorate did not undertake specific pain relief audits to assess its overall effectiveness in treating pain.
- We found that one ward was using the Abbey Pain Scale as they preferred it to the trust wide pain scale used on other wards. Using different documentation makes it difficult to audit the effectiveness of services such as pain relief across the trust.

Nutrition and hydration

- Most of the patients we spoke with were complimentary about the meals served at the trust. People had a choice of suitable and nutritious food and drink and we saw that hot and cold drinks were available throughout the day. Staff were able to tell us how they addressed peoples' religious and cultural needs regarding food. We saw that, where possible, there was a period over mealtimes when all activities on the wards stopped, if it was safe for them to do so. This meant that staff were available to help serve food and support those patients who needed help. We also saw that a 'red tray' system was in place to highlight which patients needed assistance with eating and drinking.

Patient outcomes

- An analysis of data submitted by the trust in January 2013 as part of the Sentinel Stroke National Audit Programme (SSNAP) placed the hospital in the bottom 25% of trusts nationally for the effective management of

stroke patients. SSNAP is a programme of work that aims to improve the quality of stroke care by auditing stroke services against evidence-based standards. We discussed findings from the audit with the ward manager and the stroke consultant and were shown an action plan that documented a series of actions to be taken to enable the hospital to improve its performance. Several actions required more specialist nurses and allied health professional staff. Although one stroke specialist nurse had been recruited there was no indication of how the additional members of staff would be funded. Particularly concerning were 'door to needle' times for patients suitable for thrombolysis.

Thrombolysis is the administration of a 'clot-busting' drug to patients who have had a stroke following a blood clot to the brain. Eleven patients had been thrombolysed between April 2013 and April 2014, but only two had received treatment within the recommended time of one hour. Seven of the patients had door to needle times of over two hours, with the most recent thrombolysis, in April 2014, taking two hours and six minutes.

- An analysis of the National Diabetes Inpatient Audit 2013 showed that the hospital was not performing well against some of the indicators. Of particular concern were data showing that only 3.6% of diabetic inpatients received a foot risk assessment within 24 hours of admission, compared with an England average of 37.6%. This was a deteriorating trend from 9.4% in 2012. Also of concern were the data showing that only 11.5% of patients with diabetes were visited by a member of the diabetic team, compared with an England average of 34.5%. This was also a deteriorating trend, from 26.5% in 2012. We spoke with the lead diabetes nurse for the Cumbria Partnership NHS Foundation Trust, who provided the diabetes specialist nurse in-reach services into the Cumberland Infirmary. An analysis of the Myocardial Ischaemia National Audit Project (MINAP) data showed that the hospital was performing in line with or above the averages for England for the provision of treatment, referred to as 'door to needle/balloon times' once the patient arrived at the hospital.

Competent staff

- Medical and nursing staff were receiving appraisals. Staff spoke positively about the process in terms of their involvement and development.

Medical care (including older people's care)

- It was not possible to establish accurate levels of appraisals for nursing staff. This was because some ward managers had not been able to input the information into the electronic system as they were awaiting the relevant training. One ward we visited reported numbers of completed appraisals of 10% but could actually provide evidence that 100% of appraisals had been completed for nursing staff.

Multidisciplinary working

- Multidisciplinary teams (MDTs) worked well together to ensure coordinated care for patients. From our observations and discussions with members of the multi-disciplinary team, we saw that staff across all disciplines genuinely respected and valued the work of other members of the team. We saw that teams met at various times throughout the day, both formally and informally, to review patient care and plan for discharge. MDT decisions were recorded and care and treatment plans amended to include changes.
- There was an ambulatory care unit on the Emergency Assessment Unit. It was staffed by nurse practitioners who assisted in the clerking of admitted patients, and worked well.

Seven-day services

- A consultant was available for the medical directorate between 8am and 10pm, with a consultant on call out of hours. There were usually daily doctors ward rounds, although sometimes these were replaced by 'board rounds' where the multi-disciplinary team discussed patients around a white board but did not see them. Only newly admitted patients or those whose condition had deteriorated saw a doctor at weekends.
- There was reduced support from allied health professionals, imaging and pharmacy staff out of hours. Staff on the medical wards said this could cause delays.

Are medical care services caring?

Good



Medical services were delivered by a hardworking, caring and compassionate staff. We observed that staff treated patients with dignity and respect and planned and delivered care in a way that took into account the wishes of the patients.

Compassionate care

- Medical services were delivered by a hardworking, caring and compassionate staff. We observed that staff treated patients with dignity and respect. All the people we spoke with were positive about their care and treatment.
- We spoke with 14 patients and three relatives and everyone spoke very positively about the care that they, or their family member, had received. Some comments made were, "They look after me so well here I will be sorry to go home" and "Everyone is wonderful, I was worried about coming into hospital but I have had no complaints at all."
- We also saw examples of ways in which people were encouraged to share give feedback about the hospital and ways in which improvements could be made. Between October 2013 and January 2014, the trust had performed below the national average for the Friends and Family Test, which asks patients how likely they are to recommend a hospital after treatment. Of the 31 inpatient wards at Cumberland Infirmary, 13 scored below the trust average, four of which were medical wards. Findings from an analysis of the most recent adult inpatient survey demonstrated that the trust had performed within expectations compared with other trusts for all areas of questioning.
- We observed that nursing staff carried out regular 'comfort' rounds to ensure that patients' needs were met. Staff ensured that patients had drinks, were comfortable and had easy access to call bells. However, on one ward we saw that the nail care for patients was poor and we saw that two patients who had been at the hospital for several weeks had excessively long, dirty fingernails.

Patient understanding and involvement

- Staff planned and delivered care in a way that took patients' wishes into account. We saw staff obtaining verbal consent when helping patients with personal care. Patients we spoke with told us they felt involved in their care and treatment, and staff explained benefits and risks to them about care and treatment. Patients also told us that if they did not understand any aspects of their care the medical, nursing or allied health professional staff would explain to them in a way that they could understand. A named nurse system was in place throughout the medical wards and most patients we spoke with were aware who their named nurse was.

Medical care (including older people's care)

Emotional support

- An analysis of the National Diabetes Inpatient Audit 2013 showed that 100% of patients reported that they had received enough emotional support from staff to manage their diabetes, compared with an England average of 84.4%.

Are medical care services responsive?

Requires improvement



Medical patients admitted to wards outside of the medical directorate were well managed and were seen regularly by medical staff. However, some patients were moved several times before being admitted to the most appropriate ward to treat their medical condition. Other patients were moved after 11pm in order to avoid breaches of waiting times in the Accident and Emergency department.

There were no clearly defined pathways of care in place for the care, treatment or support of patients once an initial diagnosis of dementia had been made.

Service planning and delivery to meet the needs of local people

- The senior medical team presented to members of the CQC inspection team three options currently under consideration to manage pressures on the medical services across the trust in the short and longer term. This demonstrated that the trust was planning services regarding the best way to deploy the medical staffing resource at all the trust hospitals, including Cumberland Infirmary.

Access and flow

- The medical directorate was an active participant in the capacity and bed management meetings that were held three times daily. Staff worked hard to manage patient flow and timely discharge so the service was able to manage unplanned admissions and avoid patients being admitted to wards outside of the medical directorate.
- When medical patients were admitted to wards outside of the medical directorate they were well managed and were seen regularly by medical staff.
- Transfers of patients across the wards were sometimes made after 11pm, particularly from the Emergency Assessment unit when breaches of waiting times in the

Accident and Emergency department were likely. A review of the 'Emergency Assessment Unit Nurse in charge daily staff safety check list' established that during one week in April 2014, seven patients were moved after 11pm on one night, two patients on another night and 'multiple' patients on a third night. Staff told us that patients did not like it and neither did the staff. They told us, "We feel embarrassed having to wake people in the middle of the night and tell them they need to move wards, they get upset and confused."

- All urgent GP referrals for suspected cancer and any routine GP suspected cancer referrals that have subsequently been reclassified as urgent by a cancer specialist should commence treatment within 62 days of referral. An analysis of data submitted to NHS England by the trust for the last three months of 2013 indicated that for 84% of patients, treatment commenced within the 62-day target. This was only slightly below the England average of 85.8%.

Meeting people's individual needs

- From reviews of care plans we established that patients were screened for dementia on admission to medical wards. However, there were no clearly defined pathways in place for the care, treatment or support of these patients once a diagnosis of dementia had been made. The manager of one ward also told us that they relied on a charity based in the hospital for supplies of stationery for the "Butterfly" scheme to support patients living with dementia. This was because there was no mechanism to order the relevant stationery on the trust's ordering system. The trust had recognised this as an area that needed to improve and we saw an action plan to improve the care, treatment and support of people with a diagnosis of dementia. Although the documentation and processes around dementia care were not well embedded within the hospital, we observed several examples of good interactions and care being delivered by staff at all levels to people with a diagnosis of dementia.
- For patients whose first language was not English, staff could access a language interpreter if needed. We saw the services of an interpreter being used on one of the medical wards during our inspection. British Sign Language (BSL) interpreters were available for deaf people.

Medical care (including older people's care)

Learning from complaints and concerns

- Staff we spoke with were aware of the trust's complaints system and how to advise patients and relatives to make a complaint, if they wanted to do so. Large prominently displayed posters informing people how to make a complaint were visible on each medical ward and in corridors throughout the hospital. We heard how patient facilities had been improved on one ward following patient feedback, with a water cooler and access to snacks.

Are medical care services well-led?

Requires improvement



The trust had a vision and values for the organisation which had been cascaded across the medical directorate. We found examples of good leadership by individual members of medical and nursing staff throughout the medical directorate. Generally, the wards/departments were well-led, although there was a disconnect between the staff providing hands-on care and the executive team.

Vision and strategy for this service

- The trust had a vision and strategy for the organisation with clear aims and objectives. These had been cascaded across the medical wards and most staff had a clear understanding of what they involved. Ward managers in each of the areas we visited reinforced the organisation's vision and values regularly and all ward staff we spoke with were aware of what they were or where they were displayed.

Governance, risk management and quality measurement

- Information about core objectives and performance targets were displayed in all of the areas we visited.

Junior nursing and ancillary staff on most wards reported that they had been consulted about the setting of the key objectives specific to their wards, which gave them a feeling of 'ownership' and commitment to achieving the objectives.

Leadership of service

- We saw several examples of good leadership by individual members of medical and nursing staff throughout the medical directorate that were positive role models for staff.
- Staff told us they attended regular staff meetings and that their immediate line managers were accessible and approachable. They told us they felt disconnected from the executive team and did not feel that the executive team appreciated the day-to-day operational challenges involved in delivering direct care and treatment to patients. One member of staff told us, "All the senior team seem interested in sometimes is targets and KPIs."






Culture within the service

- Many staff spoke enthusiastically about their work. They described how they enjoyed their work, and how proud they were to work at the trust. There was a culture of 'goodwill' within the medical directorate, where many members of staff worked considerably beyond their contracted hours to support colleagues and to provide good patient care.
- Openness and honesty was the expectation within the medical directorate and was encouraged at all levels.

Innovation, improvement and sustainability

- Most staff told us that the levels of voluntary hours given to support patient care and treatment that were in excess of their contracted hours were unsustainable in the longer term.

Surgery

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

Information about the service

Surgical services at Cumberland Infirmary in Carlisle provided emergency trauma and orthopaedic, ophthalmology, elective, obstetrics and gynaecology and vascular surgery. We visited theatres, ophthalmology, day surgery and Aspen, Beech, and Maple wards during our inspection. We observed care, looked at records for seven people, spoke with six patients, two relatives and 24 staff across all disciplines.

Summary of findings

Surgical services were delivered by a hardworking, caring and compassionate staff that treated patients with dignity and respect. Surgery was managed in accordance with national standards and guidance. The physical environment on the surgical wards and theatres were clean and safe.

Shortages of both nursing and medical staff and bed pressures were having an adverse impact on the hospital's target of meeting the 18-week referral to treatment (RTT) times.

There was evidence that learning from incidents and complaints and national audit of outcomes was disseminated and used to support service improvement.

However, There had been six surgical never events between November 2012 and April 2014. This is a higher number than similar trusts.

Locally, the wards/departments were well-led, although there was a lack of connection between the staff providing hands-on care and the executive team.

Surgery

Are surgery services safe?

Requires improvement



There had been six surgical never events during the period November 2012 to April 2014. There were shortages of both nursing and medical staff combined with bed pressures. There was evidence that learning from incidents and complaints had been disseminated. The environment on the surgical wards and theatres we visited was mostly safe and we found no issues of concern.

Incidents

- There were six surgical never events (events that are very serious but largely avoidable) during the period November 2012 to January 2014, which was higher than the England average for a trust of this size.
- Each never event had led to a full root cause analysis with the learning disseminated throughout the trust. However, there were reoccurring themes in relation to surgical never events that indicate learning from events is not systematically embedded. Nevertheless, there was a clear process for investigating never events and patient safety incidents, including serious incidents requiring investigation (SIRIs).
- Staff were competent in reporting incidents and were able to use the reporting system to report and escalate appropriately. Staff confirmed that they received verbal feedback about incidents reported and that this was used to improve practice and the service to patients.
- Learning from incidents was shared at weekly staff meetings and on staff notice boards in resource areas on the wards.

Steps to Safer Surgery

- The World Health Organisation (WHO) checklist had been recently re-launched within the day surgery unit as the trust realised that local implementation had significantly deviated from the national documentation.
- WHO checklists were correctly implemented and completed in the theatres we inspected.
- The trust had recently implemented a WHO checklist audit, but results were not available at the time of our inspection.

Safety thermometer

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient

harms and 'harm free' care. Safety thermometer information was clearly displayed at the entrance to each ward. This included information about all new harms, falls with harm, new venous thromboembolism (VTE), catheter use with urinary tract infections and new pressure ulcers. In all areas the trust's performance fluctuated around the England average.

Cleanliness, infection control and hygiene

- Ward areas were clean and we observed staff regularly washing their hands and using hand gel between attending to patients. Staff adhered to the 'bare below the elbow' policy. Staff were aware of current infection prevention and control guidelines and applied them appropriately.
- Cleaning schedules were in place, and there were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.
- Hand hygiene audits had been undertaken on the wards showing effective hand hygiene among staff.
- We saw on one ward that hand hygiene equipment (alcohol gel holders) were stored on the floor next to a macerator in the dirty sluice area. We also saw bed/mattress extensions and gutter frames on the floor in the linen cupboard. It is not appropriate to store clean products in dirty areas as there is a risk of cross contamination.
- We reviewed documents during our inspection and found that both MRSA and C. difficile infection rates were within expected limits.

Environment and equipment

- The general environment in theatres was clean, safe and well maintained.
- Equipment was appropriately checked and cleaned regularly and we found that there was adequate equipment on the wards to support safe care.
- All the equipment we saw had service stickers displayed and these were within date.
- Equipment was serviced by the trust's maintenance team under a planned preventive maintenance schedule. Staff raised requests with the maintenance team by phone and told us they received good support.
- All items of equipment needed for surgery were readily available and any faulty equipment could be replaced

Surgery

from the hospital's equipment store. Staff in each team were responsible for checking equipment every day and any equipment failures or issues were logged as incidents on the electronic system.

- Resuscitation equipment, emergency drug packs and the defibrillator were checked daily.

Medicines

- Medicines were stored correctly on the wards and in theatres, including in locked cupboards or fridges where necessary. Fridge temperatures were checked daily to ensure medicines were stored correctly.

Records

- All records were kept in paper format and all healthcare professionals documented in the same place. When not in use, records were stored securely.
- We looked at patients' records in theatres. These were complete and accurately maintained.
- Patient records showed that staff carried out appropriate checks for consent and medical history before starting a procedure or operation.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had the appropriate skills and knowledge to seek consent from patients, and had received mandatory training in consent. The staff we spoke with were clear on how to ask for verbal and written consent before providing care or treatment. We looked at records which showed that both verbal and written consent had been obtained from patients and that planned care was delivered with their agreement. We also found that records were completed sensitively and that discussions with patients were recorded.
- Records showed that staff had assessed patients' mental capacity to make a decision and when patients lacked capacity staff sought advice from appropriate professionals, and others as appropriate, so a decision could be made in the patient's best interest.

Safeguarding

- There was a system for raising safeguarding concerns. Staff were aware of the process and could explain what was meant by abuse and neglect. This process was supported by staff training and all the staff we spoke with about safeguarding had received relevant training.

Mandatory training

- We looked at mandatory training records for staff on the wards we visited and found that between 70% to 78% of staff had received mandatory training in the period 2013 – 2014. However, these figures differed from those on display within the wards, which were higher. This disparity was explained by the need to update the electronic system.

Management of deteriorating patients

- The surgical wards used the National early warning score (NEWS) tool 'to assess the severity of acute illness'. We found clear directions for escalation and staff were aware of the appropriate action to take if a patient's condition deteriorated.
- We looked at completed NEWS charts and saw that staff had escalated correctly, and repeat observations were taken within necessary time frames to support patient safety.

