North Cumbria University Hospitals NHS Trust

West Cumberland Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

At the previous inspection in April 2014 we found that since our last inspection and the Keogh review, there had been a significant improvement in mortality rates, which were now within expected limits. Infection rates had also improved and were within expected limits. There were numerous consultant vacancies that were adversely affecting timely treatment for patients and effective support for junior doctors in a number of core services. Nurse staffing levels, although improved, remained of concern and there was a heavy reliance on staff covering extra shifts, and bank and agency staff to maintain adequate staffing levels. Adequate staffing levels were not consistently achieved in all core services.

There had been changes to the functions regarding the management of trauma, high risk general surgery and colorectal cancer patients, which began in June 2013. This care had transferred to the Cumberland Infirmary in Carlisle. This has led to routine elective work being regularly cancelled at the Cumberland Infirmary, but the transfer of routine work to West Cumberland has not been as systematic as anticipated, as patients preferred to wait to have their procedure at Carlisle. The distance between the two sites appeared to be a major factor in patients' decisions regarding where to have their surgery rather than the quality of care delivered. This had exacerbated the trust's inability to meet referral to treatment time (RTT) targets for admitted patients, particularly in orthopaedics. Communication from the executive team with front line staff had improved. However, we were concerned about the culture within the trust as we received a high number of anonymous whistleblowing concerns before, during and after the inspection. This demonstrated a lack of openness and that staff felt unable to share their concerns with the trust directly.

At this inspection our key findings were as follows:

Medical Staffing

- Medical staffing in the emergency department consisted of three consultants with vacancies for another three consultants. Two of the posts were covered by locums.
- In medicine, in February 2015, five out of seven consultants in on call positions were filled by locums and all resident doctors were locums. At the time of our inspection there were consultant vacancies in specialist posts such as gastroenterology, respiratory, care of the elderly and general cardiology. A medical workforce review produced by the trust, which is dated February 2015, described the nature of medical cover at the hospital as "fragile and unsustainable".
- In surgery during February 2015, there were nine whole time equivalent consultants employed by the hospital, which met the consultant establishment requirement. Additional cover was also provided by one locum consultant during the month. The wards and theatres we inspected had a sufficient number of medical staff with appropriate skills to ensure that patients were safe and received appropriate care. We found there was sufficient on-call consultant cover over the 24-hour period and there was sufficient medical cover outside of normal working hours and at weekends.
- There were five vacancies for consultant anaesthetists at the hospital during February 2015. The hospital used a locum consultant anaesthetist to provide additional cover during the month. The clinical business unit director told us they had appointed four anaesthetists during March 2015 to address the shortfall across both hospitals. The consultants had not yet commenced their employment at the time of our inspection.
- At our last inspection there were concerns raised that there was no dedicated anaesthetist for the maternity services and one consultant anaesthetist during the night who was available for both maternity services, general surgery and intensive care. The position remained the same at this inspection. We raised this with the trust who took immediate action to improve anesthetic cover in these areas. In gynaecology the number of consultants had increased since the last inspection and there were now no vacant posts. Those recruited had a variety of interests including gynaecology, oncology, foetal medicine and minimal access gynaecology. This had led to an increase in the services offered, such as laparoscopic surgery. There should be seven middle grade doctors employed by the trust however there were five locum middle grades working at the time of the inspection.

Summary of findings

- In children and young peoples services there was still a shortage of medical staff that meant consultants were filling in gaps in the rota and there was a reliance on locum staff at both junior and middle grades.
- Within the radiology department the service was challenged in recruiting senior radiologists in particular a senior MRI radiologist for the new hospital.

Nurse Staffing

- In urgent care the trust was reviewing the draft NICE guidance at the time of the inspection and confirmed professional judgement was currently applied in relation to safe staffing levels and additional nurses had been approved by the board in March 2014 based on this judgement.
- We observed the numbers of nursing staff in A&E to be below requirements especially when the number of patients increased.
- There was no provision for a specific paediatric trained nurse in the A&E department. At the time of the inspection, a nurse had been transferred from the children's ward and was working in a supernumerary capacity within the department to support the paediatric element of A&E care. The trust had recruited 2.8 whole time equivalent (WTE) Emergency Nurse Practitioners (ENP) to work in the new hospital; one ENP was in post and a further two were due to start their employment in the following weeks.There were a total of 12 advanced nurse practitioner (ANP) posts which the trust were recruiting into at the time of the visit.
- Although nurse staffing levels had improved since our last inspection, there were still high nurse vacancy rates on some medical wards. Of particular concern were the trained nurse staffing levels on Pillar/ Patterdale ward where there were six whole time equivalent vacancies, increasing to eight within two weeks of our inspection.
- The surgical wards and theatres we inspected had sufficient numbers of trained nursing and support staff with appropriate skills to ensure that patients received appropriate care.
- The surgical wards were supported by a team of Advanced Nurse Practitioners (ANP'S) with at least two ANP's on shift over a 24-hour period. This included at least one nurse trained as a nurse prescriber. However some were still undergoing training and were not yet able to carry out all aspects of this role.
- Nurse staffing levels were appropriate to meet the needs of Children and young people.
- The midwife to birth ratio was 1 to 24. This was better than the England average which was 1 to 28.
- In maternity there were now surgical assistants, which were qualified nurses who had completed additional training so they could assist in operating theatres should there be a need for an emergency caesarean section out of hours or when a team of theatre personnel were not available.
- A rolling recruitment programme to fill vacant nursing posts was on-going. Several new initiatives had been implemented, including an increase in the student nurse intake to two per year, with a view to retaining them once qualified and partnership working with other trusts. The trust was in the process of recruiting 50 nurses from the Philippines.

Patient outcomes

- Performance reported outcomes measures (PROMs) data between April 2013 and March 2014 showed that the percentage of patients with improved outcomes following groin hernia, hip replacement, knee replacement and varicose vein procedures was either similar to or better than the England average.
- The average length of stay for elective and non-elective patients across all specialties was better the England average.
- The rate of normal births was in line with the England average and maternal readmission rates were in line with the England average.
- .A local audit of End of Life Care had taken place as a base line for the pilot of the new End of Life Care plans. This showed that patients had access to anticipatory medications for pain and distress at the end of life. There were no robust systems in place to monitor that all patients received good end of life care.
- Outcomes for stroke patients between April to September 2014 had improved with the Sentinel Stroke National Audit Programme (SSNAP) showing the trust's stroke services moved from an 'E' rating to a 'D' on a scale of A to E, with A being the best.

Summary of findings

- The latest National Diabetes Inpatient Audit (NADIA) 2013 showed that the hospital was performing below the England average in 10 of the 21 indicators and was unchanged from the previous inspection.
- Submission of data to the Intensive Care National Audit and Research Centre (ICNARC) was now consistent. The data showed that patient outcomes and mortality were within the expected ranges when compared with similar units nationally.
- Myocardial Ischaemia National Audit Project (MINAP) showed that West Cumberland Hospital achieved a similar or better performance than England averages.
- National Diabetes Inpatient Audit 2013 showed that the hospital was performing below the England average in 11 of the 21 indicators.
- The national joint registry data up to July 2014 showed that hip and knee mortality rates were in line with the national average.
- The lung cancer audit 2014 showed the trust performed better than the England and Wales average for the number of cases discussed at multidisciplinary meetings and the percentage of patients having a CT scan before bronchoscopy. The trust performed worse than the England and Wales average for the percentage of patients receiving surgery in all cases (9.8% compared with the average of 15.1%).
- The national bowel cancer audit of 2014 showed that the trust was performing better than the England average for the number of patients that had a CT scan, the number of patients for whom laparoscopic surgery was attempted and length of stay above five days.
- The Trust had not participated in the Care of the Dying National Audit. However, we were given assurances that the Trust would participate in 2015.
- High risk clinical pathways within the trust had been reviewed, including the stroke pathway. A business case was in the final stages of development.