Nursing staffing

- Nursing numbers were assessed using a recognised staffing tool, and the ideal and actual staffing numbers were displayed on wards. Staffing rotas on the day of our inspection confirmed that staff numbers and skill mix were appropriate to meet the needs of patients. However, most of the wards we visited had nurse vacancies. Staffing rotas for the surgical wards for March 2014 showed that the surgical wards had sufficient qualified staff numbers between 88% and 100% of the time, and for healthcare assistants between 84% and 100% of the time. This meant that at other times the wards were not adequately staffed. It was notable that all wards made significant use of extra shifts, by both registered nurses and healthcare assistants, to try to maintain staffing levels.
- We observed several nursing and medical staff handovers during our inspection. Communication between staff was comprehensive and effective. Staff handover meetings took place between daily shift changes so staff were aware of each patient's condition and needs. Handovers also addressed staffing issues, safety risks and mitigating actions.

Medical staffing

- Within theatres, there was a sufficient number of staff with an appropriate skills mix to ensure surgical operations and procedures could be carried out safely.

Surgery

- Throughout the service there were numerous vacant consultant posts. All the surgical wards we inspected had vacant consultant posts, most of which had been filled with locum doctors, who were sometimes employed for short periods and could leave with very little notice. This had implications for the continuity of care for patients, and relied on accurate record keeping to ensure staff were fully aware of care and treatment plans for each patient. This raised the risk of inadequate continuity of care.

Major incident awareness and training

- It was unclear whether there was a major incident plan for the surgical directorate and whether this has been tested recently, as staff could not direct us to a plan of this nature for surgical services. We found there was a plan, but it had not been reviewed since the changes to the surgical pathways and had not been recently tested.

Are surgery services effective?

Requires improvement



Surgery is managed in accordance with recommendations from the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and the Royal College of Surgeons standards for emergency surgery. We looked at audit data for general surgical, orthopaedic and ophthalmology at a trust wide level and found evidence that this information was available in the areas we visited. Patient reported outcome measures, although available, were not used or discussed.

Evidence-based care and treatment

- Emergency surgery is managed in accordance with the NCEPOD recommendations and the Royal College of Surgeons standards for emergency surgery.
- The monthly departmental meetings discussed changes to national and best practice guidance, how it would impact on services and how it would be implemented.
- Enhanced recovery programmes were used in a number of surgical specialities.
- There were 'snapshot' audits of the monthly ward health check and safety thermometer in the areas we visited. No remedial actions had been identified or acted on in response to the audits.

- Audit data for general surgical, orthopaedic and ophthalmology surgery at a trust wide level was used to inform the provision of the surgical service.

Pain relief

- Patients were assessed pre-operatively for their preferred and appropriate pain relief post-operatively.
- There was a dedicated pain team and specialist nurses saw patients daily to effectively manage pain relief and patient comfort. This was supported by the patient records we reviewed.

Nutrition and hydration

- Patients were complimentary about the meals. People had a choice of suitable food and drink and we saw that hot and cold drinks were available throughout the day. Wards had protected mealtimes in place when all activities on the wards stopped, if it was safe for them to do so. This meant that staff were available to help serve food and assist those patients who needed help. We also saw that a red tray system was in place to highlight which patients needed assistance with eating and drinking.

Patient outcomes

- Mortality outliers (where applicable) were discussed during the Elective Surgery and Emergency Care governance meeting.
- The Patient Reported Outcome Measures (PROMs) were not discussed as part of the governance meeting despite two PROM related indicators indicating that the trust had two elevated risks in relation to hip replacement surgery and the proportion of cases assessed as achieving compliance with all nine standards of care measured within the National Hip Fracture Database.
- We discussed this with the matron, who explained that the PROM data was not currently used as the information was presented in a format that was difficult to interpret.
- Standardised relative risk readmissions were comparable with national expectations.

Competent staff

- Both medical and nursing staff were receiving appraisals and staff spoke positively about the process. Appraisal data was also listed on boards in each ward so that the

Surgery

current rate of appraisal was clear. We found the surgical wards to have completed no less than 80% of appraisals. The appraisal process was used to support the professional development of staff within the service.

- We saw evidence that staff were receiving mandatory training. This information was displayed on walls in staff resource rooms or on corridors and it clearly indicated to staff who required training and when.

Multidisciplinary working

- We saw that multi-disciplinary staff worked well in the majority of areas we inspected. There was effective communication between the teams within the surgical specialties. Trainee doctors and nurses told us they were supported well and were able to make referrals to physiotherapy, occupational therapy and dietetics as required.
- Allied health professionals worked well with ward-based staff to support patients' recovery and timely, safe discharge following surgery. Multi-disciplinary team meetings were well established to support patient safety, good recovery and timely discharge home.

Seven-day services

- A consultant was available for the surgical directorate between 8am and 10pm, with a consultant on call out of hours. There were usually daily doctors ward rounds, although sometimes these were replaced by 'board rounds' where the multi-disciplinary team discussed patients around a white board but did not see the patients. Only newly admitted patients or those whose condition had deteriorated saw a doctor at weekends.

Are surgery services caring?

Good



Surgical services were delivered by a hardworking, caring and compassionate staff. We observed that staff treated patients with dignity and respect and planned and delivered care in a way that took patients' wishes into account.

Compassionate care

- Patients were treated with dignity, compassion and empathy. We observed staff speaking with patients and providing care and support in a kind, calm, friendly and patient manner. Patients we spoke with were

complimentary about the staff, the level of care they received, staff attitude and engagement. Comments received included: "All the staff are very good" and "given a good explanation of what was happening and future plans." The comments received from patients showed that staff cared about meeting patients' individual needs.

- We saw that patients' bed curtains were drawn and staff spoke with them in private. Patients told us the staff respected their privacy and dignity.
- We saw that staff respected patient dignity whilst transferring patients between the wards and operating theatres. We saw staff helping patients throughout our visit and noted that patients were not rushed and staff regularly checked with them to see if they needed help.
- We watched a ward round and saw that doctors introduced themselves appropriately and that curtains were drawn to maintain patient privacy and dignity.

Patient understanding and involvement

- Staff respected patients' right to make choices about their care. The patients we spoke with told us they were kept informed about their treatment. They told us the clinical staff fully explained the treatment options to them and allowed them to make an informed decision. We observed staff speaking with patients clearly and in a way they could understand.
- We noted that each patient had a named nurse and this helped establish continuity and a good rapport.
- Patients felt well informed on what to expect upon admission.
- One patient who was an emergency admission told us that although they were delayed going to theatre they were kept informed about the reasons for the delays.
- Patients who had been transferred from the West Cumberland Hospital in Whitehaven to the Cumberland Infirmary, or vice versa, all stated that this made visiting difficult for family and friends.

Emotional support

- Patients we spoke to confirmed that they had access to emotional support if required, and on each ward we found appropriate information available for counselling services and services providing assistance with anxiety and depression. Staff could support patients to access these services as appropriate.

Are surgery services responsive?

Surgery

Requires improvement



Senior managers are aware of the current issues within surgery services and are considering changes in the way the service is delivered. Referral to treatment time (RTT) was not being met for admitted patients. Staff were able to learn from complaints as weekly team meeting minutes showed that the discussion of complaints was a regular agenda item and there was also a box containing all complaints relevant to the ward located at the nurse's station.

Service planning and delivery to meet the needs of local people

- The CQC inspection team discussed service planning and delivery with the Clinical Director, who provided evidence which suggested that key areas had been identified, current performance levels were being monitored, and changes to the way the service was being delivered had been considered.

Access and flow

- Data showed that national targets for 18-week referral-to-treatment (RTT) standards at the end of December 2013 were not being met for most specialties for admitted patients and mostly being met for non-admitted patients. The data showed that for admitted patients general surgery was 90.5%, which is above the final required position of 90%, whilst orthopaedics was below the final required position at 62.4%.
- The trust was aware of this issue. It commented that the reason North Cumbria found it difficult to achieve its performance was because the Cumberland Infirmary site is under significant pressure as a range of high risk surgical cases are transferred from the West Cumberland Hospital in Whitehaven. Since June 2013, trauma operative work, high risk general surgery and colorectal cancer work has all transferred to the Cumberland Infirmary. This has led to routine elective work being regularly cancelled. The transfer of routine work has not been as systematic as anticipated because patients prefer to wait to have their procedure or operation in Carlisle. The distance between the two sites appears to be a major factor in patients' decisions regarding where to have their surgery rather than the care delivered.

- The trust's detailed action plan includes such measures as: additional number of procedures per month, fully utilising capacity at West Cumberland Hospital and recruiting extra consultants. It was envisaged that these actions would support improved performance.
- We looked at the trust's overall performance for patients receiving surgery for fractured neck of femur within 48 hours. The trust reports an average time to theatre of 34.6 hours, an average length of stay in accident and emergency of 6.5 hours and an average length of stay of 14 days. This was better than the national average.
- During the period April 2013 to February 2014, there were 129 cancellations for patients requiring orthopaedic surgery.
- Theatre list starting times were frequently delayed because of ward rounds and patient pre-operative review by surgeons and anaesthetists. This sometimes meant that theatre lists over-ran, which increased patient waiting times.
- Waiting times for patients with cancer awaiting first treatment was highlighted as a risk, as the 62-day target was not consistently met.
- Between July and September 2013, the bed occupancy rate for general and acute beds (which would include beds for surgical patients) was 87.5%. The national target is below 85% as high bed occupancy rates can affect the quality of care provided.
- The proportion of patients whose operations were cancelled was similar to expected.
- The number of patients not treated within 28 days of a last minute cancellation due to non-clinical reason was similar to expected.
- The numbers of delayed discharges were within expected limits.

Meeting people's individual needs

- Support was available for patients with a learning disability and those living with dementia. The service had implemented the Butterfly scheme to identify patients living with dementia or memory impairment, which enabled staff to take this into consideration when providing care. We noted on the wards that two nurses had been identified as dementia champions and that staff had received training.
- Information leaflets were available on the entrance to wards for many different minor complaints, but these were only available in English.

Surgery

- For patients whose first language was not English, staff could access a language interpreter if needed. We saw the services of an interpreter being used on one of the medical wards during our inspection. British Sign Language (BSL) interpreters were also available for people who were deaf.

Learning from complaints and concerns

- Complaints were handled in line with the trust's policy and efforts were being made to deal with complaints initially at a local ward level. If this was not acceptable, people would be directed to the Patient Advice and Liaison Service (PALS) and following this they would be advised to make a formal complaint. We noted that booklets were available on wards, but they referred to the Care Quality Commission as providing an independent review of complaints, which is inaccurate.
- Staff were encouraged to learn from complaints. Weekly team meeting minutes showed that complaints was a regular discussion agenda item and there was also a box containing all complaints relevant to the ward at the nurse's station for discussion and action.

Are surgery services well-led?

Requires improvement



The trust had a vision and strategy for the organisation with clear aims and objectives. The trust's vision, values and objectives had been cascaded across the surgical wards and departments and most staff had a clear understanding of what these involved. From the information provided, it is unclear whether information on the surgical dashboard was discussed during governance meetings for all the surgical specialities.

Vision and strategy for this service

- The trust had a vision and strategy for the organisation with clear aims and objectives. These had been cascaded across the surgical wards and most staff had a clear understanding of what they involved. Ward managers in each of the areas we visited regularly

reinforced the organisation's vision and values and all ward staff we spoke with were aware of what they were or where they were displayed. However there was not a distinct service level vision or strategy.

Governance, risk management and quality measurement

- There were monthly governance meetings for: the surgical business unit; the orthopaedic department; theatres governance; the anaesthetics cross-site department; and incidents reporting. Notes of the meetings confirmed that incidents and risk are discussed. However the documents made no specific reference to quality improvements or complaints. These are missed opportunities to learn and improve the service.
- The surgical directorate provided a surgical dashboard that contained performance data. This information was disseminated to the Clinical Directors for each speciality to discuss in their speciality governance meetings. It was unclear from documents whether this information was discussed during these meetings for all the surgical specialities.







Leadership of service

- The business unit of Emergency Surgical and elective care was divided into five clinical business units based on specific surgical specialties. Each unit was led by a clinical director of business unit and supported by a service, clinical matron and clinical consultant leads. Vacancies had been recruited to and the hospital had a start date for the Clinical Business Unit Director.
- Each ward had a ward manager, and a matron oversaw all of the wards. We found in talking to staff that they felt leadership was good at this level.
- Matrons met with ward sisters every day, but they did not hold formal meetings.

Culture within the service

- Staff spoke positively about the service they provided for patients. Staff felt supported by their immediate line managers. There was good local leadership, good multi-disciplinary working and good communication with the business manager and consultants. However, the Executive Team was felt to be less visible and accessible to staff.

Critical care

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

Information about the service

We reviewed and inspected the services in the intensive care unit (ICU)/high dependency unit at the Cumberland Infirmary. The unit had eight beds allocated with a ninth used for emergencies. During our visit, the ICU/HDU unit was at full capacity with all eight beds occupied.

We reviewed the records held within ICU/HDU and spoke with the ward manager, a consultant, a band 5 nurse and the ward manager.

Summary of findings

Care and treatment was delivered in accordance with national guidance. We were concerned that the service had not submitted Intensive Care National Audit & Research Centre (ICNARC) data for the last year to measure the effectiveness of the service. The implementation of care bundles had not been supported by staff training and they were not fully utilised.

There were sufficient numbers of competent nursing staff in place to meet patients' needs at the time of our inspection. However, there were nurse vacancies within the service that were being covered by staff working extra shifts.

Multi-disciplinary working was well established and staff worked well together as a team. There were daily consultant ward rounds and out-of-hours medical cover was provided by ACCS and anaesthetists in training with an on-call consultant.

Staff were caring and compassionate, and patients and relatives spoke highly of the care and treatment.

Staff were aware of current infection prevention and control guidelines and applied them appropriately.

Medicines, including controlled drugs, were safely and securely stored.

Critical care

Cleaning schedules were in place, and there were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.

Are critical care services safe?

Good



There were robust systems for reporting incidents and managing risk within the hospital and the evidence we saw during our inspection demonstrated that the unit had learned from any incidents that had happened. We saw that trust wide learning from these had been recorded and disseminated. We observed from the records that staff were regularly asked to transfer to other wards which had occasionally left the unit understaffed. There were provisions in place for staff to be returned to the unit if needed.

Incidents

- Staff knew how to report incidents and 'near misses'. Staff confirmed their awareness of incidents and reported that the lessons learned had been discussed and applied within their specific team.
- The top incidents between September 2013 and February 2014 were: pressure ulcers (21), staffing levels (15), medical devices/equipment (9), and lack of resources (7).
- Remedial actions were taken as a result of the investigation into never events. For example, additional checks were now in place for the removal of a surgical femoral guide wire, and as a result of feedback from the investigations, from 21 May 2014 longer guide wires were being introduced.

Safety thermometer

- The Safety Thermometer on display within the units provided a quick and simple method for surveying patient harms and analysing results in order to measure and monitor improvement. Examples included pressure ulcers, catheters and venous thromboembolism (VTEs).
- The unit completed documentation about pressure areas each day and completed an incident report on any variances identified on a patient's condition. The information was input on the unit's computerised system that tracked the patient's progress. There were also comprehensive nurse records that supported the risk management of inpatient harms.

Critical care

Cleanliness, infection control and hygiene

- The unit was clean and well organised and staff adhered to good practice guidance for the control and prevention of infection by regularly washing their hands, using hand gel and personal protective equipment (PPE) between patients.
- Staff used different coloured aprons to ensure that infection control was well supported. There were copies of the Ward Assurance Report available that identified random sampling of practice in relation to infection control. Compliance rates were consistently of a high standard.
- The ward sister informed us that they had recently had an outbreak of C-Difficile that was antibiotic related.

Environment and equipment

- All equipment was appropriately checked, cleaned and regularly maintained. Safety check-lists were completed daily.
- Staff informed us they had implemented an “equipment loan book” for equipment that was “loaned” out to various departments. For example, accident and emergency currently had the unit’s portable ventilator. Staff informed us that once the equipment left the unit it was very difficult to get it back and they had to “chase” its return.
- There had been nine recorded incidents relating to equipment.

Medicines

- All patients’ medicines were kept securely within a locked cabinet.
- Staff conducted a balance check of all controlled drugs. The controlled drugs index book was accurately maintained with identified regular balance checks completed by the night staff.
- The unit had a good working relationship with the pharmacy department, who took responsibility for checking and re-stocking medicines that were in use. The computerised system on ICU/HDU meant that pharmacists had access to all patients’ prescriptions at a glance, which enabled them to supply medicines quickly.

Records

- All documentation was accurate, legible, signed and dated. All records reviewed had appropriate risk assessments in place.

- Care plans were comprehensive, reflected patients’ individual care needs and were regularly reviewed. Care records also contained information as to whether the patient required the services of the learning disability team or had mental health concerns.
- The unit had a robust discharge system in place that included recording all relevant information for the ongoing management of patient needs.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated a good knowledge of the Mental Capacity Act 2005. They assessed patients’ mental capacity to make a decision and if a patient lacked capacity they sought the advice of appropriate professionals, and others as appropriate, to ensure that decisions were made in the patient’s best interest.
- Staff were able to show us how to access the trust’s intranet for policies and procedures relating to consent and capacity.

Safeguarding

- There was an internal system for raising safeguarding concerns. Staff were aware of the process and could explain what was meant by abuse and neglect. This process was supported by training and all of the staff we spoke with confirmed they had undertaken safeguarding training.

Mandatory training

- Mandatory training records showed that all staff had received safeguarding training. Also 96% of staff had received Mental Capacity Act training level 1 and 63% at level 2. However, the trust’s information showed that only 40% of staff had received Tissue Viability (TV) training. The matrix also identified additional training undertaken by staff for example, advanced life support and paediatric care.
- The electronic training records showed that approximately 85% of staff within the unit had completed their mandatory training. However, the ward manager informed us that the percentage was actually higher because they had entered the information into the electronic system and they were waiting for updated figures.

Critical care

Management of deteriorating patients

- There were tools in place for the early detection of changes in a patient's condition. Staff informed us that if a patient's condition deteriorated, they could call for appropriate and immediate medical support.
- Staff had access to a critical care outreach service and had telephone numbers for members of the team. We were informed that the outreach team would deal with all referrals to the unit although they did not have admission rights. Admission to the unit had to be agreed by a consultant.

Nursing staffing

- The unit had a full complement of staff on the day of our visit.
- We were informed that they were currently 61 hours short of band 5 nurses. Shortfalls in staffing were covered by the ICU staff working extra shifts to maintain appropriate and safe staffing levels.
- Staff were sometimes asked to help out in other departments when the unit was not at full capacity. There were guidelines in place for loaned staff to be moved back to the ICU if required, but staff felt that they had to be quite forceful at times to bring loaned staff back to the unit.

Medical staffing

- The unit had access to a consultant and an anaesthetist seven days a week. There were daily consultant-led ward rounds.
- We were informed that the anaesthetist also covered other areas and that they had occasionally 'lost' their allocated doctor.
- Staff said they used preventative measures by phoning around and "grabbing" a doctor to support them in an emergency.
- Staff felt the unit needed a permanent consultant and junior doctor to ensure continuity in care.

Major incident awareness and training

- Staff confirmed that they had been made aware of the never events and lessons learned. Discussions about the learning from these events were recorded in team meeting minutes.
- Staff had received training on how to complete incident reports and had access to the trust's internal system.

Requires improvement



From the evidence inspected and discussions with ward managers and front line staff, we saw the trust was able to demonstrate that the patients who use this service received care and treatment in line with the current best practice guidance.

However, the ICNARC data had not been submitted for the last year so we could not compare the services performance against national expectations.

Evidence-based care and treatment

- Care and treatment was delivered in accordance with NICE guidelines. However, the service had not contributed any data regarding patient outcomes to the Intensive Care National Audit and Research Centre (ICNARC) database for the last year. Consequently, we could not compare the service's performance against national expectations.
- We noted that all policies and procedures were accessible for staff on the intranet and they received a copy by email.
- Staff felt there was some conflict regarding the implementation of some policies, for example, antibiotic prescribing. They felt that the board had not discussed the policies before putting them into practice or considered how the new policies would impact on the service. Therefore there was no assurance that this new policy was being adhered to.
- "Care bundles" had been introduced on the unit but staff told us that they had not received any training regarding their use. Staff said that they were a "nice check-list" but were not used fully.

Pain relief

- We observed good interaction between the unit and the pharmacy department with regard to the timely provision of medicines, including analgesics.
- Patients' pain relief requirements formed part of care planning and were regularly reviewed and monitored for efficacy.

Are critical care services effective?

Critical care

Nutrition and hydration

- People had a choice of suitable food and drink and hot and cold drinks were available throughout the day. Staff had easy access to a dietician who was able to support patients who were unable to tolerate an oral diet or who required specialist dietary requirements.
- Hydration observation charts were in place and accurately maintained.
- Patients who had swallowing difficulties were supported by the Speech and Language Therapist (SALT).

Patient outcomes

- Although the unit did not ask for patient feedback, the unit had involved patients through a structured approach by developing and implementing “patient diaries.” This is an ICU steps programme to get former patients and family members to talk about their experiences whilst at ICU.

Competent staff

- Staff completed an equipment competency framework to assess their ability and review the effectiveness of the guidance provided.
- We noted that staff had not received any clinical supervision but had received an annual appraisal.
- The unit had some staff personal development plans in place for example; developing band 6 nurses to cover band 7 nurses.
- Medical and nursing staff had received appraisals and they spoke positively about the process. It was not possible to establish the accurate levels of appraisals for staff. The records and information from the trust did not agree with the ward manager’s figures, who said that appraisals were 100% completed.

Multidisciplinary working

- Multidisciplinary teams (MDTs) worked well together to ensure co-ordinated care for patients. We saw that staff across all disciplines genuinely respected and valued the work of other members of the team.
- We saw that teams were involved in the appropriate and timely discharge of patients.
- Protocols were in place to facilitate the smooth transfer of patients from the unit to an appropriate care setting.

Seven-day services

- The unit had the services of both a consultant and anaesthetist seven days a week from 8am to 5pm and 8am to 8pm respectively.

- Out-of-hours services were covered by the staff anaesthetist with the consultant available on an ‘on-call’ basis.
- At the weekend, cover was provided by the staff grade anaesthetist and a consultant.

Are critical care services caring?

Good



The observation and evidence that we saw showed that people who used the service were treated with compassion, dignity and respect and that staff delivered care in a way that took their wishes into account. The evidence ensured that the trust was good at involving patients, family and friends in all aspects of their care and treatment.

Compassionate care

- Services in critical care were delivered by a hardworking, caring and compassionate staff. We observed that staff treated patients with dignity and respect. Patients were positive about their care and treatment.
- Patient records were completed sensitively and detailed discussions with relatives had been clearly documented. Relatives were encouraged to visit and we were informed that visiting times, at the discretion of the ward manager, were flexible.
- Difficult conversations regarding a patient’s condition and prognosis were sensitively managed.
- Staff could also access psychological support for the families of patients who were seriously ill.

Patient understanding and involvement

- Where reasonably possible, patients’ views and preferences were taken into account.
- Patients had an allocated nurse who was able to support their understanding of care and treatment and ensure that they were able to voice any concerns or anxieties.
- Staff supported patients and families to complete “patient diaries” to provide an overview of what had happened while the patients were ventilated and not conscious.

Critical care

Emotional support

- The unit manager told us that following admission to the unit, the consultant covering the unit would arrange to talk with families to discuss their relative's care and treatment.
- The family member was also given an overview of the intended plan for the patient alongside what they could expect from the unit.
- Where necessary, further face-to-face meetings would be organised to ensure family members were kept informed and had the opportunity to have their questions answered.

Are critical care services responsive?

Good



The evidence seen showed that patients were well supported when, and if, they underwent a transition from the ICU to the ward or in preparation for their discharge. Patients were admitted to or discharged from the unit within four hours of the making of the decision. The unit was very proactive in ensuring appropriate length of stay and patients' rehabilitation needs were assessed within 24 hours of admission to the critical care unit. The unit had the resource of an outreach team to provide follow-up service for patients discharged from ICU.

Access and flow

- The service ensured that patients were admitted to the unit within four hours of making the decision to admit. It also ensured that the discharge to the ward was within the four hours of making the decision to discharge.
- We noted that non-clinical transfers from ITU had increased. Increase in demand came from the heart centre, vascular centre, and trauma. The consultant we spoke with expressed concern that demand for the services were increasing particularly during the winter months.
- We were informed there was some conflict among medical staff regarding non-clinical and clinical decisions in relation to elective flows. The unit had an elective diary in place whereby bed management were notified and bed allocation pre-booked for elective

procedures. Unfortunately, if the unit was full due to non-clinical transfer this impacted on the elective patients and meant that on occasions beds were not available as required.

- We saw from data that the unit was very proactive in ensuring appropriate length of stay. It "treated the symptoms aggressively and early" and "withdraws aggressively and early."
- Patients' rehabilitation needs were assessed within 24 hours of admission to the critical care unit with clear guidance regarding their individual needs.
- The unit had the resource of an outreach team to provide follow-up service for patients discharged from ICU. Between 1 January and 30 April 2014, the critical care outreach team saw 365 patients; 53 were admitted to ICU, nine were readmitted to ICU and 162 were follow-ups after ICU care.

Meeting people's individual needs

- Patients on admission underwent a dementia assessment as well as ensuring that their needs were met.
- Staff had access to external multi-disciplinary teams as well as the internal "link" nurse to support the needs of patients with learning disabilities.
- The ward sister informed us that they had symbols and picture boards to support people with communication difficulties during their stay in the unit.
- Staff maintained conversations with sedated patients on the premise that they understood what was being said to them.
- Staff had they had received "equality, diversity and human rights" training to support cultural and spiritual needs of patients
- Staff had access to a translating and interpreting service where this was required.

Learning from complaints and concerns

- Staff were aware of the trust's complaints policy and confirmed that any complaints were addressed through the trust's complaint procedure.
- Complaint records indicated that the unit had received one complaint this year. Staff had involved family in the resolution of the issue.
- Complaints were recorded on the trust's incident system. Evidence of trust wide learning from incidents was demonstrated through the trust's staff briefing and team meeting minutes.

Critical care

Are critical care services well-led?

Good



The trust had a vision and values for the organisation, which had been cascaded across the hospital. We found examples of good leadership by individual members of staff. We found the unit to be well-led with good interaction with the executive team.

Vision and strategy for this service

- Staff said they were aware, and able to identify the trust's "wheel" which outlined the trust's vision and values. The ward manager had created a development plan which addressed a number of questions for example; "why are we here, what we deliver, our priorities, how we deliver it and our people are the key to our success."
- There was a long term development plan for the service (three to five years) which included areas such as clinical supervision, leadership, demonstrating a secure, open and transparent environment and the provision of audit data to monitor the performance of the critical care service.

Governance, risk management and quality measurement

- We reviewed the trust's risk register against locally identified risks and noted some non-alignment between the risks highlighted on this document and the potential risks to the organisation. This showed us that the trust needs to make improvements in order to review the existing trust risk register in the light of these concerns.

Leadership of service

- Weekly management meetings took place and information was shared with staff during their weekly meetings. Areas addressed included incidents, complaints and staff related matters. Staff told us they felt supported by their line manager.

- Every two months the ITU team and anaesthetists had a cross-site meeting with colleagues at West Cumberland Hospital.
- The ICU governance structures functioned well despite the anaesthetists residing in medicine.

Culture within the service

- Many staff spoke enthusiastically about their work and told us they loved their job. Staff reported a positive and inclusive culture within their particular team. Concerns and issues were raised in an open and honest way and staff felt managers listened to their concerns.
- Similarly, Staff said that the trust board engaged more than previously and promoted an open culture. Staff said they were encouraged to speak up and air their views. It was felt that information was more freely available with regular feedback received from the board.
- Staff said the head matron had engaged more and it was noted there was a different management style evolving. Staff said that information coming 'down the line' was slow although this was improving.







Public and staff engagement

- Staff worked alongside the patients and their family members to complete the patient diary so that both patients and family were able to reflect on their relative's stay within the unit.

Innovation, improvement and sustainability

- Staff we spoke with were confident for the future and the ward manager's vision for the unit. Cross working between the West Cumberland Hospital in Whitehaven and the Cumberland Infirmary in Carlisle was beginning to have an impact to ensure that both were using the same systems and ways of working to ensure continuity for patients visiting either area.

Maternity and family planning

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

Information about the service

The maternity service provided care and treatment for maternity and family planning for the population of Carlisle and district. The inpatient units included a range of maternity services at the Cumberland Infirmary in Carlisle, with other services available at another location in Whitehaven. Services available included delivery suite, antenatal care (OPD/inpatient), post natal (inpatient/OPD), ultrasound and 'Level 3' family planning. The service also included community midwifery services providing antenatal care, home birth and post natal care. The service had close links with the birthing centre at Penrith and accepted transfers from the centre.

During our visit we spoke with 11 staff, five relatives, and 10 patients. We observed care and treatment to assess if patients had positive outcomes and looked at the care and treatment records for seven of the patients. We gathered further information from data we requested and received from the trust. We also reviewed information regarding their internal quality assurance and compared their performance against national data.

The service was managed through the North Cumbria University Hospital Emergency Surgical and Elective Care Business Unit and was led by a Clinical director with a Head of Midwifery professional lead. The consultant Obstetric lead was based at the Infirmary.

The service averaged 1,800 births a year and had recently undergone a midwifery review across the trust's service.

Summary of findings

The maternity service at the hospital was delivered by committed and compassionate staff that treated patients with dignity and respect. All the people we spoke to were positive about their care received.

The service had identified its own risks and was monitoring its own performance against national and local maternity indicators. However, we found that the risks identified were still in place and sufficient actions to mitigate them had not yet been implemented. The obstetrics and gynaecology service accounted for 29% of all incidents reported across the trust.

The service did not provide a key option for pain relief as identified in the NICE quality statement (QS60) which relates to induction of labour. The lack of access to pain relief may be impacting on the significantly higher rates of elective and emergency caesarean sections at the service. The higher than national average use of surgical intervention in child birth increases the risk to both mother and baby, which reduces the overall safety of the service. We found no evidence of a clear strategy or plan for reducing the number of caesarean sections.

There was a lack of dedicated medical staff cover, a dedicated second theatre, pressure on space and lack of compliance with key NICE guidance, which impacted on the service's ability to respond in a timely manner and deliver a safe and effective service.

The service had the standard ratio of one midwife to 28 patient hospital births. It had undergone a review of

Maternity and family planning

midwifery service and the introduction of a midwifery governance lead had improved the approach to governance and monitoring of clinical practice. The specialist midwife roles had been welcomed but staff felt that the roles were not yet fully embedded and did not fully understand the roles of the clinical leads and the business manager. This had led to some confusion in regards to clear identification of roles and responsibilities.

The midwifery staff felt well led. However there was a lack of capacity in medical leadership and no evidence of an articulated strategic vision for the future of maternity and family planning services at the Cumberland Infirmary, Carlisle.

Are maternity and family planning services safe?

Requires improvement



The service had identified its own risks and was monitoring its own performance against national and local maternity indicators.

We found that the risks identified were still in place and sufficient actions to mitigate them had not yet been implemented. There was no dedicated second theatre available for obstetrics; this may increase potential risk on foetal/maternal care because of a delay in accessing theatre time.

There were high numbers of caesarean sections at the service. The higher than national average use of surgical intervention in child birth increases the risk to both mother and baby.

The issues identified by the maternity service: the lack of dedicated medical staff cover, dedicated second theatre, pressure on space and lack of compliance with key NICE guidance, raised the risk of the service not being able to respond in a timely manner and deliver a safe and effective service.

Incidents

- We asked staff directly if they reported incidents. They told us that they reported incidents and were confident to report them. No never events had been reported by the service. Our review of incident data indicated that the obstetrics and gynaecology service accounted for 29% of all incidents reported across the trust. The service had one of the highest numbers of patient incidents across the trust. We found that the service classified the majority of its patient incidents with a moderate degree of harm. The incidents related primarily to 3rd degree tears following labour.
- The service also completed a maternity dashboard to monitor key maternity indicators. We reviewed the data provided as part of our inspection. The trust data and the maternity dashboard showed that the maternity service had lower than national rates for normal delivery. The service also had significantly higher rates

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of elective and emergency caesarean sections when compared nationally. During discussions with the clinical leads we did not find evidence of a clear strategy or plan for reducing the number of caesarean sections.

- The maternity service monitored all its risks and had a local risk register, which we reviewed.
- There was no dedicated second theatre available for obstetrics; this raised the risk of an impact on foetal/maternal care because of a delay in accessing theatre. We found that delays had occurred on at least one occasion but no harm had occurred. We did not see evidence of clear actions to resolve this risk. We also found that there is no provision for urgent obstetrics/gynaecology surgery at the West Cumberland Hospital site. This had a potential risk on the service's ability to undertake grade 3 caesarean sections. The trust was monitoring the number of patients affected by the lack of dedicated theatre time through the monthly maternity governance group.
- The service had reviewed and strengthened its systems for reporting incidents and near misses across the whole service. All incidents were captured on the electronic incident reporting system.
- We were shown the maternity service integrated governance action plan. This had been developed by the service governance lead to capture all the learning from audits and incidents. Staff reported that the new role of governance lead for the service had resulted in an increased awareness in risk and that feedback on lessons learned had improved.
- Staff received feedback, and we saw examples of learning from incidents being applied and implemented, such as improvements to communication and discharge to community services.