Access and flow

- The trust had done extensive work to investigate why the 4 hour waiting target was sometimes exceeded. Factors contributing to poor performance included bed occupancy within the hospital, which had been above the England average of 85% between April 2013 and September 2014 for general and acute beds.
- The A&E department met the target between April 2014 and September 2014 with a range of 95.9% to 97.9% compliance with the four hour target. However, over the second half of the year, West Cumberland Hospital only achieved the target in November 2014 (95.1%) with the lowest achievement in February 2015 (86.3%). All individual breaches of the four hour target were investigated. At the time of our inspection we found that a number of four hour target breaches had occurred. We found patients who had been in the department for over seven hours and others that had been in the department for five hours. One patient had stayed overnight in the monitoring bays. Overall a total of 12 patients waited for more than 12 hours from the decision to admit to being admitted in the last quarter.
- Bed occupancy in the trust overall exceeded the England average throughout 2014, with bed occupancy levels for medical patients frequently in excess of 100%.
- The excessive number of medical patients meant they were being cared for on all of the surgical wards. This was having a negative effect on the numbers of operations that were cancelled. Trust data for all operations cancelled across the trust (including prior to admission and on day of surgery) showed that there had been a total of 695 operations cancelled for non-clinical reasons between January and March 2015, and 419 (62%) of these cancellations were due to ward beds unavailable and bed shortages. Medical review of medical patients being cared for on surgical wards varied. Some consultants would visit the ward regularly to review patients, while others did not. We reviewed eight sets of records of medical patients who were receiving care and treatment on surgical wards and found that none of them received a daily review during the week, with four receiving a review only twice weekly. We spoke with three of these patients who told us they were unhappy about the frequency of medical reviews.

Summary of findings

- Beds were frequently occupied by patients, otherwise fit for discharge, who were awaiting transfer to Carlisle Infirmary for diagnostic tests such as angiograms. We reviewed the records of two patients who had been waiting seven and eight days for this procedure. Staff confirmed that these waits were unusually long, but that a wait of three or four days was normal.
- Bed management meetings were held throughout the day. We found these to be disorganised and lacking basic essential information, such as exact patient numbers. The meetings were too focused on the specifics around the care and treatment of individual patients rather than the flow of patients throughout the hospital.
- Referral to treatment times were close to meeting national targets but up to December 2014 the percentage of patients waiting longer than 6 weeks for diagnostic tests was almost 12% against a target of less than 1% and in dermatology and rheumatology where no patients had been seen within 18 weeks. There had been a deteriorating trend in the referral to treatment times across the medical specialities throughout the last year.
- NHS England data showed national targets for 18 week referral to treatment (RTT) standards for admitted patients were not achieved between April 2013 and November 2014. There was an on-going action plan to improve performance against RTT standards for each specialty. This included key actions such as improved planning to reduce the back log of patients, improving theatre capacity and use of private sector healthcare organisations to treat patients awaiting surgery.

Importantly, the trust must:

Urgent and Emergency care

- Ensure equipment is stored correctly, decontaminated effectively and all single use items are within expiry date.
- Provide safe and secure storage for medication with access limited to qualified staff only.

Surgery

- Improve compliance against 18 week referral to treatment standards for admitted patients.
- Improve number of patients whose operations were cancelled and were not treated within the 28 days.

Medicine

- Improve medical staffing levels.
- Increase numbers of trained nurses.
- Improve the way in which medicines are stored.
- Provide sufficient infusion pumps so that there are pumps always available for patient use.
- Ensure the requirements of the Mental Capacity Act 2005 are followed with regard to the application of Deprivation of Liberty Safeguards.
- Improve the routine review of medical patients receiving care and treatment on wards outside their speciality.

Maternity

- Ensure out of hours surgical cover to protect the safety of patients in a surgical emergency.
- Ensure a dedicated obstetric anaesthetist is available at all times.
- Ensure that resuscitation equipment is appropriately checked in order to that it is suitable for use at all times.
- Ensure the safe management and storage of medicines in the maternity unit.
- Ensure medical and midwifery staff are up to date with the training necessary for their role.
- Improve the governance arrangements to include investigation of the higher than target rate of unexpected admissions to the neonatal unit; the potential wait for patients requiring a termination of pregnancy from referral to procedure, especially when medical staff were absent from work; the necessary measures to adequately manage patients with a high body mass index, multi-disciplinary clinics which should be routinely available for patients with complex needs or multiple health needs; possible extension of the early pregnancy service to a seven day service, the standardisation of the post natal listening service across the trust and introduction of mechanism for monitoring the number of cancelled inductions of labour.

Summary of findings

Services for Children
- Review the consultant paediatric cover provided out of hours. This was a concern as the service still offered a 24 hour emergency service for children and young people.
- Recruit a ward manager and ensure oversight from a matron.

Outpatients and diagnostics
- Recruitment of senior radiologists in particular a senior MRI radiologist and ultrasound radiologist.

End of Life
- Improve the accurate completion of DNACPR forms.

In addition the trust should:

Urgent and Emergency care
- Improve the four hour wait target results.
- Improve the mandatory training completion rate.

Medicine
- Ensure that medical staff document information in patient records appropriately.
- Work towards JAG accreditation in endoscopy.
- Improve access to psychiatric review.
- Improve access to information systems for newly appointed doctors and locums.
- Continue with plans to improve outcomes for stroke patients.
- Implement the Butterfly scheme on all medical wards
- Review and improve bed management.

Surgery
- Improve bed capacity on the surgical wards.

Maternity
- Systems to protect the privacy and dignity of gynaecology patients accommodated on a mixed sex ward should be in place.
- Improve incident reporting, monitoring and mechanisms for sharing learning across the whole staff team on both sites.
- Complete the actions identified on the mortality action plan within the agreed timescales.
- Improve the level of staff with up to date with training in the prevention and control of infection.
- Medical staff should be up to date with practical obstetric multi-professional training.
- Staff should have information and advice regarding the management of patients who may have received female genital mutilation surgery.
- Make sure the emergency pager system works in all parts of the hospital for all staff.
- Audits of clinical practice should included recommendations and actions where a shortfall in provision is assessed.

Services for Children
- Progress work regarding the longer term strategy for children's services.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	Following our inspection in April 2014 we found the urgent and emergency services at West Cumberland Hospital required improvement. In the course of this inspection we found that although there had been improvements in practice the overall rating of requires improvement remained unchanged. Staffing levels were not always sufficient to meet patients' needs. Mandatory training levels were below the trust target of 80%. Staff had difficulty finding time to do their training as a result of staffing pressures. In addition, checks of essential equipment and medication were not always completed appropriately or in a timely way. Care and treatment was provided in accordance with national guidance and evidence based practice. Multidisciplinary team working was well established and staff worked well together for the benefit of patients. Suitable processes were in place to obtain patient consent and staff understood the legal requirements of the Mental Capacity Act 2005.Patients spoke positively about the care and treatment they had received and we observed many positive interactions between staff and those in their care. However, the hospital struggled to meet the Department of Health target to admit, transfer or discharge patients within four hours of arrival over the second half of the year, with only 86.3% compliance in February 2015. Senior staff in the department provided visible leadership, particularly at times when the department was stretched. However, morale was low within the service as staff felt they were pressured to meet targets. Staff were anxious about the future of the service in light of proposals for service reconfiguration and the transfer of acute services to Carlisle infirmary.
Medical care	Inadequate 	Following our inspection in April 2014 we found that elements of the medical services at West Cumberland Hospital were inadequate. In the course of this inspection we found that the rating of inadequate remained unchanged.

Summary of findings

Medical cover at the hospital remained fragile and was presenting a significant risk to the care of patients. Junior medical staff did not have access to consistent and effective leadership due to the extreme shortages of senior medical staff within the medical specialties. Although nurse staffing had improved it remained a challenge and we found shortages of trained nursing staff on some of the medical wards.

There were also shortages of some essential equipment and the way in which medicines were stored required improvement.

Outcomes for patients were mixed, with outcomes for stroke patients being particularly poor, although action was being taken to improve patient experience and outcomes in this regard. The lack of available of medical beds was very apparent. The high numbers of medical patients placed in areas not suitable to their needs was having a negative effect on the routine review of patients. Patients were not always reviewed in a timely way.

Bed management meetings were disorganized and lacked basic essential information and were not as productive as required in managing patient access and flow within the service.

Surgery

Good

Surgical services had significantly improved since our last inspection. Staffing levels and skill mix was sufficient to meet patients' needs. The staffing levels in the wards and theatres were maintained through the use of bank and agency staff, as well as existing staff working additional hours.

There were no consultant vacancies during February 2015. Locum doctors were used to provide cover for consultant surgeons and anaesthetists. Ward staff were also supported by a team of advanced nurse practitioners.

Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in safe, clean and suitably maintained premises. Medicines were stored and administered appropriately.

The surgical services provided effective care and treatment that followed national clinical guidelines.

Summary of findings

The surgical services performed in line with similar sized hospitals and performed within the England average for most safety and clinical performance measures.
The majority of patients had a positive outcome following their care and treatment, receiving care and treatment by trained, competent staff. Patients spoke positively about their care and treatment.
However, the surgical services had failed to meet 18 week referral to treatment standards across all specialties between July 2013 and September 2014.
There was insufficient bed capacity in the wards due to surgical beds being occupied by medical patients. This meant that operations were frequently cancelled. The number of patients whose operations were cancelled and were not treated within the 28 days was worse than the England average between July 2013 and September 2014.
There was effective teamwork and clearly visible leadership within the surgical services. Staff were positive about the trust.

Critical care

Good

The critical care unit at West Cumberland Infirmary in Whitehaven was commissioned for five level 3 beds or four level 3 beds and two level 2 beds, which were used flexibly as the service demanded. All six of the available bed spaces were equipped to provide level 3 care and treatment. There was also a side room with an atrium or gowning area that was used for patients with specific infection control issues. The side room could provide either positive or negative pressure as required. At the time of our inspection there were four patients on the unit.
The unit is old with limited space and can only be accessed by walking through the endoscopy unit. It falls significantly short of most recent health building note (HBN-04-02) specifications.
For the purposes of governance the unit sits in the emergency care and medicine business unit.
During the inspection we spoke with two medical staff, nine members of the nursing team, two patients and two sets of relatives. We also reviewed patient records, policies, guidance and audit documentation.

Maternity and gynaecology

Requires improvement

In the course of this inspection we found that the service had made inspection insufficient improvement to provide high risk patients with an

Summary of findings

effective service. There was still no dedicated second theatre and the lack of dedicated medical staff and surgical cover out of hours still presented a risk to patients who required surgery. There were however sufficient numbers of midwives to meet patient needs.
There had been an increase in the clinical and quality audits completed however resulting actions for improvement and change were not always articulated and followed up. There were some concerns regarding medicines management and how learning from errors was managed and shared.
There had been positive changes made in the gynaecology services to improve the patient's experience.

Services for children and young people	**Good**		Following our last inspection it was evident that the service had made some improvements to prevent avoidable patient harm. It was evident at this inspection that these improvements had been maintained. Children and young people received their care in a visibly clean environment. Child Safeguarding was well understood and supported by staff training. Nurse staffing levels were appropriate to meet the needs of Children and young people. However there was still a shortage of medical staff that meant consultants were filling in gaps in the rota and there was a reliance on locum staff at both junior and middle grades. Consultant paediatric cover was provided out of hours by a consultant on call. Care and treatment was delivered in accordance with NICE guidance. The service participated in the national audit programme including the paediatric diabetic and asthma national audits. Where shortfalls were identified, action plans were completed and implemented to secure improvement. There was a positive, child centred culture within in the service. Staff were motivated and offered care that was kind, sensitive and supportive. Governance arrangements had been strengthened and cross site working with the children's service in Carlisle was providing good opportunities for the sharing of information and good practice.
End of life care	**Requires improvement**		There was evidence of improvement in this service since our last inspection; We found that space to

develop bereavement offices on the site had been identified. There were plans in place to develop a Bereavement Support Team. A Bereavement Information booklet was near completion.
In response to the national withdrawal of the Liverpool Care Pathway, a new End of Life Care Plan had been developed. This was in a draft format and had been piloted in the hospital. Senior staff were more aware of how the service should be developed and were active in taking the service forward.
We saw eight DNACPR forms which were inconsistently completed. This was supported by the Trusts annual audit figures for DNACPR which showed 54 of 276 forms (19%) were not fully completed.
An End of Life and Bereavement Group had commenced in July 2014 which included representation from the chaplaincy service, medical, nursing, administration, porters and other external providers of care. Its remit was to review how standards for end of life care could be enhanced. A draft strategy for end of life care had been developed and would be overseen by the group reporting to the Safety and Quality Committee.
Formalisation of the governance mechanisms was within the service was still required .For example a structured service level agreement with a neighbouring trust so that clear collaborative working using specific parameters to measure performance and delivery was formally agreed and understood.

Outpatients and diagnostic imaging

Good

At the previous inspection we found and reported a serious concern regarding the management of systems for patient records, which impacted on both staff and patients. At this inspection the availability of records had significantly improved with 98% of patient records available at the start of clinics. The storage of records had also significantly improved with off site storage in place.
There were challenges with consultant recruitment. There were a number of consultant vacancies in ophthalmology. The lack of an ultrasound radiologist had resulted in patients waiting over six

Summary of findings

weeks for vascular and musculoskeletal scans. A full time manager had been recruited and an outpatient's improvement group had been established.
An Intensive Support Team (IST) had been commissioned from July to December 2014 to develop capability and support the development of robust demand and capacity plans to deliver sustainable 18 week Referral to Treatment Times (RTT). However, RTT in most specialties were below the target rate and patients could wait for longer than average for diagnostic tests. Morale had improved and staff were motivated and positive about the management changes.

West Cumberland Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging

Detailed findings

Contents

Background to West Cumberland Hospital

Along with the Cumberland Infirmary in Carlisle, the West Cumberland Hospital in Whitehaven delivers acute care services as part of North Cumbria University Hospitals NHS Trust. The West Cumberland Hospital structure no longer meets modern needs, and a £97 million Phase 1 redevelopment of the hospital is currently underway. 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 inspection in June 2013 and CQC inspections in October 2013 and A.