Safety thermometer

- Information from the NHS safety thermometers (a tool designed for frontline healthcare professionals to measure harm such as falls, blood clots, catheter and urinary infections) indicated that the service was performing within expected ranges for these measures. This information was displayed on the unit and was freely available for patients and staff.
- We reviewed the maternity dashboard as part of the inspection and found low puerperal sepsis rates compared with nationally expected figures. The service outcomes were within expected limits for most of the indicators except caesarean sections.

Cleanliness, infection control and hygiene

- The unit was clean and tidy and each room was stocked with appropriate personal protective equipment.
- During our inspection we observed poor hand hygiene practice, as we saw that not all staff were washing their hands or using hand gel between patients.
- MRSA and C. Difficile rates for the service were within an acceptable range.

Environment and equipment

- During our inspection we were told that issues had been identified with the ventilation system within the department, which removed anaesthetic gases when women were using Entonox. The service had agreed that until remedial action had been taken, windows were to be left open in rooms where labouring women were using Entonox. The inspector noted that the birthing pool had been deemed unusable as the room did not have windows. Our inspectors raised this issue with the service managers, who were unaware that the pool had been unavailable for a month and no start date had been agreed to start remedial action. The lack of awareness of key risks about the service affected the ability of staff to protect people from risks.
- The unit was very busy during our visit and we observed several patients waiting to be seen. Four staff members told us that space was limited on the unit and mothers were sometimes induced on the labour ward due to lack of space. They also told us that there were problems with adequate storage, particularly for dirty utility facilities. This was confirmed on the service risk register. We noted that no plans had yet been identified to address the issue.
- Equipment required in case of a cardiac arrest and resuscitation of a new-born was stored on suitable trolleys that were able to contain the equipment safely if it was moved.
- The inspection team found that different equipment was available for maternal emergencies on different sites across the trust. One staff member told us that this could be confusing if they were working on different sites. There was no consistency in the provision of equipment across hospitals for the management of maternal emergencies such as post-partum haemorrhage.

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- The team found some evidence of inadequate checking and recording of equipment. We found that the emergency equipment daily checklist was completed and up to date.

Medicines

- Staff records showed that midwives had received appropriate training in line with professional standards for the management of medicines. Staff we spoke with were clear on which drugs they used and that they had received the relevant training.
- Medicines were stored correctly, in locked cupboards or fridges where necessary, and fridge temperatures were checked.
- Records showed clear documentation of medication with standardised medication charts across the service.

Records

- During our inspection we reviewed eight sets of patient records. Documentation was accurate, legible, signed and dated, and easy to follow in all these records, and gave a clear plan and record of the patient's care and treatment. The records were in paper format.
- We saw that the 'Child health record' (red book) was issued to mothers and advice was available on how to keep it as the main record of a child's health, growth and development.
- Midwives audited documentation regularly and results were fed back through statutory supervision and professional development days.
- An external assurance visit for safeguarding noted that although safeguarding information such as risk assessments and vulnerability assessments were included in the notes, they were not easily accessible and the service planned to ensure that summaries were available and located clearly within the records.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There were policies and procedures in place regarding the Mental Capacity Act 2005.
- Patients were consented appropriately. We looked at records for a patient who had undergone a caesarean section and found that the appropriate documentation had been completed with informed consent recorded.

- Staff had received training in maternal mental health, and if required, had access to appropriate clinical support for acute peri-maternal health issues. We saw that the service had clear policies and procedures for managing the acute mental health needs of a patient.

Safeguarding

- Women and their babies were protected from the risks of abuse and staff were trained to deal with suspicion of abuse. Staff were aware of the signs of abuse and the appropriate actions and systems for reporting allegations of this nature.
- The use of lead midwives for safeguarding had a positive impact on the staff and they felt well supported to manage any safeguarding concerns.
- An external assurance visit for safeguarding noted that safeguarding information such as risk assessments and vulnerability assessments were in place and completed.
- 92% of staff had completed their mandatory training. Some staff told us that they felt they would like further more detailed training, but felt supported by their supervisor.
- Pregnant women were assessed in the community as part of their antenatal care and information about patients who were at risk was shared with the appropriate staff.
- There was good evidence of multi-agency liaison and communication for some high risk pregnancies.

Mandatory training

- Staff told us they had been encouraged to complete their mandatory training prior to our visit. Staff we spoke with were aware that the service had achieved 92% completion rate for mandatory, but some staff told us they would have preferred less 'e-learning' and more practical sessions as part of the mandatory training.
- The service had developed a robust training needs analysis to ensure that maternity services provide training in accordance with the national recommendations for all professionals working in maternity services. Staff we spoke with confirmed that they had access to professional development days, and regular PROMPT (Practical Obstetric Multi professional training) sessions were held, which included all members of the maternity service.

Management of deteriorating patients

- The service had processes in place to ensure the recognition of severely ill women during the pregnancy,

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delivery and the postnatal period. The maternity service had introduced a modified early obstetric warning scoring system (MEOWS) to assist in improving the detection of life-threatening illnesses. There were clear directions for escalation printed on the reverse of the observation charts. Staff told us that they were aware of the actions to follow.

- The staff also showed us a 'Sepsis 6' pathway, which they also used as appropriate for the management of sepsis.
- Staff were able to describe the actions they would take to manage a deteriorating patient and liaise with other departments and described the need for a quick response with access to scanning in a timely manner.

Midwifery staffing

- Arrangements were in place to ensure a sufficient number of staff to provide safe care. Information provided by the trust outlined how staffing levels were calculated. The service had the standard ratio of one midwife to 28 patient hospital births. Figures showed that 100% of women had one-to-one care in established labour, and staff confirmed this.
- We noted that staff had reported several incidents when staffing had not been adequate on the unit. They told us that they knew how to access more staff if required and were aware of the escalation policy for short term management of staff shortages/capacity issues.
- We noted that the sickness rate was 4.8 % against an England average of 4.3%. Some staff told us that the sickness levels had been higher than usual during the recent staffing review, but felt things were now more settled.
- The service had tested an acuity tool to assess the dependency criteria for maternity patients and had plans to introduce a formal acuity tool such as Birth Rate Plus, a recognised tool developed for maternity services to assess the staffing levels needed. However, the service did not currently use a formal acuity tool to help calculate appropriate staffing levels.
- We observed staff carrying out shift handovers to ensure clear communication and continuity of care.
- Postnatal services are also provided in the community (women are transferred home to the care of the Community Midwives until at least the 10th and up to the 28th day following delivery).

Medical staffing

- Medical staffing at Cumberland Infirmary Carlisle included trainees rotating from Newcastle. The trainees reported good opportunities for training, although some staff reported that the rota at middle grade level was imbalanced with a lot of weekend working for junior grades that impacted on training opportunities. The lead obstetrician for maternity was based at in Carlisle. The clinician was acting as lead for risk, diabetes, twins, and obstetrics, as well as lead for the termination of pregnancy services. The staff told us that there was no dedicated obstetric anaesthetist at the hospital, and records confirmed this. The trust is currently not meeting national guidelines of having an anaesthetist available at all times for obstetrics.
- The medical staff carried out regular handovers during the day and in the evening on the labour ward to ensure clear communication and handover of care for patients. We were told that the team met each Friday to review patients and to capture any lessons learned from the individual case reviews, and records confirmed this.

Are maternity and family planning services effective?

Requires improvement



Maternity services required improvement to become more effective.

The service did not offer epidurals and did not have access to a dedicated anaesthetist. This impacted on the ability of the service to deliver effective pain relief in a timely manner. The trust is currently not meeting national guidelines of having an anaesthetist available at all times for obstetrics. The inspection team noted that the high caesarean section rate did not include high risk cases as these were already transferred to Newcastle.

The delivery of care was based on guidance issued by professional and expert bodies such as the National Institute for Health and Care Excellence (NICE). Records showed that the department had developed some clinical care pathways to ensure that patients received care appropriate to their needs. These included pathways such as 'obstetric haemorrhage' and the 'severely ill women and

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management of acute collapse'. However, we found that the guidance was not always followed. Staff told us that some staff were not following the policy for induction of labour on the maternity unit, and records showed this.

The failure to implement robust quality assurance checking mechanisms across the service resulted in senior staff not being aware that the birthing pool had been out of use for a month for those women in labour who wanted to have Entonox and use the pool. This showed that the service needs to further embed its risk management processes to ensure an effective service delivery.

Evidence-based care and treatment

- The delivery of care was based on guidance issued by professional and expert bodies such as the National Institute for Health and Care Excellence (NICE). Records showed that the department had developed some clinical care pathways to ensure that patients received care appropriate to their needs. These included pathways such as 'obstetric haemorrhage' and the 'severely ill women and management of acute collapse'. However, we found that the guidance was not always followed. Staff told us that some staff were not following the policy for induction of labour on the maternity unit, and records showed this.
- The service had developed an integrated action plan to monitor all complaints, learning from incidents and audits against compliance of care provided in line with Royal College Guidelines (RCOG), relevant NICE guidance and NHSLA maternity standards. We saw audits for obesity in pregnancy, care of women in labour, perineal trauma, hand hygiene and the management of diabetes in pregnancy.
- The maternity service was not accredited as a "baby friendly" site through the UNICEF initiative. This is an initiative set up by UNICEF and the World health organisation designed to support breastfeeding and parent infant relationships by working with the public to improve standards of care. This provides a framework for the implementation of best practice. We were told that the unit did have the accreditation a few years ago, but was not currently accredited and had no current plans in place to seek accreditation.
- There was a variety of information based on research and NICE guidance, which was available to inform mothers such as "emergency caesarean section".

Pain relief

- Mothers were offered access to various forms of pain relief, such as Entonox and pethidine. The service did not offer epidurals and did not have access to a dedicated obstetric anaesthetist. This impacted on the ability of the service to deliver effective pain relief in a timely manner. The trust is currently not meeting national guidelines of having an anaesthetist available at all times for obstetrics.
- The service did not provide a key option for pain relief as identified in the NICE quality statement (QS60).

Patient outcomes

- We saw evidence of improved participation in national audits and the staff we spoke with told us that they welcomed the introduction of the lead midwife for risk and governance.
- During our inspection we saw copies of safety thermometer information and audit results clearly displayed on the units. Staff confirmed that they regularly carried out relevant audits and were able to give us feedback on the results of a recent infection control audit. We noted that the number of unexpected admissions to the special care baby unit (SCBU) was a higher than average. In discussions with medical and midwifery staff we found that the service had a low threshold to admitting babies as well as a low threshold for giving babies antibiotics. This was in response to a clinical incident in the local health economy, and showed that they were effectively admitting and treating. Plans were in place to re-audit the admissions to the SCBU and revisit the criteria for admission.
- We saw a policy on breast feeding and we were told that the service had recently appointed an infant feeding coordinator

Competent staff

- The service had clear systems in place for supervision and appraisal. Some staff felt that they would like more time to discuss cases, and junior staff we spoke with told us that they would welcome more senior clinical staff support.
- There were sufficient numbers of supervisors of midwives (SOM) within the hospital. The role of the supervisor is to protect the public through good practice. They monitor the practices of midwives to ensure that mothers and babies receive good quality, safe care. As supervisors, they provide support, advice

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and guidance to individual midwives on practice issues, while ensuring they practice within the midwives rules and standards set by the Nursing and Midwifery Council (NMC).

- We saw evidence that 100 % of midwives had an annual review by their allocated supervisor.
- The service had recently implemented a review of midwifery staffing and had introduced several specialist midwife roles to lead specific areas of practice, such as safeguarding, governance and obesity.

Multidisciplinary working

- We saw evidence of clear multi-disciplinary working across all professional groups. One person told us that “They worked well as a team and supported each other.” Another member of staff felt that they would prefer more engagement with the medical staff but they were often too busy.
- Maternity staff were regularly asked to attend multi-agency meetings and contribute to pre-birth plans.
- We observed good communication between the primary care and community health services.
- The location of the community maternity team meant that there were close working relationships with the maternity unit, and the communication processes were clear and effective.
- The midwives were aware of their responsibilities to communicate with GPs during antenatal care/discharge and we saw examples of clear communication between GPs and midwives.
- The staff had clear procedures for the transitional care of babies from SCBU to postnatal care and they worked closely with colleagues to support the mothers and babies.

Seven-day services

- Services were available seven days a week, but without an epidural service. This impacted on the ability of the service to provide appropriate care and treatment to patients in the Cumberland Infirmary.

Are maternity and family planning services caring?

Good



We found that maternity services were delivered by committed and compassionate staff. We observed that all staff treated patients with dignity and respect. All the people we spoke with were positive about the care they had received.

Compassionate care

- We found that maternity services were delivered by committed and compassionate staff. We observed that all staff treated patients with dignity and respect.
- All the people we spoke with were positive about the care they had received. Their comments included “The care was excellent.” And “I was fully included in the decisions made about my pregnancy.”
- We found that patients were encouraged to give feedback on the service, and systems were in place to gain patients views by using the “Two minutes of your time” questionnaire to gain feedback. We saw examples of feedback, which was overall positive about the service. All the comments were positive about staff attitude and a caring approach to patients.
- The Friends and Family test results for the service were within the England average.
- The results of CQC’s survey of Women’s experiences of maternity services in 2013 were in line with other trusts nationally for both care and information and explanations given by clinical staff.

Patient understanding and involvement

- Staff planned and delivered care in a way that took into account the patient’s wishes. We saw staff obtaining verbal consent when helping patients with personal care.
- Women were informed and involved in the decision about their care. Patients told us that they had been involved in their care and felt very involved in decision making. One person told us “The care has been excellent.”
- Using records held by the mothers encouraged them to be aware of their birth plans and provided further information on any specific tests or investigations that may be needed throughout a pregnancy.

Maternity and family planning

Emotional support

- Arrangements were in place to provide emotional support to patients and their families in a sensitive manner.
- The service had a bereavement midwife to support women and their partners following the loss of their baby. We saw examples of further follow-up in the community if required to support women following bereavement.
- We were told that “memory boxes” were provided with foot or hand prints or photos for the family.
- We observed that advice and support for antenatal complication and termination of pregnancy was managed sensitively, and staff confirmed this.
- Staff we spoke with were very aware of the need to provide emotional support for mothers and carried out assessments for anxiety and depression.
- If at any time mums wanted to talk through what happened, the service had an “Afterthoughts” post natal listening service. Information about how to contact the service was available in information leaflets available on the maternity ward.
- We found that breast feeding support was available across the service.

Are maternity and family planning services responsive?

Requires improvement



During our inspection staff told us that issues had been identified with the ventilation system within the department to remove anaesthetic gases when women were using Entonox. The service had agreed that until remedial action had been taken, windows were to be left open in rooms where labouring women were using Entonox. We noted that the birthing pool was out of use for women in labour who wished to use the pool and use Entonox, as the room did not have windows. The inspectors raised this issue with the service managers, who were unaware that the pool had been unavailable for use for a month with no start date for remedial action. This compromises the patient choice for women in labour who wish to use the pool and also have adequate pain relief.

The lack of an agreed service specification made it difficult to assess the delivery of the service against the needs of

the local population requirements. We were told that there was a high incidence of obesity in the area and the service had started to audit its service for this population of patients.

We found that information leaflets did not make clear that patients could not access an epidural at the hospital, which meant that they were not fully informed of all the choices available to them. Staff told us that it was explained to mothers about the lack of epidural service at the location.

There was a lack of standardisation of services across trust's two hospitals, such as the availability of evening clinics for early pregnancy advice and access to termination of pregnancy clinics, which does not allow the services to respond to the needs of the local population.

The service did not have dedicated beds for termination of pregnancy. Staff told us that these patients were treated as sensitively as possible, but it was not always possible to provide a single room for privacy

Service planning and delivery to meet the needs of local people

- The service had systems in place to manage patients with complications. Babies with certain complications would be transferred to the tertiary centre in Newcastle.
- The Maternity Services Liaison Committee had not met for two years. We were told that a meeting to re-establish the committee was planned for the week of our inspection to seek the views of women using the service. This was being led by the consultant midwife.
- The lack of an agreed service specification made it difficult to assess the delivery of the service against the needs of the local population. We were told that there was a high incidence of obesity in the area and the service had started to audit its service for this population of patients.

Access and flow

- Policies were in place for the escalation of midwife staffing issues on the unit. Staff were aware of how to access extra support if required.

Meeting people's individual needs

- The service had systems in place to meet people's religious and cultural needs.
- Leaflets were available for mothers to help them decide where to have their baby. The leaflet outlined the choices available for women, including the difference between midwifery-led care, consultant-led care and

Maternity and family planning

the options for home births, or the Penrith birthing centre. However, the inspection team felt that the lack of epidural was not clearly outlined in the information provided to enable mothers to plan their choice of care in line with their own individual needs and wishes.

- The needs of the women were assessed and birth plans were developed to meet those needs. Staff told us, and records showed, that each patient had a comprehensive assessment using nationally recognised pregnancy record documentation. This included a full medical history, personal preference plans for pregnancy, birth and parenthood. This took into account the individual mother's wishes, such as preferences for birth and any specific wishes with regards to breast feeding.
- Risk assessments were in place within the service. We saw copies of completed risk assessment for venous thromboembolism (VTE) to assess women's risk for blood clots, which was completed at booking, all antenatal admissions, and labour admissions and postnatal. Where risks were identified, treatment plans were in place, which included anti embolic stockings.
- Staff explained how they could access interpreters when required. A translation service is available but we saw no signs or leaflets for translation services.
- The service did not have information available throughout the service in different languages or formats such as braille or audio versions for the visually or hearing impaired.

Learning from complaints and concerns

- Some staff told us that they had not had any training in handling complaints and would welcome some practical sessions in managing patient concerns.
- We found that some complaint leaflets were available but had out of date and inaccurate information for both the role and contact details for the Care Quality Commission.
- We saw information on who to contact if people had concerns with information on the Patient Advice and Liaison Service (PALS).

Are maternity and family planning services well-led?

Requires improvement



The midwifery staff felt positive about their clinical leadership but felt that the roles were not yet embedded, and did not understand the roles of the clinical leads and the role of the business manager. One person told us “Staff are willing to change.”

Staff welcomed the maternity dashboard, but the inspection team was told that it had only recently been introduced so the data could not yet be compared with previous year's activity.

Staff were not clear what the trust's vision was for the hospital and had anxieties about the provision of care.

The lead obstetrician for maternity was based in Carlisle. The clinician was acting as lead for risk, diabetes, twins, and obstetrics, as well as lead for the termination of pregnancy services. The inspection team felt that this suggested no long term strategy and a lack of capacity to lead strategically in all the required areas.

Although we found evidence of feedback from patient questionnaires and local informal feedback from mothers and partners, we did not see evidence of any formal meetings to engage with members of the public about the maternity services.

Vision and strategy for this service

- Staff we spoke with told us that they had attended awareness sessions on the trust's vision. Not all staff clearly understood the corporate information boards on the walls on each unit.
- Staff told us that they felt things have improved since the maternity review, but they were still embedding the changes.
- Staff were not clear what the vision was for the hospital, and had anxieties about the provision of care in the future due to the level of change they had seen recently in other service areas.
- We noted that the service had a draft service specification but did not have a clearly documented overview of the maternity service provision and articulated vision for future service delivery.

Maternity and family planning

- We were shown the maternity service integrated governance action plan. This had been developed by the service governance lead to capture all the learning from audits and incidents.

Governance, risk management and quality measurement

- The maternity service monitored all its risks and had a local risk register. The service had a monthly Maternity Governance group, which reviewed all incidents. This committee also reviewed relevant national guidance published each quarter to ensure that they were assessing themselves in line with appropriate current national standards.
- Monthly departmental meetings had a set agenda, with certain standing items including the review of incidents and monitoring of the maternity dashboard.
- The maternity dashboard was welcomed by staff but the inspection team was told that it had only recently been introduced so the data could not yet be compared with previous year's activity.

Leadership of service

- The midwifery staff felt positive about their clinical leadership, but felt that the roles were not yet embedded and did not understand the roles of the clinical leads and the role of the business manager.
- Staff welcomed the post of the midwife consultant as a leadership role. The consultant post had a remit for Public health-Obesity but none of the leadership roles had a clear remit to promote 'normality' in child birth. The inspection team considered that the role was not clearly defined and the capacity to lead on public health and 'normality' was limited due to the significant management component of the role in managing the specialist midwives. The staff in Carlisle told us that they would prefer the post holder to be more visible on the maternity unit.

- The lead obstetrician for maternity was based in Carlisle. The clinician was acting as lead for risk, diabetes, twins, obstetrics as well as lead for the termination of pregnancy services.

Culture within the service

- The inspection team found a positive culture among the midwives compared with other staff at the trust. They acknowledge the recent challenges with the service review but were now positive about the changes, although they had concerns about future sustainability of services at the hospital.







Public and staff engagement

- Although we found evidence of feedback from patient questionnaires and local informal feedback from mothers and partners, we did not see evidence of any formal meetings to engage with members of the public about the maternity services.

Innovation, improvement and sustainability

- We found that the service had made significant improvements in regards to developing an improvement culture.
- Staff had been engaged with the development of new roles and now felt they were getting feedback on complaints and starting to learn from incidents. One person told us that they felt some of the reviews were being rushed and they would welcome more support to ensure that the service learned from incidents.
- The inspection team noted that the lack of electronic information systems was having an impact on the service's ability to adequately record information for audit with regard to the clinical care of women and the complexity of their cases. We were told that approval had just been given to introduce the IT data systems needed to help in developing innovation and improvements.

Services for children and young people

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

Information about the service

The children's department at the Cumberland Infirmary, Carlisle, comprised of a 24-bedded children's ward; 12 cot Special Care Baby Unit (SCBU) and the children's outpatients department.

The outpatient department adjoins the ward through secure doors and has six consulting rooms. The rooms were permanently allocated to the individual paediatric consultants.

The ward accommodation was a configuration of single rooms with en-suite facilities, two of which had been designated isolation rooms and shared bays. Two bays were single sex designated. A third bay (Rainbow) was a medical assessment unit used by children who had direct access to the ward following either referral from their GP, the hospital's accident and emergency department or by individual arrangement. The ward also included a High Dependency Unit for children who required specialist medical intervention and one-to-one care.

There was a fold-out bed in each bed space so that parents or guardians could be comfortable if they remained overnight. Facilities included a lounge and kitchen for parents and visitors; bathrooms including a rise and fall bath; shower and toilet facilities. There was a brightly decorated treatment room. The ward had a well-equipped sensory room, which children and parents could use. Staff commented that this room was particularly popular with children with special needs.

There was also a 'chill-out' room specifically designed for teenagers. There was a large, bright, well-organised and

clean play room. The ward kitchen was a good size and stocked with snacks and drinks that could be provided to children and their relatives at any-time. A seminar room and the on-call sleeping room were also a part of the unit.

There were nine patients on the ward and we talked with five patients or their relatives. We reviewed the records and information available on the ward. We interviewed a number of medical doctors including the consultant on duty; the ward matron; the ward sisters on duty on the ward and SCBU, a staff nurse, paediatric nurse practitioner and a health care assistant. We also talked with the play worker for the ward.

Services for children and young people

Summary of findings

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Services for children and young people

Are services for children and young people safe?

Requires improvement



We found that the trust needed to take more action to make children safe from avoidable harm. This was because emergency equipment on the ward and SCBU was incomplete and not fit for purpose.

Lack of experienced paediatric medical cover is a concern because although the hospital runs a 24-hour Accident and Emergency service, experienced paediatric doctors are only on site from 9am to 5.30pm although consultants were contactable.

Entry to the ward was monitored so that children could not leave unescorted.

Staff were keen to cooperate with changes that would improve the quality of the service. The safeguarding team was effective and well run.

Incidents

- No 'never events' had been reported by the trust through the National Reporting and Learning System for the children's ward or Special Care Baby Unit at the hospital.
- Staff reported incidents to the trust's auditors through the electronic incident reporting system.
- We found that the information provided through the systems for the children's ward at the Cumberland Infirmary was complete.
- We talked with nursing and medical staff and found that they all had access to the system and knew how to complete a report.
- Staff understood the difference between a minor, moderate and serious incident. This was in keeping with the trust's strategy because the Board Risk and Assurance Framework 2014/2015 stated that all staff would receive guidance about completing the online system.
- We were informed that a weekly meeting was held to review incidents in the seminar room on the children's ward.

- There were copies of the incident logs in the seminar room and we reviewed the most recent copy. This document provided information about reports made between 5 March and 4 April 2014.
- The trust provided feedback about the outcomes of incident reviews the information identified that local lessons were learned. Information also confirmed that these had been reviewed at a senior level.
- Staff we talked with were clear about recording incidents.

Safety thermometer

- A safety dashboard was on display, which provided information about the level of compliance in different aspects of practice; including hand hygiene and completion of the specialist paediatric observation tool called the Paediatric Early Warning score (PEWS). Each area had scored 100% compliance.
- We noted that the results for PEWS compliance were charted as 100% even though the audits found that blood pressures had not been recorded. This finding was discussed with staff and it was agreed that the information was incorrect. This demonstrated a weakness in the audit system.
- The ward safety dashboard also provided information about the use of specialist care pathways such as pain management, the number of falls and complaints.

Cleanliness, infection control and hygiene

- All the areas and side rooms we visited on the children's ward were clean and tidy.
- We noted that although all screening curtains between the beds looked clean they were not labelled with a replacement for laundering date.
- Equipment was in place to encourage effective hand hygiene.
- All clinical and direct 'hands-on' staff adhered to the 'bare below the elbow' dress code.
- Hand hygiene was audited and the results entered onto a central auditing system.
- There were dedicated isolation rooms.
- The hospital provided data from its most recent infection control audit dated March 2014. This showed that the children's ward and SCBU were fully compliant and effective with regards to infection prevention.
- However, the audit did not include a review of antibiotics prescribed on the ward. This did not meet good practice guidelines such as the Department of

Services for children and young people

Health ARHAI Antimicrobial Stewardship Guidance 2011. The trust informed us there are plans to have a “coast to coast” paediatric antimicrobial guideline, but this was not in place at the time of the inspection.

- This meant that the hospital did not have a complete picture about management of all infection control and management systems.

The Special Care Baby Unit.

- Infection control measures on the SCBU were not adequate.
- The clean utility room with a washing machine and tumble drier did not have a hand wash basin. This meant that staff or parents could not wash their hands in this area after handling dirty or soiled items.
- Yellow bags, which were used for heavily soiled items or those requiring disinfection, were left untied on the floor of the dirty utility close to white bags with items that would not be sterilised.
- Baby milk was not stored securely and parents had unsupervised access to milk. This meant that giving the correct milk to babies was the responsibility of the mothers.

Environment and equipment

- The resuscitation equipment on the children’s ward and SCBU was not fit for purpose. It was not an identifiable discreet resuscitation trolley and did not have a list of required equipment to check against regularly to ensure a full kit was always available.
- The resuscitation trolley on the children’s ward was kept in the High Dependency Unit. There was no trolley on the main ward and so there would be a delay if the HDU trolley was in use and a child on the ward deteriorated. The trust informed us there was a mitigation plan in place if this was ever to happen.
- It was not clear if the equipment and drugs required for paediatric cardiopulmonary resuscitation were checked as outlined in the Resuscitation Council (UK) 2013 guidance.
- Children who required intensive care at the hospital were treated on the hospital’s adult intensive care unit. This meant an added requirement for the staff of ICU to provide appropriate care for the child.

Special Care Baby Unit

- The resuscitation trolley was portable but adult-sized advance support life equipment was attached and paediatric-sized equipment was not immediately available.
- The good practice guidance for equipping a paediatric resuscitation trolley was dated 2000 and so was out of date.
- The contents of the trolley did not meet the minimum equipment requirements of the Resuscitation Council (UK) 2013 guidance.

Medicines

- Medication on the Children’s ward was stored securely and in keeping with the Royal Pharmaceutical guidance.
- The medication administration record sheets were completed in full and provided evidence that medication was given as prescribed.
- The medication administration record sheets did not provide the opportunity to record a pain score with each administration of analgesia, which would allow the effectiveness of the medication to be reviewed and changed accordingly.

The Special Care Baby unit.

- Controlled drugs and other medication on the Special Care Baby unit at Cumberland Infirmary was stored in keeping with the Royal Pharmaceutical Society guidance.

Records

- There were nine children and young people on the ward during the inspection. We reviewed the nursing file records for five of the children.
- Paperwork in each of the files had been labelled with hospital identification stickers.
- We did note that one file contained two sets of labels with different addresses. This had been identified by a nurse and highlighted on the admission form.
- The initial assessments; care plan; daily records and other correspondence were neatly arranged and secure in the files.
- Information was easy to find and records were arranged in chronological order.
- Written information was legible.
- Confidential information was not on display in the main ward area. This was in keeping with the ‘Code of Practice on Protecting the Confidentiality of Service User Information’.

Services for children and young people

- The trust's 'Health records information group' completed a clinical audit of medical records on the children's ward at the hospital. The 2013/2014 report showed a rating of 'amber', which meant improvements were needed. This report also included suggested changes, an action plan and timescale for a follow-up review.

Consent, and Deprivation of Liberty Safeguards

- Best practice in assessing the ability of a child under 16 to give consent is covered by the principles of Gillick competence. We could not find evidence that paediatric business unit staff had received training in these guidelines.
- The admission assessment forms included basic information about the level of consent given by a parent, child or young person.
- The trust's most recent training information confirmed that the majority of staff in the hospital's Paediatric department had completed Mental Capacity Act and Deprivation of Liberty Safeguards training level 1 in regard to young adults.
- There was no information in the care assessment about the child's ability to give consent or make decisions about their treatment or care, and so did not fully support staff in considering this aspect of care.
- Young people on the ward told us that the doctors and nurses always explained procedures to them in a way that was easy to understand.
- We saw that the World Health Organisation surgical safety checklist had been completed for children who were on the dental surgery list, and this included confirmation that consent had been obtained.

Safeguarding

- The trust has a dedicated team for safeguarding including Named Nurses.
- We saw that multidisciplinary safeguarding conferences were held on the ward.
- There was a clear review process for checking the robustness of staff response to safeguarding issues. This included a safeguarding assurance visit to wards.
- The team used a reporting database to identify trends in the type of safeguarding concerns referred, such as the number of children who missed outpatients appointments.

- The database kept a track of the children and flagged up those who had already been referred if they returned to the hospital. This meant early intervention and review of the condition of the child was possible.
- The database also prompted safeguarding staff to follow up concerns until issues were fully resolved.
- We saw reports and observed telephone conversations that confirmed that there was a multidisciplinary approach to dealing with safeguarding, which included conversations with other statutory services.
- The training records provided by the trust dated May 2014 showed that the appropriate safeguarding training had been provided to all nursing and clinical staff. The majority of ancillary staff had also received this training.
- Ward staff we talked with knew how to recognise signs of abuse and neglect in children.
- Staff knew how to raise a safeguarding alert and how to access the safeguarding team for guidance.

Mandatory training

- The mandatory training record provided by the trust in May 2014 showed that the majority of staff on the paediatric department had completed of the required training for their role.

Management of deteriorating patients

- The ward uses the paediatric early warning score (PEWS) for recording the vital signs of children on the ward so that early signs of deterioration can be identified and remedial action taken.
- The trust checks the quality of the charts and staff response monthly.
- The report we reviewed covered the months between October 2013 and March 2014 with the exception of December 2013. This PEWS audit showed that the children's ward at the hospital had achieved ongoing improvements in completing these observations for children who attended the ward.
- The remaining area for improvement was carrying out blood pressure checks. Information from the trust did not include a plan of how it would achieve this improvement.
- We discussed the management and transfer of the deteriorating child with ward staff. Nurses were clear about the processes in place to ensure that children were transferred to specialist children's hospitals as safely and quickly as possible.
- The lead consultant paediatrician and the senior management team were clear about the transfer

Services for children and young people

process and stated that the trust had a standard operating agreement with the North West and North Wales Paediatric Transport Service (NEWTS). This is a specialist ambulance transport service which provides highly trained paediatric nurses and is suitably equipped to support a very sick child during transfer.

- The trust's 'Transfer of patients policy' did not include information about transferring paediatric patients using NEWTS. The information did not highlight to staff the necessity to use the PEWS observation tool to assess the stability of the patient's condition and assist with ensuring the correct level of clinical support was provided.
- Children were escorted to the High Dependency Unit by a consultant paediatrician or Paediatric Nurse Practitioner (PNP) who is a highly trained paediatric specialist nurse able to complete complex clinical procedures.
- The training records for March 2014 confirmed that all staff had completed basic or Advanced Paediatric Life Support training.

Nursing staffing

- The children's ward has 24 beds. Information on display showed that the planned staffing was four registered nurses (RN) and one health care assistant (HCA) on duty Monday to Friday; three RNs and one HCA at weekends and two RNs and one HCA at night.
- The ratio of one registered nurse to six patients reducing to one registered nurse to eight patients at weekends and one registered nurse to 12 patients at night is significantly below the Royal College of Nursing (RCN) guidance of one registered nurse to four patients minimum ratio. As the ward was running at 60% occupancy the staffing was correct. However, this would not have been adequate if the ward was at full occupancy.
- The manager informed us that the HDU was always staffed separately and there was an effective escalation process when required for the ward.
- The trust's escalation policy gave staff guidance about requesting additional staff. However this did not provide an assessment or acuity tool to assess the level of need for each patient and then relate this to the number of staff required.