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 two Inspection Managers, nine CQC inspectors and a variety of specialists including Clinical governance experts; a safeguarding expert; Clinical Manager NHS 111 / Advanced Care Paramedic; Consultant in Palliative Care; Honorary Consultant Physician; Professor of Surgery; Consultant Obstetrician & Gynaecologist; Speciality Doctor Anaesthetics; Consultant Paediatrician & Honorary Senior Lecturer; Specialist Registrar Vascular Surgery ST5; Nurse; End of Life Nurse; Lead Surgery/Post Anaesthetics Nurse; Leadership Consultant and Physiotherapist; A&E Emergency Nurse Practitioner; Head of Midwifery; Senior Nurse, Chief Nurse; Advanced Paediatric Nurse Practitioner; Fellow of the RCP and a sexual health consultant 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?

Detailed findings

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

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

We carried out an announced inspection visit of the hospitals between 31 March and 2 April 2015. We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, junior doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested. We talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment. We did not carried out an unannounced inspection at this hospital.

Facts and data about West Cumberland Hospital

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

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Urgent and emergency services

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

Information about the service

Urgent and emergency services were provided across two sites as part of North Cumbria University Hospitals NHS Trust. The consultant-led emergency department at West Cumberland Hospital consists of an accident and emergency department (A&E) that is open 24 hours a day, seven days a week, providing urgent and emergency care and treatment for children and adults.

The A&E department at West Cumberland Hospital saw just over 32,000 patients between April 2014 and March 2015.

There were separate walk-in and ambulance entrances with a main reception which was staffed 24 hours a day. Within the main department there were two beds in the resuscitation area, one of which was used for paediatric patients when necessary. Four minor treatment cubicles and three monitored cubicles were adjacent to the nursing station. A five-bedded major's facility was open from 10am to 8pm Monday to Friday. When this facility was closed, the three monitored cubicles adjacent to the minor's area were used to treat major's patients.

As part of our inspection we visited the emergency department during our announced inspection on 31 March 2015. We spoke with patients and relatives, observed care and treatment and looked at care records. We also spoke with a range of staff at different grades including the matron for A&E, the clinical lead, consultants, associate specialists, nurses of various grades, a student nurse as well as ambulance staff. We received comments from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Summary of findings

Following our inspection in April 2014 we found the urgent and emergency services at West Cumberland Hospital required improvement. In the course of this inspection we found that although there had been improvements in practice the overall rating of requires improvement remained unchanged.

Staffing levels were not always sufficient to meet patients' needs. Mandatory training levels were below the trust target of 80%. Staff had difficulty finding time to do their training as a result of staffing pressures.

In addition, checks of essential equipment and medication were not always completed appropriately or in a timely way.

Care and treatment was provided in accordance with national guidance and evidence based practice. Multidisciplinary team working was well established and staff worked well together for the benefit of patients. Suitable processes were in place to obtain patient consent and staff understood the legal requirements of the Mental Capacity Act 2005.Patients spoke positively about the care and treatment they had received and we observed many positive interactions between staff and those in their care. However, the hospital struggled to meet the Department of Health target to admit, transfer or discharge patients within four hours of arrival over

Urgent and emergency services

the second half of the year, with only 86.3% compliance in February 2015. Senior staff in the department provided visible leadership, particularly at times when the department was stretched.

However, morale was low within the service as staff felt they were pressured to meet targets. Staff were anxious about the future of the service in light of proposals for service reconfiguration and the transfer of acute services to Carlisle infirmary.

Are urgent and emergency services safe?

Requires improvement

At the previous inspection we reported the service was provided in a suitable environment by trained, competent medical and nursing staff. The standard of cleanliness was good. There was good access to medicines, which were handled safely. Electronic patient care and treatment records were used effectively to track the patient's care and there were good mechanisms in place to monitor patients and escalate their care. There was a culture to report incidents, and evidence showed that staff reported and reviewed incidents and took action accordingly and therefore were learning from incidents.

There were nursing staff vacancies but these were being recruited to and the staff requirements were being met through overtime and bank. There were three whole time equivalent (WTE) consultants covering the department, of which one was covered by a locum.

At this inspection the nurse staffing levels met the criteria set through in-house data which had been analysed to account for peaks and troughs in attendances and used to inform staffing numbers but not when the department was busy and didn't account for the five-bedded major's facility which was opened in September 2014. The trust was recruiting 12 advanced nurse practitioners (ANP) (trained nursing specialists who could efficiently care for patients, avoiding admission to hospital). The trust had recruited 2.8 whole time equivalent (WTE) Emergency Nurse Practitioners (ENP) to work in the new hospital; one ENP was in post and a further two were due to start their employment in the following weeks.

Medical staffing had improved slightly and consisted of three consultants with vacancies for another three, two of which were covered by locums. There was no specific paediatric consultant but one was available on-call if required.

Sterile single use equipment such as swab packets, masks and paediatric airway tubes were past their expiry date. Medications for the minor's area were kept in the eye and ear, nose and throat room which caused a disturbance to any patients being treated if drugs had to be collected. Drugs such as adrenaline (used for emergency

resuscitation), were stored in an unlocked drawer in the resuscitation room that could be accessed by all staff. Checks for equipment and medication were not always completed appropriately or in a timely way. Mandatory Training levels were below the target of 80%.

Incidents

- Incidents were raised via the electronic incident reporting system. A policy was in place to support this. Staff were confident about reporting incidents, near misses and poor practice.
- The top incidents reported at Whitehaven were lack of resources, issues in transport, security of persons and treatment and patient care. From these the most incidents were raised for delays in patient treatment and lack of beds.
- Staff were able to describe recent incidents and clearly outlined actions that had been taken as a result of incident investigations to prevent reoccurrence.
- Learning from incidents was shared across the department via noticeboards, newsletters and at handovers.

Cleanliness, infection control and hygiene

- All areas were clean, well maintained and in a good state of repair. Staff knew about current infection prevention and control guidelines and we observed good practices such as hand washing facilities and hand gel being available throughout the departments. We noted one sink in the minor's area behind the nurse's station that was low sink and didn't meet current guidance. Staff were using this sink as opposed to the one at the other end that met the current guidelines.
- Staff followed hand hygiene and 'bare below the elbow' guidance and staff wore personal protective equipment, such as gloves and aprons, while delivering care.
- Data showed that healthcare-associated infections MRSA and Clostridium difficile (C.diff) rates for the trust were within expected limits. There were no cases of C.diff attributed to the A&E department for the previous year.
- The policy was to screen all patients admitted to a ward area from A&E for MRSA. The electronic patient administration system made a note and tracked all patients with any infectious conditions so staff could be alerted.