- The matron, nursing staff and senior paediatric consultant said that there was flexibility in the nursing roster to allow regular staff to work additional shifts when this was required.
- The roster confirmed that a band 7 paediatric nurse was usually on duty.
- We were informed by the ward sister that the usual number of inpatients was 12 children.
- The matron, nursing staff and senior paediatric consultant each confirmed that additional staff would always be made available to provide one-to-one support for children with special needs. However, the staff had found that this was not usually required because the children were usually supported by carers.
- The ward was calm and staff were available to provide the correct level of observations, care and treatment required by each child.

Medical staffing

- The service did not provide 24-hour paediatric consultant presence on the hospital site. Information we received showed that on most days consultant paediatric cover was provided from 9am until 5.30pm. There was only one period of 24 hours each week where on-site cover was provided by a staff grade who slept on site overnight.
- An experienced paediatrician was available through the on-call system, which operated after hours and weekends including consultant presence until 12 noon on weekends.

Major incident awareness and training

- The training record confirmed that the majority of staff had up-to-date fire safety training, but a practice evacuation had not taken place.

Are services for children and young people effective?

Requires improvement



The trust needs to take more action to ensure services for children and young adults are effective.

Innovative plans of care and treatment were not in use. The service reported a high rate of emergency readmissions within 30 days of discharge and there was no evidence that the trust had investigated this issue.

Services for children and young people

Evidence-based care and treatment

- The trust wide policies were based on the appropriate best practice guidelines and legislation such as National Institute for Health and Care Excellence (NICE); the Mental Health Act 1983 and NHS Executive guidance.
- We reviewed the trust's monthly audit of the use of NICE and other best practice guidelines but this information was not specific to a ward or department.
- Staff readily referred to the trust's intranet for guidance.
- The trust's internet home-page advertised care bundles. However, when we asked to view the contents we were informed that the programme on the children's ward was not fully operational.
- We reviewed the nursing records and assessments for five children and young people and talked with their parents.
- Assessments were not person-centred and lacked depth. There was very little information about the child's social or family circumstances.
- Initial records did not highlight the child's relationship to the adult escorting them.
- The relevant standardised risk assessments and paediatric care pathways were not always initiated.

Pain relief

- Young people told us that pain control was very good and staff offered alternatives to make sure pain was well controlled in between doses.
- Patients said that staff asked them about their pain levels as a score of 1 to 10, but this was not seen to be recorded. Pain assessments on the reverse of the paediatric early warning assessment tool had not been completed.
- Analgesic gel was used to numb an area so that procedures were as pain-free as possible.
- The skills of the play worker were used to distract children during blood tests or physical and intrusive examinations.

Nutrition and hydration

- Each nursing record that we reviewed held a copy of a nutritional screening assessment tool called STAMP and these had been completed in full.
- The menu offered a good variety of hot and cold meals, which included fresh vegetables, salads, pasta bakes and curries.
- Additional menus were readily available for patients with special dietary needs.

- Snacks and cold drinks were provided for relatives and children periodically throughout the day.
- The milk room was clean and the ward kept a number of different brands of baby milk in stock.

Patient outcomes

- The trust's Clinical Audit Annual Report 2013/14 confirmed that it participated in the expected National and local paediatric audits to support service improvement.
- Audits included Paediatric CQUIN to reduce Paediatric admissions for Asthma and Asthma related conditions.
- The trust provided feedback about improvements that had been made, including development of a patient advice leaflet. This was not underpinned by policy.
- The quality performance dashboard April 2013 and February 2014 showed that the emergency readmission rate within 30 days of discharge for the paediatric division was 10.2%. The information did not distinguish between the ward at West Cumberland Hospital in Whitehaven and the children's ward at Cumberland Infirmary, Carlisle. This was above the trust target set within their performance dashboard, which was equal to or below 6%. We did not receive information about any action taken by the trust in relation to this finding. Neither had the finding been highlighted in the trust's paediatric risk register.

Competent staff

- The trust's Report to the Safety & Quality Committee held on 18 February 2014 showed improvements in staff appraisal for the paediatric service.
- Appraisal for non-medical (nursing and ancillary) staff stood at 89.1% for the 3rd quarter. This was an increase from 74% for the previous quarter.
- Appraisals for consultants increased to 78% from 68% for the same period.
- The trust's training needs analysis 2 May 2014 confirmed that nurses working on the paediatric and SCBU unit at Cumberland Infirmary, Carlisle completed specialist paediatric training in addition to their mandatory training.

Hospital security

- Porters at the hospital acted as security staff and so were expected to support a young person if they

Services for children and young people

displayed challenging behaviour that required physical intervention. The information from the trust showed that porters had completed safeguarding children training level 1.

- Control and restraint training was out of date for all staff.
- No porters had completed conflict resolution training.

Multidisciplinary working

- The 'transfer to adult services policy' for children with long term conditions only related to children with diabetes.
- Transition to adult services begins at 16 years and involves the patient and a multiagency team.
- The diabetes transition policy stated that children between 16 and 18 years would be given a choice of using adult or children's services.
- There was some flexibility in the upper age limit for young people with special needs who were still at school full time.
- Staff described effective working with community nurses, doctors and nurses and allied health care professionals.
- Nursing notes confirmed effective working with physiotherapists and the dietician.
- Observation confirmed that staff alerted other departments about children with special needs so that suitable arrangements could be made to prevent unnecessary stress.
- Nursing and medical staff described the Child and Adolescent Mental Health Service (CAMHS) referral process.
- The trust board was aware that there was a deficit in the CAMHS and so children and young adults with acute mental health needs did not always receive psychological and psychiatric treatment in a timely way.
- The trust flagged a lack of CAMHS provision and need for mental health training for staff as a high or 'red' risk on its paediatric risk register dated 21 March 2014 and had raised it with the commissioners, LSCB and local mental health trust.
- Discussion with the management team confirmed that this was an ongoing concern, which was not isolated to the North Cumbria Trust.
- The management team outlined an action plan in relation to improving the trust's service for children and young people. This included mental health training for staff.

Seven-day services

- 24-hour specialist paediatric medical cover was not available on site for children attending the Cumberland Infirmary, although consultants were available to be contacted if required.

Are services for children and young people caring?

Good



Patient satisfaction surveys indicated that parents and patients were satisfied with the conduct of staff and felt the service was caring.

Staff took action to provide information that would offer reassurance to parents.

Compassionate care

- In the 'Better Care, Better Experience' report for quarter 4 (2013/14) the Family and Friends score for the ward showed that customer satisfaction averaged 9.51 out of a possible score of 10 between October, November and December 2013. The national average was 9.72. A further breakdown for this ward was not available.
- We talked with parents and children during the inspection. We were told that "the nurses were very kind and friendly."
- Nurses were described as "extremely caring" and "quick to answer the bell". Patients said nurses were always available and children didn't have to wait for anything.
- The matron, nurses, doctors, play worker and other staff we talked with were dedicated to their work and caring towards the patients.

Patient understanding and involvement

- We talked with five parents and children. Each was complimentary about staff and said they were fully involved in planning their care and treatment.
- Staff were attentive and treated patients and their parents with dignity and respect.

Emotional support

- We discussed with staff the care and support of patients with long term or life-limiting conditions. Staff stated that such care was led by a tertiary children's hospital

Services for children and young people

such as Newcastle or Alder Hey. The discussion was multidisciplinary and the information would be recorded in the patient's notes and their wishes would be recorded and agreed.

- The records reviewed did not contain evidence of assessments for anxiety or emotional wellbeing for the children or parents who used the service.

Are services for children and young people responsive?

Good



Evidence confirmed that systems in place for responding to foreseeable concerns, such as short-term staff shortages, were flexible and effective.

Information from the trust demonstrated that the service responded to complaints or concerns from patients or their relatives. However, this evidence did not confirm that outcomes were routinely analysed and used to influence the changes at ward level.

Service planning and delivery to meet the needs of local people

- Taff followed the trust's escalation policy to alert the bed managers about times when the ward became busy.
- We saw written evidence that effective action was taken to ensure that patient safety was not compromised, such as alerting ambulance services and so ensuring that admissions from this route were diverted to other children hospitals.
- The evidence showed that the trust had not yet successfully introduced systems that would ensure that the medical, social and emotional needs of children were consistently risk assessed and planned for in accordance with good practice guidance.

Access and flow

- The children's ward has 24 beds. On the day of the visit nine children were being treated as inpatients. Other children were attending the ward following referral from either the A&E department; returning to the ward through direct access from GP referrals or through direct access agreed as part of the discharge plan. This meant that the admissions process was flexible and responsive.

- There was also a dental list of three children and an Ear Nose and Throat (ENT) surgery list. This demonstrated the breadth of services for children.

Paediatric outpatients

- The outpatient clinic was held by two paediatric consultants.
- The department was comfortable and child-friendly.
- The waiting area did not become crowded and children were seen promptly on arrival.

Meeting people's individual needs

- The trust has a translation policy and access to a translation service. Staff we talked with were clear about how to access the service. The staff said that some languages were not covered by the service but this was infrequent.
- Staff were aware of how to download advice leaflets and information in different languages and formats from different best practice websites such as the Department of Health; NICE or NHS Choices.
- We saw leaflets about aftercare for procedures and illnesses and saw that they were provided to people appropriately.
- Provision of information for patients and parents was confirmed as a part of the patient discharge process.

Learning from complaints and concerns

- Information in the recent quarterly audit report for October November and December 2013 showed that two complaints or concerns had been raised about the ward. The audit showed that each had been resolved following involvement of the Patient Liaison Service at the Cumberland Infirmary.
- The report did not identify an analysis of trends regarding these complaints and there was no indication of lessons learned from the investigations.
- Complaint data for 2014 had not been analysed at the time of the inspection.
- We saw that complaints leaflets were readily available on the ward.
- We were informed that a 15-Step Challenge patient stakeholder visit had taken place on the ward the week before our visit, and verbal feedback had been acted on. As the visit was so close to CQC's, the report was not yet available.

Services for children and young people

Are services for children and young people well-led?

Requires improvement



The staff we talked with spoke positively about the management team. They felt encouraged to voice their opinion and information about CQC's focus groups and meetings for staff had been posted in the staff room. The leadership on the paediatric ward and special care baby unit at the Cumberland Infirmary needs time to follow through on plans in order to make sure that changes are fully embedded. There was a strategic overview of the service but this seemed patchy. However, plans are in place to improve the quality of the service.

Vision and strategy for this service

- The operational leadership for the paediatric services at the hospital has experienced recent changes and consequently it was difficult for the team to be clear about the vision and long term strategies that will be put in place to secure sustained improvement. There was a strategic overview of the service with plans in place to improve quality, but these were not yet fully embedded.
- The Paediatric Business Unit Quarter 3 plan for October to December 2013 that was reported to the Safety and Quality Committee in February 2014, provided an overview of the strengths and weaknesses in the service and an indication of progress towards excellence so far.

- Senior managers informed us that the trust's board was considering commissioning a high level independent peer review for the paediatric service.

Governance, risk management and quality measurement

- The trust's risk register lacked depth and did not fully address and reflect the risks highlighted in the various reports, data and quality measurements available in relation to this service.
- There was insufficient assurance that action to mitigate risks had been followed up. For example, despite training staff to use equipment, no checks had been made to ensure resuscitation equipment in SCBU and the HDU met the required standard.

Culture within the service

- The staff we talked with spoke positively about the management team.
- Staff on the ward felt encouraged to voice their opinion and share their concerns openly. There was a positive culture within the service.







Public and staff engagement

- The trust had completed staff surveys for the trust as a whole but results relating exclusively to the children's ward at the Cumberland Infirmary were not made available.

Innovation, improvement and sustainability

- We saw plans in place such as the trust's 'Local quality incentive scheme' for the business year 2014/15, which confirmed that trust managers were forward planning in respect of improving the paediatric service.

End of life care

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

Information about the service

Care for patients at the end of life was provided on the medical wards and supported by the Palliative Care Team. We visited four wards where end of life care was being provided. We also visited the hospital mortuary, chapel of rest and the chaplaincy service.

We spoke with staff on each ward visited, members of the hospital specialist palliative care team, and with the Macmillan nurse who supports end of life patients and their families.

We reviewed care records, policies and procedures, and performance information, and received comments from the listening event.

Summary of findings

End of life care was well supported on the wards through a dedicated specialist team. Patients received, sensitive individualised care and those close to patients were also supported sensitively.

The sharing of information was good and ensured that continuity of care was supported by robust record keeping. Pain and discomfort was managed well and medicines were readily available as required.

DNACPR (do not attempt cardio-pulmonary resuscitation) forms were appropriately completed and we saw that the decision had either been discussed with the patient themselves, or where that was not appropriate, the decision had been discussed with professionals and others as appropriate so a best interest decision could be made.

However, there were concerns about patients' dignity and respect after death when they were transferred to the mortuary, following incidents involving harm to deceased patients in transit between the ward and mortuary.

Some equipment used in the mortuary needed to be replaced or upgraded.

Staff felt that the lack of permanent consultant cover for end of life care was impacting on the effectiveness and

End of life care

quality of care, as medical staff were already very stretched because of high vacancy rates for consultants. This also impacted on the level of education and training for staff regarding end of life care.

The trust was developing an alternative pathway to use for people who were at the end of life to replace the 'Liverpool Care Pathway'. However, this was not in place at the time of our inspection.

Are end of life care services safe?

Requires Improvement



End of life care was well supported on the wards through the dedicated team. Handover of information was good and on a continuous basis, ensuring continuity of care which was supported by robust record keeping. Pain was managed well and medicines were readily available when required.

However, there were dignity and respect concerns particularly around the treatment of patients after death when being transferred to the mortuary. Some equipment was in need of replacement or up-grade.

DNA CPR (Do not attempt cardio-pulmonary resuscitation) forms were appropriately completed and we saw that the decision had either been discussed with the patient themselves, or where that was not appropriate, the decision had been discussed with the patient's relatives.

Staff felt that lack of permanent consultant cover for end of life care was impacting on the effectiveness and quality of care as medical staff were very stretched. This also impacted on the education and training able to be provided to staff around end of life care.

Incidents

- Mortuary staff reported incidents of deceased patients being transferred from the wards to the mortuary without receiving the expected final cares from ward staff.
- Mortuary staff expressed concerns about the lack of training in mortuary and end of life procedures for the porters employed by an outside agency. We were made aware of two incidents where the deceased person had been injured within the last 12 months whilst being transferred to the mortuary by porters. No portering staff had accessed training since to improve this situation.

Cleanliness, infection control and hygiene

- Mortuary staff reported two safety incidents regarding patients with an infectious disease being transferred to the mortuary without appropriate preventative measures in place.
- A problem had been identified with the downdraft air ventilation system in the mortuary, which posed an infection control risk to staff. There had been one

End of life care

incident where a deceased patient with an undiagnosed infection had undergone post mortem at the hospital since, which had placed staff at risk of acquiring infection.

Environment and equipment

- Equipment such as syringe drivers were readily available for patients and were clean and safely maintained.
- Patients were nursed in clean and well maintained wards. Single rooms were provided for patients when available.
- Staff had been informed that funds have been made available for one new post mortem table as both were not functioning properly, but the new table had not yet been provided.

Medicines

- Anticipatory medication was appropriately prescribed for patients at the end of life to manage symptoms and promote patient comfort.
- Appropriate syringe drivers were available to deliver sub-cutaneous medication.
- Staff were able to access medication for pain and symptom management out of hours by contacting the 'on-call' pharmacist.

Records

- Patients' care and treatment was recorded in individualised care plans that were regularly reviewed. Patients' wishes were recorded and met appropriately.
- DNA CPR (do not attempt cardio-pulmonary resuscitation) forms were appropriately completed and we found that the decision had either been discussed with the patient themselves, or where that was not appropriate, with other professionals and in consultation with the patient's family so that a best interest decision was made.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There were systems in place to review the needs of a patient with fluctuating capacity to consent in response to their changing ability to consent

Nursing staffing

- The hospital had a specialist palliative care team that supported staff on the wards who were caring for patients at the end of life.
- There was also a Macmillan nurse who supported patients and those close to them at the end of life.

Medical staffing

- Staff felt the lack of permanent consultant cover for end of life care was impacting on the effectiveness and quality of care, as medical staff were very stretched. This also impacted on the education and training able to be provided to staff in relation to effective end of life care.

Are end of life care services effective?

Requires Improvement



Staff followed the guiding principles of the Liverpool Care Pathway, but following a national review, the trust no longer formally followed the processes and protocols of this pathway. The trust was in the process of developing alternative documentation for staff to use for people who were at the end of life.

After the national withdrawal of the Liverpool Care Pathway staff were unsure whether it was still appropriate to follow the principles of the Liverpool Care Pathway. This did not support evidence-based consistent practice.