Environment and equipment

- The admission route was set up so patients who self-presented and those conveyed by ambulance had their own entrances. Patients at risk of deteriorating or those with high acuity were placed in cubicles visible from the nursing stations for quick intervention.
- Staff had a cloakroom in the majors area used to store their personal belongings and to change into work uniforms in. This was key coded on the outside but there was no lock on the inside which meant other staff could walk in. This wasn't segregated for males and females.
- The x-ray service could be easily accessed from the department.
- The relative's room was used by the CRISIS team to assess patients with metal health needs. The room was inadequate for this as it had moveable furniture and no emergency alarms and the door didn't open two ways as per the guidance for secure rooms used to assess patients with mental health needs (Mental Health Act (1983)).
- The resuscitation area had two cubicles with one designated for children. The cubicles were all well-equipped for adult and paediatric patients. We saw equipment in place for specific procedures that may only be carried out several times a year. However, we noted two "grab boards" on the wall in two of the bays where staff could access equipment promptly. These had opened and uncovered instruments such as syringes, scissors and laryngoscope blades with dust and dirt on them. There were no checks to ensure this equipment was clean and maintained.
- Sterile single use equipment was available throughout all areas. However, we noted that items such as swab packets, paediatric airway equipment, sterile strips, films and coatings were past their expiry date with some items having expired since 2010. The decontamination room had masks that were ordered for outbreaks that had expired since March 2012.
- Electrical and mechanical equipment was appropriately checked and decontaminated. Staff confirmed all items of equipment were readily available and any faulty equipment was either repaired or replaced efficiently.
- Checklists for daily, weekly and monthly checks of equipment were available in the resuscitation trolleys and within the cubicles. However, we noted the

paediatric resuscitation trolley had not been checked regularly. Weekly checks were supposed to be done every Tuesday but the paperwork was not signed nor dated as being done.
- The plaster room was used a as "dumping ground" with items such as beds and blood pressure monitoring equipment stored there. The room couldn't be used as it was intended. Staff told us items were left here as it was "more convenient than taking them back to their actual place of storage".

Medicines

- Pharmacy staff were responsible for maintaining minimum stock levels and checking medication expiry dates.
- When issuing medication for patients to take home, the prescriptions and drugs dispensed were checked by two nurses.
- We checked the storage and balance of controlled drugs in the emergency department and found the stock balances were correct and the registers had been signed by two members of staff upon dispensation. The volume of any wasted drugs was recorded accurately where necessary.
- Medicines were generally stored correctly and safely in locked cupboards or fridges and temperatures were recorded where necessary throughout the emergency department.
- However, the drugs for the minor's area were kept in the eye and ear, nose and throat (ENT) which caused inconvenience to any patients being treated if drugs had to be collected.
- We also noted drugs such as adrenaline and pain killers, used for emergency resuscitation, were stored in an unlocked drawer in the resuscitation room. Although the room was accessed by a key coded lock, it was apparent many staff, including porters, knew the access code and we saw them enter and leave the room unsupervised. The matron showed us a daily reconciliation sheet for the drugs. Staff had ticked the sheet to confirm they had checked the drug was available but hadn't followed procedure and noted the quantity of each drug. This meant drugs could be taken unnoticed.

Records

- The emergency department had developed its own patient clinical assessment records for adults and children. Information was completed around personal details, previous admissions, alerts for allergies and observation charts. All records were kept securely and confidentially.
- The integrated electronic care record tracked the patient through the department. We reviewed five patient records and saw the patients' care and treatment was carried out in accordance with their needs. One patient had been reviewed by a stroke nurse and had the associated observation charts in place and another patient had an allergy to penicillin which was clearly identified at triage and highlighted in the notes.
- One patient record stated a patient had arrived at 2am and had been assessed as needing a mental health assessment. The patient was left to sit in the waiting area and didn't leave the hospital until 8pm the next day. A sister stated this patient had received food and fluids but this wasn't evidenced in the notes we reviewed.
- The department had an electronic booking in system which tracked all the patients in the department and those who needed to be moved to the ward areas. This screen with all the patient details such as names, date of birth and presenting ailment could be seen in the receiving ward areas. Staff raised concerns this caused confidentiality issues especially when staff had previously been admitted to A&E.

Safeguarding

- Policies outlined processes for safeguarding vulnerable adults and children. Data showed all staff were currently up to date with training in vulnerable adults and children.
- Staff confirmed they could contact the safeguarding team, social services or a health visitor if a patient was suspected of being at increased risk of neglect or abuse.
- It was mandatory for staff to complete a safeguarding trigger in the clinical assessment record for all children who attended A&E. The electronic patient record system alerted staff to any previous safeguarding issues. The reception staff would also make a specific note upon admission and alert the staff if any current flags had been raised.
- Safeguarding records were generally well completed but one for a looked after child had not been completed correctly. The name, date of birth, address and parental details weren't fully completed.

Urgent and emergency services

Mandatory training

- Staff had received an induction specific to their role when they had begun work in the department.
- Induction checklists included departmental safety instructions, orientation and policies and procedures and had been signed by staff and their supervisors.
- Staff received mandatory training in areas such as infection prevention and control, moving and handling and safeguarding children and vulnerable adults.
- Staff within the emergency department also received role specific mandatory training such as medicines management, Basic and Advanced Life Support covering adults and paediatrics (BLS, ALS, EPLS), Advanced and Immediate and Paediatric Immediate Life Support (ALS, ILS and PILS).
- There was a nursing lead for education within the department and staff were responsible for maintaining their own training, which meant that training could be missed. The trust target was to have 80% of staff having received mandatory training. The performance dashboards showed this target hadn't always been met at Whitehaven. For example only 53% of nursing staff had undertaken adult advanced life support training and only 67% were up to date with their basic life support. Figures for medical staff for the same training were lower.
- Only 69% of nursing and medical staff had completed medicines management training. Training in infection prevention and control was at 59% for the nursing staff and only 28% compliance for the medical staff.
- Mandatory training was delivered on a rolling programme and the matron and clinical lead told us all non-compliant staff had been identified and lists had been sent to their line managers for remedial action to be taken.

Assessing and responding to patient risk

- Patients' with minor injuries were booked in via the receptionist and triaged following the Manchester Triage System to determine the nature of the ailment. This involved looking at the pain score, conducting observations and providing pain relief if applicable.
- Patients conveyed by ambulance were seen immediately on arrival via a separate entrance.
- Patients were assigned an acuity status and were seen in order of acuity rather than the order they attended.
- Children in A&E were classed as being under the age of 18 but the definition on the wards was under 16. This sometimes caused confusion and wasn't standardised. Children were triaged in the same room as adults but had a dedicated waiting area.
- An appropriately qualified nurse performed the screening of patients and depending on the severity of their ailment streamed patients to the appropriate area such as the minor or major injuries.
- The department's operations policy provided staff with guidance on how to escalate patient pathway delays in order to meet the needs of the patients.
- Patients at high risk were placed on care pathways to ensure they received the right level of care.
- An early warning score (EWS) tool was part of the patient record with clear directions for escalation (EWS is a system that scores vital signs and is used for identifying patients who are deteriorating clinically).
- Nurses in triage could request initial blood tests and x-rays so patients were not delayed. This meant results were available when consultants reviewed patients and allowed efficient diagnosis.
- The electronic admissions system automatically alerted staff if any patients had attended the hospital and the A&E department previously and whether they were assigned to any specialist team in the hospital, for example the oncology team, so staff in A&E could seek appropriate care for the patient.
- An escalation policy was in place and bed management meetings took place regularly to address and escalate risks that could impact on patient safety, such as low staffing and bed capacity issues.
- Emergency resuscitation equipment was available throughout the areas including "grab bags" and defibrillators for adults and children.
- Risk assessments were in place where necessary in all departments.
- The A&E department had a folder for patients who regularly attended the department with ongoing conditions such as asthma. This was for adults and children and included information of patients at high risk in the community.