Evidence-based care and treatment

- Staff followed the guiding principles of the Liverpool Care Pathway but following a national review, the trust no longer formally followed the processes and protocols of this patient pathway and it was developing an alternative care pathway for people who were at the end of life.
- In response to the national withdrawal of the Liverpool Care Pathway, staff were unclear whether to use the existing Liverpool Care Pathway and if the trust was still accepting its use. This lack of clarity did not support consistent practice.
- Information was displayed on wards regarding caring for patients in the last hours of life, which was based on the NICE quality standard.
- The hospital had acted on the Department of Health's National End of Life Strategy recommendations. It had introduced the AMBER care bundle. This is an approach used when clinicians are uncertain whether a patient may recover and are concerned that they may have only a few months left to live. It encourages staff, patients and families to continue with treatment in the hope of recovery, while talking openly about people's wishes and putting plans in place if end of life care is planned.

End of life care

Pain relief

- Pain and discomfort was well managed for patients at the end of life.
- Staff were able to access medication for pain management and equipment such as syringe drivers out of hours by contacting the 'on-call' pharmacist.

Nutrition and hydration

- Patients' dietary requirements were appropriately met and there was specialist support for patients who were unable to take diet and fluids orally.

Patient outcomes

- From our conversations with staff it was apparent that they were working to the principles of the Leadership Alliance for the Care of Dying People guidance, but this could not be supported with documentation.
- This hospital did not participate in the national care of the dying audit that was last reported in May 2014.

Competent staff

- There was insufficient documented assurance that staff had received specialist palliative care training, although we were informed that staff were currently able to access this type of training.
- Preceptorship supervision was in place for nursing students. This included setting care goals for end of life care.

Multidisciplinary working

- Specialist palliative care doctors visited the wards regularly and offered advice and guidance to ward-based teams regarding the care of patients at the end of life.
- Staff worked well with the Macmillan Nurse at the hospital.
- Staff had regular liaison with the local hospice to support patients in choosing their preferred place of care.
- There was a strong multi-disciplinary approach to discharge planning for patients who wished to return home at the end of life.

Seven-day services

- During out-of-hours periods (weekend and nights) patients at the end of life were supported by the duty medical staff. There was no specialist palliative care support available out of hours.

Are end of life care services caring?

Good



We saw patients being treated with compassion, dignity and respect. Staff were very supportive to both patients and those close to them, and offered emotional support to provide comfort and reassurance. Additional support was provided in a caring way by the chaplaincy, MacMillan nurse and other support services.

The patients we spoke with were complimentary about the manner in which staff communicated with them and those close to them.

Compassionate care

- Throughout our inspection we saw patients being treated with compassion, dignity and respect.
- Staff were very supportive to both patients and those close to them and offered emotional support to provide comfort and reassurance.
- We looked at patient records and found they were completed sensitively and staff had undertaken detailed discussions with patients and relatives.
- The staff told us that they worked hard to assist individual patients to achieve their wishes at end of life, which had included, for example, facilitating people to get married on the ward.
- Normal visiting times were waived for relatives of patients who were at end of life.
- Mortuary services offered a well-appointed and appropriately furnished viewing room.
- Mortuary staff explained their good practice of wearing the same kind of tabards that nursing staff wore on the children's wards in order to reduce the stress for children.

Patient understanding and involvement

- Ward staff told us they worked hard to understand and support the needs of patients living with dementia and checked with patients' relatives what they believed the patient's wishes to be at the end of their lives.
- Staff said they felt they had received insufficient training in understanding the needs of people living with dementia and how best to meet their care needs when they were at the end of life.
- Staff worked hard to establish a good rapport with patients and those close to them.

End of life care

- Staff encouraged patients to ask questions about their care and responded openly and honestly.
- The patients we spoke with were complimentary about the manner in which they communicated with them and those close to them.

Emotional support

- The hospital had a specialist palliative care team who supported staff on the wards who were caring for patients at the end of life.
- The palliative care team provided emotional support in a sensitive way.
- There was also a Macmillan nurse who supported patients at the end of life and their families.

Are end of life care services responsive?

Requires Improvement



The Chaplain regularly visited the wards and chaplaincy was available 24 hours a day, seven days a week. Staff demonstrated an understanding of, and respect for, the needs of patients with multi-faith needs and ward staff were able to make contact with other faith leaders through the chaplaincy service. They were able to 'fast track' patients to be able to return home quickly.

However, staff recalled that on some occasions there were long waits for deceased patients to be taken to the mortuary, and that it was not always easy to view the deceased out of office hours, when porters would be providing this service, and relatives sometimes had to wait for quite a long time.

Concerns were expressed that the patients' panel had raised funds for patients to have a separate room to receive bad news, but these funds had been used within the trust for other purposes and patients were still being given bad news simply behind a curtain on the ward. The trust did not provide a bereavement office on site and all patient paperwork and belongings had to be collected from the wards.

We noted that there was no paediatric palliative care policy in place in the trust.

Access and flow

- Staff informed us that they liaised with Macmillan nurses, the palliative care social worker, the district nursing service and other support services to enable patients to be discharged home if that was their preferred location to die.
- They were able to 'fast track' patients for urgent discharge, which speeded up the discharge process to support them being able to return home quickly. We saw evidence of this in the patient care records.
- Staff mentioned that on some occasions there were long waits for deceased patients to be taken to the mortuary, as this required two porters to be free.

Meeting people's individual needs

- Staff told us that they did try to provide single rooms when possible for end of life care, but they often experienced other pressures for these rooms such as demand for patients requiring specialist stroke support.
- The wards were introducing the Butterfly Scheme so that people living with dementia could be identified and given additional support.
- The chaplain regularly visited the wards and chaplaincy was available 24 hours a day, seven days a week. Staff demonstrated an understanding of and respect for the needs of patients with multi-faith needs and ward staff were able to make contact with other faith leaders via the chaplaincy service.
- Mortuary staff demonstrated their awareness of and sensitivity to cultural and faith practices.
- When families were travelling from a distance, staff told us that it was not always easy to arrange viewing of the deceased out of office hours when porters would be providing this service, and relatives sometimes had to wait for quite a long time at the mortuary.
- The trust did not provide a bereavement office on site and all patient paperwork and belongings had to be collected from the wards. We were informed that plans had been agreed 18 months previously to create a bereavement office, but these plans had not yet been implemented.
- Concerns were expressed that the patients' panel had raised funds for patients to have a separate room to deliver bad news, but these funds had been used within the trust for other purposes and patients were still being given bad news simply behind a curtain on the ward, and staff felt this was inappropriate.

End of life care

- We did not receive any information from the trust on the percentage of patients dying in their preferred location. But they were able to 'fast track' patients for urgent discharge, which supported them to return home quickly.
- There was no paediatric palliative care policy.

Learning from complaints and concerns

- We were informed that the End of Life Care Strategy Group, which was trust wide and included external partners, was regularly cancelled due to key members having other priorities. This left a potential for a lack of focus on end of life care, including complaints management, because meetings were so infrequent.

Are end of life care services well-led?

Requires Improvement



The trust lacked vision and strategy for end of life care and staff were not able to articulate the organisation's quality goals and priorities for end of life care. There was a lack of ownership about end of life care within the trust and there did not appear to be a member of the executive team with a lead role for end of life care.

Since the national withdrawal of the Liverpool Care Pathway, the trust had not yet developed a formal End of Life Care standard framework to assure safe effective care at the end of life. Plans need to be in place to formally replace the Liverpool Care Pathway by July 2014.

The service was well-led at a middle management and ward level, but there was a lack of leadership at senior and board level.

Vision and strategy for this service

- There was a lack of a trust vision and strategy for end of life care.

- There was a lack of clarity regarding the organisational structure to develop the service for the future.
- There was a lack of ownership about end of life care within the trust.
- There did not appear to be a Non-Executive Director with a lead for end of life care.

Governance, risk management and quality measurement

- Since the national withdrawal of the Liverpool Care Pathway, the trust had not yet developed a formal End of Life Care standard framework to assure safe effective care at the end of life.
- Plans need to be in place to formally replace the Liverpool Care Pathway by July 2014 and no training package has yet been agreed to support these changes.

Leadership of service

- The service was well led at a middle management and ward level.
- There was a lack of leadership at senior and board level and staff did not appear to be aware of who in the trust had responsibility to lead on end of life care.






Culture within the service

- Staff providing end of life care were committed, dedicated and hardworking and spoke positively about the service they provided. However, the staff responsible for the delivery of end of life care felt that the service did not have a high profile in the trust. Staff were very positive about the commitment and service provided by the specialist team.

Public and staff engagement

- None of the staff we spoke with were able to articulate the organisation's quality goals and priorities for end of life care.
- We found no information on consultation with the public regarding this service area.

Outpatients

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

Information about the service

There was a comprehensive set of medical and surgical clinics at the Cumberland Infirmary, Carlisle. These were based in a designated outpatients area. These clinics provided services to the 293,915 patients attending across the two hospitals in the trust.

Summary of findings

Overall, patients received safe and appropriate care in the department. The outpatient areas were clean and well maintained and measures were taken to control and prevent infection. The outpatient department was adequately staffed by a well-trained, professional and caring team.

Outpatient clinics were, in general, comfortable and friendly with suitable facilities. However, the environment in the atrium was draughty and cramped.

The outpatient services were less effective than they should be due to an issue regarding the management of systems for patient records, which impacted on both staff and patients through delayed clinic start and finish times and longer waits for patients. We were informed that patients would not be seen without the patient records, and in some cases patients had not been seen by the doctor because their records were not available. This has already been recorded as high risk on the trust risk register.

People did not complain to us about the waiting times, although patients waiting at clinics said that they found it undignified for inpatients to be moved from wards through the main atrium area in their beds or wheelchairs while wearing bed clothes when attending for diagnostic imaging.

Staff treated patients with dignity and respect. However, patients waiting for day surgery were afforded limited privacy and the waiting area was cold and

Outpatients

uncomfortable. Changing facilities lacked dignity and privacy and we were informed that many people became distressed at having to walk through the public area to the theatre in a night gown. Others refused to change until they were in the theatre area.

Patients told us that they were very satisfied with the service they received. They were positive about staff attitudes and had confidence in the ability of staff to look after them well during a procedure. It was clear to the inspection team that staff were very committed and worked to achieve the best outcomes for patients. People were very complimentary about the digital imaging unit.

Oncology and digital imaging were meeting the two week waiting targets for urgent patients. Targets for six week and 18 week appointments were not being met. Plans were in place to retrieve this situation by June 2014. The service was looking creatively at how to meet increased patient demand by best use of staff skills and by offering clinics at alternative locations and by expanding and developing capacity.

Performance was reported monthly and considered by the trust board. Plans for the service included addressing issues related to capacity planning. There was board ownership of the plans and a commitment at all levels to secure the required improvements. Staff overall were positive about the Chief Executive and the engagement and visibility of senior staff. Staff had confidence in their managers and felt there was a new, strong culture of leadership.

Are outpatients services safe?

Inadequate



The outpatient areas were clean and well maintained and measures were taken to control and prevent infection. The outpatient department was adequately staffed by a well-trained, professional and caring team.

However, a recent case note audit undertaken in March 2014 showed there had been a 25% shortfall in case notes being delivered on time or being fully complete. This presented a risk of safety of people were being treated without their records. The environment was draughty and cramped in the atrium area. Some of the equipment in the digital imaging department was very old and there was an issue with obtaining replacement parts and therefore continued safety. Funding had been agreed to start replacing the equipment incrementally.

Incidents

- Senior staff were aware of how to escalate incidents.
- Staff and consultants regularly completed the incident report forms to report incidents of incomplete medical records and late arrival of records at clinics. This issue had already been recorded as a high risk on the trust's risk register. The clinic coordinators were currently undertaking an audit of medical records and were collecting information about the time of arrival and missing information.
- A backlog of typing with the secretarial staff, particularly in ophthalmology, ENT and orthopaedics, had been identified as a further issue that impacted on the availability of complete notes and the date of follow-up appointments.
- The diagnostic imaging department operated a clear error reporting system.

Safety thermometer

- We did not see safety thermometer information in outpatients.

Cleanliness, infection control and hygiene

- Clinical areas appeared clean and we saw staff wash their hands between patients.
- There was an ample supply of hand washing facilities.
- There was a lack of signage to encourage hand washing by the public.

Outpatients

- Staff observed 'bare below the elbow' guidance and we saw that they were adhering to the hospital's policies on control and prevention of infection.

Environment and equipment

- Outpatient clinics had ample seating areas and facilities for patients to purchase drinks and refreshments nearby.
- Concern was expressed that within the newly-built unit, no room had yet been identified to store medical records. It is imperative that records are stored safely and are accessible.
- Some of the equipment in the digital imaging department was very old and there was an issue with obtaining replacement parts. Funding had been agreed to start replacing the equipment incrementally.

Medicines

- Medicines were stored and managed safely in accordance with the British Pharmaceutical Society's guidelines.

Records and case note availability

- A recent case note audit undertaken in March 2014 showed there had been a 25% shortfall in case notes being delivered on time or being fully complete. This presented a risk of safety of people were being treated without their records.
- New locked trolleys had been ordered to store records for the duration of clinics.
- In some clinic areas we noticed that several sets of confidential patient records were left unattended in consulting rooms with doors open, with no staff nearby, leaving them potentially accessible to other waiting patients.
- In one consulting room we saw notes and two swabs marked with patient details left unattended.
- Staff worked extra hours to prepare case notes due to late arrival and had to prepare case notes quickly. There was much reliance on staff goodwill. We heard about staff preparing notes on the morning of our inspection for the afternoon clinics.
- Staff identified this as their biggest cause of concern and said that lack of records sometimes meant the service was unsafe.
- The General Manager had employed a temporary case note 'runner' at band 2 to fetch missing files to mitigate the impact on patients. This temporary appointment had now ceased due to financial constraints.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The department managers had recently audited the quality of request forms looking at patient consent, but the results were not available at the time of our inspection.
- The records we viewed demonstrated that consent for procedures was appropriately sought and recorded.

Safeguarding

- Training records confirmed that staff in the department had received mandatory safeguarding training.
- Staff understood and could identify issues of abuse and neglect and knew how to escalate their concerns appropriately.

Mandatory training

- If clinics were cancelled at short notice, senior staff arranged for staff to use this time by providing training.
- Training was accredited and senior staff undertook competency assessments which were signed off and noted in the staff files.
- The radiology department had achieved 100% mandatory training.

Nursing staffing

- Notices were displayed in each clinic area stating how many qualified nursing staff and health care workers were on duty.
- Clinics generally operated on the basis of 40% qualified staff and 60% health care assistant band 3. Oral surgery had more qualified staff due to the medicines monitoring and sedation requirements.
- Band 3 radiography helpers were multi-skilled and worked across all modalities.
- Staff worked flexibly across the three areas of medical/surgical, head and neck and orthopaedics.
- There was an analysis of the number of nursing hours needed for the additional clinics that were provided, which had led to a formal request for additional nursing hours and this had been put in place by December 2013.
- There was a shortage of specialist skills in the radiology department. This mirrors a national skills deficit. To mitigate this, the department had outsourced plain film reporting to an independent provider, and having reviewed the best use of skills on site, it had moved to overnight reporting.

Outpatients

Medical staffing

- Medical staffing in clinics was adversely affected by the number of consultant vacancies. This meant that clinics were cancelled at short notices or ran late because consultant medical staff were unavailable. Patients waited for long periods to see a consultant in some clinics.
- Senior staff told us that chaperones were always available during clinic sessions for the protection of doctors and patients.

Major incident awareness and training

- There was a trust policy, which staff were aware of and could refer to.

Are outpatients services effective?

Not sufficient evidence to rate

The outpatient services were less effective because of an issue regarding the management of systems for patient records, which impacted on both staff and patients through delayed clinic start and finish times and longer waits for patients. We were informed that patients would not be seen without the notes and in some cases patients had not been seen for their appointment as a result. This has already been flagged as high risk on the trust's risk register.

People did not complain to us about the waiting times, although staff felt they could deliver a more effective service. People were very complimentary about the digital imaging unit.

Evidence-based care and treatment

- An audit of fine needle aspiration in digital imaging had led to change in practice in the use of scanning equipment.
- Digital imaging services were following best practice guidance in the use of intravenous contrast in CT scans
- Digital imaging services were following NICE guidelines for detecting prostate cancer and risk category-use of MRI for 'active surveillance', which has increased the request for MRI scans.

Pain relief

- Medicines, including those for pain relief, were stored and handled appropriately. Pain relief was appropriately prescribed.

Patient outcomes

- We were informed that two days before our visit, records had arrived 45 minutes late for four outpatient clinics, resulting in patients having to wait. The gold standard is that patient records should arrive 48 hours before the appointment or a minimum of 24 hours. A new central hub was being created in the outpatient clinic area to receive records as they were delivered, and a designated room was being created for records to be placed in while waiting to be retrieved.