Nursing staffing

- Nursing staff of differing grades were assigned to each of the patient areas within the department. Teams consisting of a band 6 lead with support from band 5 nurses and healthcare assistants.
- The department didn't have a recognised staffing acuity tool in place to determine the nursing establishment. The matron explained in-house data had been reviewed and analysed to account for peaks and troughs in attendances and used to inform staffing numbers. Patient acuity wasn't taken into account.
- The trust was reviewing the draft NICE guidance at the time of the inspection and confirmed professional judgement was currently applied in relation to safe staffing levels and additional nurses had been approved by the board in March 2014 for the Cumberland Infirmary based on this judgement.
- The matron confirmed the current staffing levels met the set criteria but not when the department was busy. Staffing consisted of one nurse in triage, two nurses in the minor's area and two nurses covering the majors area and monitor bay area with one healthcare assistant floating between the department. The five-bedded major's facility was opened in September 2014 to help with service demand and with the aim of reducing waits on trolleys. This was supposed to be open from 10am to 8pm with one trained nurse. In discussion with the matron, the staffing figures hadn't fully accounted for this area and the type of patients that were being treated here.
- We observed the numbers of nursing staff to be insufficient during the inspection especially when the flow of patients increased.
- There wasn't provision for a specific paediatric trained nurse in the department. At the time of the inspection, a nurse had been transferred from the children's ward and was working in a supernumerary capacity.
- There were two vacancies for band 5 nurses. Cover for staff leave or sickness was provided by bank staff made up of the existing nursing team or by agency nurses to provide cover at short notice. The organisation carried out checks on all agency staff to ensure they had the right level of training in delivering emergency care.
- The trust was recruiting 12 advanced nurse practitioners (ANP) (trained nursing specialists who could efficiently care for patients, avoiding admission to hospital). The trust had recruited 2.8 whole time equivalent (WTE) emergency nurse practitioners (ENP) to work in the new hospital; one ENP was in post and a further two were due to start their employment in the following weeks.

Medical staffing

- All staff worked various shifts over a 24-hour period to cover rotas and to be on call during out-of-hours and weekends. Consultant cover during the week was available from 9am to 9pm weekdays and 9am to 5pm at the weekend with 24-hour/seven days a week on-call cover. Middle grade and specialist doctors, together with junior doctors, were on duty 24 hours a day, seven days a week for 365 days a year.
- Medical staffing in the emergency department consisted of three consultants with vacancies for another three consultants. Two of the posts were covered by locums. There was no specific paediatric consultant but one was available on-call from the children's ward who would attend if required. The department had found it difficult to recruit to these posts.
- The clinical lead told us there was a stable workforce but that maintaining steady staffing was a challenge and the aim was to develop new staffing models that would be sustainable.
- Existing vacancies and shortfalls were covered by locum, bank or agency staff when required. All agency and locum staff underwent a local induction before they were allowed to work in the trust.
- Staff told us maintaining medical staffing with the appropriate skill mix was a struggle, especially when the department was busy and staff took longer to perform assessments on patients.

Handovers

- Medical and nursing staff had separate handovers during shift changes involving information on the risks, treatment and care for each patient, staffing requirements and patient flow through the department.
- Information was logged to ensure those staff not present could also be made aware of any risks.
- Handovers of patients between ambulance and hospital staff were discreet, dignified and efficient.

- All staff safety huddles had been running and some staff told us they had been effective in providing cross information between the medical and nursing teams to better treat the patients. However, these had been cancelled as some staff didn't attend.

Major incident awareness and training

- Security guards patrolled the car park; corridors and public areas such as A&E. Staff in the emergency department could call security for immediate support and would also dial 999 for police assistance if required.
- Guidance for staff in the event of a major incident was available in the business continuity plan and the emergency department operational policy which listed key risks that could affect the provision of care and treatment.
- New decontamination facilities and equipment training sessions were delivered for the new decontamination tent in August 2014.
- The department had decontamination facilities and equipment to deal with patients who may be contaminated with chemicals, exposure to nuclear and other hazardous substances.
- Simulation training was run by a multi-disciplinary team and included major incidents, chemical, biological, radiological and nuclear (CBRN) incident management with table top exercises and operational training.
- Staff had received training in Ebola management, flu mask training and decontamination train-the-trainers sessions.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

At the previous inspection we reported care and treatment was evidence-based and followed recognisable and approved guidelines and nationally recognised assessment tools. Four care bundles were available in the department. Appraisals and supervision of medical and nursing staff was undertaken.

However, the Trauma Audit and Research Network (TARN) data used to promote improvements in care was nine months behind. The Northern Trauma Service review team visit in February 2014 expected to see the completeness score at 50% within six months and achieving the desired 80% within 12 months and the trust was reviewing staff resources to support improving TARN completeness. In February 2014 it was identified that out-of-hours CT reporting needed to be reviewed to ensure timely turnaround of reporting. Conversations with staff revealed that the radiology reporting could take up to a week or more.

At this inspection, patients with trauma were being transferred to The Cumberland Infirmary at Carlisle, therefore, the Trauma Audit and Research Network (TARN) data was reported within the Carlisle report.

Treatment and care was provided in line with national guidance and evidence based practice. Patients were assessed for pain relief as they entered the emergency department. We saw effective collaboration and communication amongst all members of the multidisciplinary team and between the ward areas. There were suitable processes in place to obtain patient consent. Staff understood the legal requirements of the Mental Capacity Act 2005 and had access to link workers such as the safeguarding lead.

Evidence-based care and treatment

- Care and treatment was evidence-based and followed recognisable and approved guidelines such as the National Institute for Health and Care Excellence (NICE) and College of Emergency Medicine (CEM) guidelines.
- Clinical guidelines such as trauma, stroke, pneumonia and fractured neck of femur were developed and referenced with associated nationally recognised standards. Paediatric pain assessments, prescription charts, head injury proforma with observation charts that followed the Paediatric Early Warning Score (PEWS) guidelines were available and accessible to staff electronically.
- Guidance was regularly discussed at governance meetings, disseminated and the impact that it would have on staff practice was discussed.
- Staff undertook clinical audits to assess how well NICE and other guidelines were adhered to. All of these audits resulted in staff education and changes in practice to improve patient care. A local audit in relation to

antibiotic use in the emergency department had been conducted and actions had been clearly identified and acted upon such as all junior staff had to have their practice checked by senior staff.

Pain relief

- Patients were assessed for pain relief as they entered the emergency department. A screening process identified any patients who may need pain relief which was given immediately.
- A review of patient records and patients we spoke with confirmed that they had been offered appropriate pain relief in a timely way.

Nutrition and hydration

- The department had facilities to make drinks and snacks such as toast and cereal. Staff had access to a fridge with sandwiches for patients.
- All staff were responsible for offering drinks and small snacks to patients waiting in the department. We saw patients being offered refreshments during our visit. Staff checked if patients could have refreshments before offering them due to the nature of their medical conditions.
- If patients ended up staying overnight then systems were in place for patients to choose meals as they would in ward areas.

Patient outcomes

- There was a consultant lead for audit in the emergency department. The department participated in national College of Emergency Medicine (CEM) audits so they could benchmark their practice and performance against best practice and other emergency departments. Audits included consultant sign off, renal colic, pain relief and fractured neck of femur.