Competent staff

- Health care assistants were trained to a high standard, with extended skills and were able to support and manage clinics.
- Senior nursing staff identified during appraisals the skills that nurses, and particularly health care assistants, needed to develop and arranged appropriate development opportunities.
- Staff said that supervision happened regularly but took place on an informal basis, and notes were not kept. 'Supervision' also included observed practice on a day to day basis. Staff received competency assessments.
- We were informed that although clinical supervision had originally been introduced into the trust in 2001, it had not been embedded and was now gradually being re-introduced
- Senior clinical staff were now undertaking formal training in clinical supervision but felt that the trust needed to identify a lead for Clinical Supervision in order for it to become successfully embedded.

Multidisciplinary working

- There was evidence of good multi-disciplinary working in outpatients. Staff genuinely valued each other's role and contributions to service delivery.
- The digital imaging service had good relationships with the other departments in the hospital.

Seven-day services

- The main outpatient service was delivered from Monday to Friday.
- A new fracture clinic had been established as a seven-day service and patients could see a consultant the next day following their visit to A&E.
- The digital imaging service operated seven days a week from 8am to 8pm, and an additional mobile scanner was available at weekends.

Outpatients

- There was no space to enlarge the service area in its current location.
- There was an issue of bed management/bed availability for patients who attended for interventional day procedures, such as biopsies or angiograms.

Are outpatients services caring?

Good



Staff working in the department respected patients' privacy and treated patients with dignity and respect. Patients told us that they were very satisfied with the service they received. They were positive about staff attitudes and had confidence in the staff's ability to look after them well during a procedure. It was clear that staff were very committed and worked to achieve the best outcomes for patients.

Patients waiting at clinics stated that they found it undignified for inpatients to be moved from wards through the main atrium area in their beds or wheelchairs while wearing bed clothes when attending for diagnostic imaging.

Compassionate care, dignity and empathy

- Patients and relatives waiting at clinics were all very positive about the care provided by staff.
- We observed staff speaking with patients respectfully and they were open, caring and friendly in their approach.
- Staff listened to patients and responded positively to questions and requests for information.
- Patients waiting at clinics stated that they found it undignified for inpatients to be moved from wards in their beds or wheelchairs through the main atrium area while wearing bed clothes when attending for diagnostic imaging.

Patient understanding and involvement

- Patients we spoke with stated they felt that they had been involved in decisions regarding their care.
- The provision of individual consulting rooms in the outpatient department allowed for confidential conversations to be conducted in an appropriate setting.

- Patients and relatives told us they had been supported when they had arrived at the service, they were helped to find the correct clinic and had been kept informed of waiting times.
- Digital imaging recently audited patients' experience of the service and the overall response was very positive with far more compliments than complaints.

Emotional support

- When doctors gave patients difficult news staff made themselves available and provided emotional support to patients.

Are outpatients services responsive?

Requires improvement



Outpatient clinics were, in general, comfortable and friendly with suitable facilities. Oncology and digital imaging were meeting the two-week waiting targets for urgent patients. Targets for six weeks and 18 weeks appointments were not being met. Plans were in place to retrieve this situation by June 2014. The service was looking creatively at how to meet increased patient demand by best use of staff skills and by offering clinics at alternative locations and by expanding and developing capacity.

Patients waiting for day surgery were afforded limited privacy and the waiting area was cold and uncomfortable. Changing facilities lacked dignity and privacy and we were informed that many people became distressed at having to walk through the public area to the theatre in a night gown. Others refused to change until they were in the theatre area.

Service planning and delivery to meet the needs of local people

- A review was taking place of the need for outpatient services across the county, using data and demand analysis to determine the need for outpatient services on peripheral sites.
- Although frontline staff were committed to ensuring that support was available to meet new and short notice clinics, they felt that the trust had not always planned sufficiently in advance or considered the need for support services to be available.

Outpatients

- The digital imaging department is aiming to provide a completely separate outpatient provision for both MRI and CT scans in the future.
- Staff felt that the transfer of acute care from West Cumberland Hospital to Carlisle had happened more quickly than the infrastructure had been able to support. One-stop clinics were operating in breast care and cardiology. Patients were informed in their initial appointment letter that a set of investigations would be carried out during their appointment, but to expect to be available for up to three hours.
- The availability of outpatient clinics was being extended and clinics were now being offered in other parts of Cumbria in addition to Carlisle.
- Additional services had been set up so far in Penrith, Brampton and Cockermouth. The frequency of need for these new clinics was being reviewed on an ongoing basis.

Privacy and dignity

- For patients waiting for day surgery, there was limited privacy and the waiting area was cold and uncomfortable. Changing facilities lacked dignity and privacy and we were informed that many people became distressed at having to walk through the public area to the theatre in a night gown. Others refused to change until they were in the theatre area

Access and flow

- We were informed that all oncology patients are seen at outpatients within the two-week timescale as per national guidance.
- The digital imaging service was meeting the two-week target for urgent patients. However, it was breaching the six-week target for more routine patients, particularly with regard to MRI scans, due to capacity issues. A small percentage of patients are waiting more than 10 weeks. Patients were prioritised according to clinical urgency. There was a plan in place to bring all waits down to within six weeks by purchasing additional days from an independent mobile provider. Average waiting times for patients to undergo a scan, once on site, were between 15 and 20 minutes.
- As at April 2014, 122 patients had been waiting over 18 weeks, which is the target for the longest time people should wait to be seen. The trust was closely monitoring this and a plan was in place to retrieve this situation by the end of June 2014. Some specialities were particularly problematic, such as gastroenterology,

respiratory medicine, dermatology and cardiology, due to issues such as problems in consultant recruitment, demand outstripping supply and short notice clinic changes.

- The required six weeks' notice of cancellation of clinics often did not happen, and there was a high level of short notice clinic changes.
- Waiting times for clinic appointments were displayed.
- Short notice clinics were frequently arranged to meet patient need, particularly in respect of the two-week waiting targets
- Senior nursing staff always ensured that all support services (staff and room) were in place to support the additional clinics, but there was insufficient strategic capacity planning.
- There had been an issue of overbooking at clinics, which masked capacity issues and led to long waiting times for patients. The General Manager had taken action to mitigate this by placing a ban on overbooking and focusing on correctness of clinic templates.
- Clinics often started late and over-ran as a consequence of waiting for records or doctors to arrive.

Meeting people's individual needs

- The audiology clinic offered a 'walk-in service' on Monday to Friday from 2pm to 4.30pm for hearing aid problems and battery collection.
- The pathology laboratory offered a one-hour turnaround for urgent requests and six hours for transfers from GPs. The laboratory had auto robotic analysers. They had received a large investment over the last four years and now form the hub of a centralised 'hub and spoke' system. This department felt well resourced, with excellent top grade equipment with plenty of capacity.
- Staff reported that the laboratories have been set up with excellent health and safety measures.
- This department is now developing a growing direct contact with patients, but space and location are a problem. There is no outpatient accommodation available for a haematology section on the ground floor.
- Plans were in place to develop a separate digital imaging service for outpatients with its own CT and MRI scanners. However, a lack of space is currently an issue and this will require relocating inpatient service. This was being assessed by the Director of Estates linked to PFI constraints.

Outpatients

- GP commissioning had impacted on the demand for digital imaging services, as doctors now require their patients to be scanned before referring to the outpatient department.
- GP patients were offered appointments up to 8pm on Saturdays and Sundays.
- A new fracture clinic had been established as a seven-day service and patients could be seen next day by a consultant following their visit to A&E.
- The digital imaging service operated seven days a week from 8am to 8pm, and an additional mobile scanner was available at weekends.
- One-stop clinics were operating in breast care and cardiology. Patients were informed in their initial appointment letter that a set of investigations would be carried out during their appointment, and to expect to need to be available for up to three hours.
- We noted good facilities for children in the waiting area.
- The design of the main hospital atrium meant that it was cold and draughty for patients sitting in some of the waiting areas.
- Clinics were all signposted, but the multitude of signage in the main atrium meant that it was visually confusing and not immediately easy to locate each clinic.
- Reception areas had recently been relocated, which should aid with patient enquiries.
- The majority of patients we spoke with complained about the lack of car parking spaces and many said that they had to drive around several times and wait a long time to find a space, or had parked some distance away.
- There is only one static CT scanner and one static MRI scanner for use by both inpatients and outpatients. Demand exceeded capacity for the scanners and in the short term, additional capacity was achieved by contracting with a private provider for a mobile scanner for two days a week.
- A business case had been made to purchase one additional static CT scanner and one additional static MRI scanner.
- It was a very busy patient environment, meeting the needs of both inpatients and outpatients, and the waiting areas were cramped.
- Demand for digital imaging services had been affected by the transfer of care of some surgical and trauma patients from west Cumberland Hospital in Whitehaven to the Cumberland Infirmary at Carlisle.

- The orthopaedic clinic was the furthest away from the front entrance and patients were required to walk a long distance. It had been acknowledged that patients had experienced long wait times to receive clinic appointments and long waits at the clinic itself. To mitigate this situation the clinic was due to be sited nearer to the entrance within the next few months and additional consultants were being recruited.

Learning from complaints and concerns

- The outpatient clinic service had received a recent complaint from a patient about not being responded to quickly enough at the reception area. The General Manager had spoken with the staff team and had instituted a greater focus on customer care and how patients were greeted on arrival.
- The Patient Advice and Liaison Service (PALS) reported that some patients had told them that they had experienced numerous cancellations of clinic appointments.
- PALS also reported that most informal complaints were about waiting times, linked to a lack of information and short notice cancellations, though most patients had had some notice of appointment changes.
- One patient reported that on a previous visit, they had arrived for oral surgery at 7am, not having been able to eat or drink anything, and were not informed until 4.30pm that their operation had been cancelled due to a consultant emergency. They were initially informed that it may take up to two months for a further appointment but were actually seen in three weeks.
- Digital imaging had been implicated in two complaints in the previous month with regard to how quickly they had provided the results. They had been able to track all the information and were able to respond that they had provided results within 24 hours.

Are outpatients services well-led?

Good



Senior managers held regular departmental meetings to discuss and monitor departmental performance. Performance was reported monthly and considered by the trust board. Plans for the service included addressing issues related to capacity planning. There was board ownership of the plans and a commitment at all levels to

Outpatients

secure the required improvements. Staff overall were positive about the Chief Executive and the engagement and visibility of senior staff. Staff had confidence in their managers and felt there was a new, strong culture of leadership.

Vision and strategy for this service

- The overall vision for the trust was visible throughout the outpatient area. It was available in poster format and on video.
- Most staff felt that the Chief Executive was cascading a strong vision, which had previously been lacking, and that she was clear about trust priorities. However, there was no local vision or strategy for the outpatients department.

Governance, risk assessments and quality measurement

- Feedback from managers showed that they felt the trust had now developed good governance arrangements and there was a strong audit trail of decisions and action planning.
- Monthly directorate meetings were held to discuss 'dashboard' monitoring, waiting times, actions times and reporting times.
- Clinical section leads meet weekly to discuss safety issues across modalities and issues are escalated weekly. Performance reports were provided monthly.
- The lack of CT/MRI capacity had been recognised at board level and funding was in place to obtain new equipment and efforts were being made to recruit additional radiologists. A paper requesting additional funding for skilled staff and funding of additional MRI sessions had been presented to EMT in September 2013. Approval had been received and recruitment had commenced immediately.
- Additional funding had been achieved through winter pressures funds, which had funded various initiatives including additional weekend mobile imaging provision. However, this funding had ceased at the end of March and following a benefits realisation paper, the funding was now fully included in the budget.
- Robust governance was in place in the digital imaging department. The first qualified member of staff who arrives for work in the mornings would ring through to the doctors with any unsuspected findings and those requiring urgent intervention.

Leadership of service

- Overall, staff were positive about the role of the new General Manager tier of management, who were felt to be effective, but also that they had a very large remit to the role. Staff felt well supported by managers. They felt that leadership behaviour in senior management meetings had improved, was now more professional and the managers were dealing with some longstanding issues.
- The lack of permanent consultant cover and the short duration of employment of many locums was having a significant impact on the provision of this service.

Culture within the service

- There was a very loyal, flexible and long established workforce who were committed to providing a good patient service.
- There was an overwhelming view that services worked well due to the 'goodwill' of staff.
- Staff coped well with the continual challenges within the service and demonstrated a commitment to address them.
- Overall, staff were positive about their future at the trust.
- Staff reported that the culture in meetings now feels more about openness and learning, and that discussions are focused on resolution. Staff now feel 'safe' to say if something didn't go well or offer constructive criticism.
- They also said there is also much reduced tension in the doctor /manager relationship.

Public and staff engagement

- Staff told us the Chief Executive was felt to be a strong leader
- The Chief Executive was said to be visible with a genuine desire to find out what is going on and answer questions or understand what the issues are and how to resolve them.
- Overall, staff felt valued and well-led.

Innovation, learning and improvement

- The digital imaging department has been working with Northumbria University to become part of a training programme to develop and train radiographers. The trust hoped that this would also lead to benefits in terms of eventually recruiting 'home-grown' consultant radiologists.
- The department is also training its own stenographers to support timely record keeping and correspondence.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital **MUST** take to improve

- Ensure that there are sufficient numbers of suitably qualified, skilled and experienced nurses to meet the needs of patients at all times.
- Ensure medical staffing is sufficient to provide appropriate and timely treatment to patients at all times.
- Ensure that all staff within departments in the hospital have the required skills to meet the needs of patients at all times.
- Take action to ensure that the planning and delivery of patient care and treatment is consistently carried out in accordance with published research and guidance issued by professional and expert bodies.
- Review the use of a formal acuity tool to assist in calculating the appropriate level of staff needed.
- Ensure that all equipment is stored safely.
- Ensure emergency equipment is complete and fit for purpose.
- Ensure that children are consistently risk assessed at the time of arrival into the paediatric department to meet national standards.
- Ensure triage services in A&E are always effectively staffed by appropriate personnel.
- Improve patient flow throughout the hospital to reduce waiting times in the A&E department.
- Develop a standard governance system across all surgical specialities to ensure surgical dashboard information is discussed, recorded and disseminated to all staff.
- Ensure that any children who are treated on the adult intensive care unit receive care that is appropriate for their age.
- Ensure that the maternity service reviews its identified risks and implements sufficient actions to mitigate them.
- Ensure that risk management processes in the maternity service are embedded to implement a robust quality assurance checking mechanism across the service to ensure an effective service.
- Ensure that the risk register for the hospital's children's ward accurately reflects the risks identified in the completed audits and reviews.

- Take action to protect the health and welfare of children and young people with mental health needs by ensuring that appropriate health and social care support is provided in collaboration with other providers.
- Ensure that good practice guidance in infection control is followed in the special care baby unit, particularly in relation to the management of clean and dirty laundry.
- Take action to prevent the build-up of refuse in dirty utility rooms at busy times.
- Develop a formal End of Life Care standard framework to assure safe, effective care at the end of life. Plans need to be in place to formally replace the Liverpool Care Pathway by July 2014.
- Address the problem caused by the downdraft air ventilation system in the mortuary, which was posing an infection risk.
- Improve how patient records are made available for outpatient appointments and clinics.
- Ensure that information about 'How to make a complaint' is accurate. We found that some complaint leaflets were available, but information for both the role and contact details for the Care Quality Commission was out of date and inaccurate and did not clearly direct people to the Public Health Service Ombudsman.

Action the hospital **SHOULD** take to improve

- Ensure effective patient flow through the A&E department to cope with its routine workload and reduce patient waiting times.
- Take action to prevent patients being moved between wards during the night.
- Ensure that a major incident plan for the surgical directorate is available and regularly tested.
- Ensure adequate services for patients who are accommodated in A&E overnight while waiting for a bed in the hospital.
- Make improvements to the major haemorrhage protocol to bring it into line with national standards.
- Ensure staff are aware of, and have access to, a robust policy for transferring sick children to tertiary children's hospitals.

Outstanding practice and areas for improvement

- Continue to develop robust audit processes to verify staff adherence to the 'five steps to safer surgery' and World Health Organisation (WHO) procedures.
- Ensure that the surgical service uses patient-reported outcome measures (PROMS) data effectively.
- Make sure that staff on the children's wards document whether children are able to be involved in making decisions about their care and treatment.
- Improve access to equipment and provide more suitable storage for larger pieces of equipment.
- Improve staff training with regard to all care bundles.
- Improve support given to junior medical staff.
- Improve the management of people with diabetes and stroke in line with national guidance.
- Improve the management of people living with dementia.
- Clarify a leadership role with a clear remit to promote 'normality' in child birth as supported by the Royal College of Midwives Campaign for Normal Birth and the National Childbirth Trust Birth Policy.
- Improve the use of information technology to improve the effectiveness of data flows. We were told that approval had just been given to introduce the IT data.
- Take the necessary action to ensure that staff have the opportunity to regularly discuss their personal development and any issues or concerns.
- Show how it has responded to information from patients, relatives and staff, and used this information to develop the service.