Competent staff

- Departmental records showed appraisal rates varied between staff types. As of March 2015 only 67% of nursing and 50% of medical staff in the Emergency Care and Medicine Business Unit had received appraisals for the year 2014 to 2015 against a set target of 85%. An appraisal gives staff an opportunity to discuss their work progress and future aspirations with their manager.
- Staff told us they had received an appraisal or were due to have one. Information provided by the trust identified that the process for 2014 to 2015 had started and was still ongoing.
- The nursing and medical staff were positive about on-the-job learning and development opportunities.
- Medical staff told us clinical supervision was in place and adequate support was available for revalidation.

Multidisciplinary working

- We observed collaboration and communication amongst all members of the multidisciplinary team (MDT) to support the planning and delivery of care.
- Daily meetings, involving the nursing staff, therapists and medical staff were conducted to ensure there were sufficient staffing levels and the ambulance staff also attended the bed management meetings when required.
- Collaborative working with the medical and surgical departments meant each ward area knew the number and type of patient that would be transferred to them.
- Specialist support teams such as the CRISIS team for people with mental health problems worked with staff in the emergency department. The team had specific pathways, management plans and confidential systems in place.

Seven-day services

- The emergency department operated 24 hours a day throughout the year. Auxiliary services such as the X-ray department, specifically to assist A&E, was open 24 hours a day, 7 days a week.
- Consultants, middle grades, specialist and junior doctors covered the rotas 24 hours a day, 365 days a year.
- Pharmacy services were not available 7 days a week, but a pharmacist was available on call out of hours. The department held a stock of frequently used medicines such as antibiotics and painkillers, which staff could access out of hours.

Access to information

- Patient records were easily accessible with information being updated regularly.
- The documentation was either electronic, such as the booking information and some patient notes or was available in paper format such as the consent forms.

Urgent and emergency services

- Data such as waiting times, ailments and patient acuity was available electronically via a specialist system so all staff knew which patients needed to be seen in order of acuity and which tests were outstanding.
- Information about the patient such as test results, x-rays or medical information taken during booking in, triage or in the A&E department was readily available across the receiving wards so the relevant receiving wards could co-ordinate their services and be prepared.
- The department had an electronic booking in system which tracked all the patients in the department and those who needed to be moved to the ward areas. This screen with all the patient details such as names, date of birth and presenting ailment could be seen in the receiving ward areas. Staff raised concerns this caused confidentiality issues especially when staff had previously been admitted to A&E.
- Nurses ensured all the information was collated and checked before the patient was transferred to a ward area.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had the skills and knowledge to ask patients fore consent and explained how they sought verbal and implied informed consent due to the nature of the patients attending the emergency department. Written consent was sought before providing care or treatment such as anaesthetics. Patient records showed that verbal or written consent had been obtained from patients or their representatives.
- Staff received training in and understood the requirements of the Mental Capacity Act 2005, safeguarding vulnerable adults and children and Deprivation of Liberties Safeguards (DoLs).
- When a patient lacked capacity, staff sought the support of appropriate professionals so that decisions could be made in the best interests of the patient.

Are urgent and emergency services caring?

Good

At the previous inspection we reported that staff interacted positively with patients and /or their relatives and demonstrated caring attitudes. Staff maintained patients' dignity. Patients and relatives were complimentary of the staff. They spoke positively about how well they were cared for and how well they had been involved in making decisions about their care and treatment.

At this inspection patients spoke positively about the care and treatment they had received and we observed many positive interactions. Staff treated patients with dignity, compassion and respect at all times. Staff provided patients and their families with emotional support and comforted patients who were anxious. Staff could access management support or counselling services if they required.

Compassionate care

- Patients, relatives and representatives were positive about the care and treatment provided.
- We observed many examples of compassionate care including an occasion where staff gave extra assistance to an elderly and confused patient in the major's area.
- The NHS Friends and Family Test had a response rate which was above the national average between November 2014 and February 2015. The results showed that the majority of patients would recommend the department to their family and friends.
- We saw patients' cubicle curtains were closed during consultation and staff spoke with patients in private to maintain confidentiality. Patients felt they were afforded sufficient privacy and dignity.

Understanding and involvement of patients and those close to them

- Upon admission, patients were allocated a designated nurse to ensure continuity of care.
- We observed positive interactions between staff, patients and their relatives when seeking verbal consent. Patients confirmed their consent had been sought before care and treatment was delivered.
- Patients and those close to them were also involved in the planning for discharge from the department.

Emotional support

- We observed many positive interactions between staff and patients and saw staff providing reassurance and comfort to people who were anxious or worried.
- A relatives' room was available for people who had witnessed traumatic incidents such as a road traffic

accident or bereavement. Information around bereavements was available which gave step by step instructions on the services available and how they could be accessed.
- Staff confirmed they could access management support or counselling services after they had assisted with a patient who had been involved in a traumatic or distressing event, such as a fatal road traffic accident, or if they had been subject to a negative experience.

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

Requires improvement

At the previous inspection we found that the service was responsive to people's needs through effective communication, and sensitive, safe handovers of information. There were specialist support teams for people with mental health problems. The four-hour wait target had been met for the last six months although for patients attending by ambulance the time to triage was not consistently meeting the 15 minutes target. The trust had added an additional five beds to help in the flow of patients through the department but the flow was often delayed by a lack of available beds in the hospital. Therefore, patient triage times, ambulance waiting times and ambulance transfer times required improvement to cope with the department's routine workload and reduce patient waiting times. We noted that many of these issues are longstanding and were identified previously by the Emergency Care Intensive Support Team (ECIST) in January 2012.

At this inspection the hospital struggled to meet the Department of Health target to admit, transfer or discharge patients within four hours of arrival over the second half of the year, the compliance dropped between October 2014 and March 2015. The hospital only achieved the target in November 2014 (95.1%) with the lowest achievement in February 2015 (86.3%). During the inspection we saw a number of four hour target breaches occur where patients had been in the department for over seven hours and one patient had stayed overnight in the monitoring bays. Individual breaches of the four hour target were investigated. The breach report showed the majority were due to patients waiting for a bed in the ward areas.

During routine operating hours, the department could cope with the patient flow, however, when patients could not be discharged from the emergency department, this negatively affected the patient flow which was a constant challenge in the department and in the wider trust.

Service planning and delivery to meet the needs of local people

- The trust wide escalation policy described how the emergency department would be involved in dealing with foreseen and unforeseen circumstances and when demand caused pressure on capacity.
- Papers had been presented at the emergency preparedness committee to ensure any significant demand for services over winter was accounted for such as lack of staffing or capacity.
- Daily bed management meetings were taking place where staffing and capacity was constantly monitored to treat patients in a timely way.
- There were suitable and segregated waiting areas for both adults and children with sufficient seating arrangements.
- There were set clinics daily with slots for patients to be checked following injuries such as fractures. This meant patients could be seen in a timely manner rather than wait for an outpatient appointment.

Meeting people's individual needs

- Staff had access to a telephone interpreter service for non-English speaking patients. Patient information leaflets were available mostly in English. Staff would ask relatives or family members to assist in interpretation in the first instance, but wouldn't use family members to translate for consent.
- Specialist support teams for people with mental health problems were available between 8am to 8pm with the community out-of-hours crisis team providing cover at other times.
- Patients living with dementia were assessed and treated in cubicles opposite the main nursing station to protect them and so staff could maintain visibility.
- Staff asked patients with learning disabilities if they had a completed "passport document" with them. The passport is a document completed by the patient or their representative which includes key information such as the patient's medical history and their likes or dislikes.

Urgent and emergency services

- Where a patient was identified as living with dementia or having learning disabilities, staff could contact a trust-wide specialist link nurse for advice and support.
- There was clear segregation for adults and children that attended the department. However, when patients stayed overnight in the majors area, the five bays were of mixed sex which meant they couldn't segregate males and females.

Access and flow

- During routine operating hours, the department had enough capacity to manage patient flow. However, when patients requiring admission or additional services external to the emergency department could not be discharged this caused a backlog.
- The Department of Health target for emergency departments is to admit, transfer or discharge at least 95% of all patients within four hours of arrival.
- In 2014/15, the trust as a whole, only met the target for quarter two with 95.9% compliance. The trust achieved a compliance of 93.9% in quarter one, 88.3% in quarter three and only 81% compliance with the four hour target in quarter four.
- In real terms, this meant that a total of 7903 patients waited more than four hours to be admitted, transferred or discharged from the emergency department from a total of 79013 patients who attended over both sites.
- Trust data classed patients being aged 18 and under as a paediatric attendance. Between April 2014 and March 2015 16.5 thousand patients aged 18 and under attended with the second highest age group being 19-29 with 13 thousand attendances.
- Overall a total of 12 patients waited for more than 12 hours from the decision to admit to being admitted in quarter four only.
- The Department of Health data is a trust wide combination for The Cumberland Infirmary at Carlisle and West Cumberland Hospital at Whitehaven.
- Data for West Cumberland Hospital showed the A&E department met the target between April 2014 and September 2014 with a range of 95.9% to 97.9% compliance with the four hour target. However, over the second half of the year, the compliance dropped between October 2014 and March 2015. West Cumberland Hospital only achieved the target in November 2014 (95.1%) with the lowest achievement in February 2015 (86.3%).
- During the inspection we saw a number of four hour target breaches occur. We saw patients who had been in the department for over seven hours and some that had been in the department for around five hours and one patient had stayed overnight in the monitoring bays.
- All individual breaches of the four hour target were investigated and categorised into why they occurred. The week prior to our inspection West Cumberland Hospital achieved 93.9% compliance with 621 attendances with 38 breaches. The breach report showed the majority (21) were due to patients waiting for a bed in the ward areas. This was a similar pattern for other weeks, for example, week commencing 9 March there were 606 attendances with 80 breaches and 86.7% compliance with the four hour target due to 62 patients waiting for a bed in the ward areas.
- Other reasons for delays included patients waiting for an ambulance transfer to The Cumberland Infirmary at Carlisle, waiting for a specialist opinion and waiting for a mental health assessment.
- The trust had done extensive work to investigate why the 4-hour waiting target was sometimes exceeded. Factors contributing to poor performance included bed occupancy within the hospital, which had been above the England average of 85% between April 2013 and September 2014 for general and acute beds.
- Staff reported continuing poor patient flow through the department and had concerns this had worsened in the previous six months. Staff relayed concerns this was due to the transfer of some services to The Cumberland Infirmary which had increased the number of patient transfers by ambulance. The availability of ambulances for transfer was affecting timely transfers and consequently waiting times.
- Staff felt there was a constant pressure to move patients through the department to meet targets.

Learning from complaints and concerns

- A trust wide policy included information on how people could raise concerns, complaints, comments and compliments with contact details for the Patient Advice and Liaison Service (PALS).
- Information was displayed in the department about how patients and their representatives could complain.

Urgent and emergency services

- Complaints were recorded on a centralised trust-wide system and monitored as part of the ward quality indicators. We saw a number of "you said, we did" boards identifying changes that had been made from complaints and other patient feedback.
- Staff understood the process and told us information about complaints was discussed during routine team meetings.

Are urgent and emergency services well-led?

Requires improvement

At the previous inspection we reported there was a clear governance structure with meetings at relevant levels to move information and concerns through to all staff. The trust's improvement priorities were clearly displayed throughout the hospital. 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). The operations manager was relatively new in post and the current medical lead was shortly due to leave the service.

In the course of this inspection we found that senior staff in the department provided visible leadership, particularly at times when the department was stretched. However, staff relationships had deteriorated and morale was low. The absence of a strategic vision for the service led to staff feeling excluded and changes to the local leadership team required time to embed in order for the service team to feel well led and managed. Staff felt they were pressured to meet targets in difficult circumstances. Staff expressed concerns about acute services being transferred to Carlisle and were concerned about the future of the A&E service at the hospital.

Vision and strategy for this service

- The vision was "To provide person centred best in class quality healthcare services" and had five elements to deliver this which were "Patients come first, to provide safe and high quality care, to have responsibility and accountability, everyone's contribution counts and to have respect".
- The trust's priorities, outlined in the "Quality Strategy for 2014-18", incorporated this vision and included specific strategic objectives applicable to the emergency department such as meeting national standards and developing plans to achieve 7 day working for emergency care. These were underpinned by a range of improvements such as the £90 million redevelopment of West Cumberland Hospital.
- The trust's vision, objectives and improvement priorities were clearly displayed throughout the department and staff had a clear understanding of what they meant for their practice.

Governance, risk management and quality measurement

- Emergency care was affiliated with the Medicine Business Unit. Risks and quality management were managed by the Emergency Care and Medicine Operational Board.
- Senior staff were aware of the departmental risks, performance activity, recent serious untoward incidents and other quality indicators.
- The local risk register was available to all staff and included a sign off sheet once they had read them. The top risks were poor patient flow, the lack of a paediatric triage, lack of trained children's nurses and the impact of road and multiple casualties on the department. These appeared to be reviewed monthly and any actions that had been undertaken to decrease the risks had been shared with the departmental staff.
- Day-to-day issues, information around complaints, incidents and audit results were shared on notice boards around the department and also via meetings and safety huddles
- Routine audit and monitoring of key processes took place across the department to monitor performance against objectives.

Leadership of service

- There were clearly defined and visible leadership roles in department. The departments were well led locally by the senior staff who provided visible leadership, particularly at times when the department was stretched.
- The teams appeared to be motivated and worked well together. However, staff felt there were conflicts between the medical and nursing teams and this impacted on how the department was managed.

Urgent and emergency services

- The clinical lead was based at Carlisle and delegated responsibility for daily management to an emergency consultant at Whitehaven. One consultant felt the clinical decisions were being made by management rather than clinicians.
- The nursing team was led by a matron who was visible within the department and told us it had been a difficult year with issues around the attitude and behaviour of some senior nursing staff but the situation was improving.
- There were issues around the allocation of the salary and skills of the healthcare assistant (HCA) role. The role was graded as being band 2, however, some HCA's were trained to perform additional tasks such as plastering fractures and had put in a case to be upgraded to band 3. This had been refused and had caused negative feelings within the department.

Culture within the service

- There was a somewhat negative culture within the service; staff felt the overall ethos was centred on trying to meet targets over the quality of care patients received.
- Staff told us the morale was low and dropped further when the department reached high patient capacity and flow became blocked.
- Staff felt their efforts were not always acknowledged and medical staff spoke of a culture whereby they felt if they raised any concerns or issues in relation to patient care or any adverse incidents, these would not always be acted upon.
- Staff expressed concerns in acute services being removed from Whitehaven and transferred to Carlisle.

Public and staff engagement

- Staff received communications in a variety of ways such as newsletters, emails, briefing documents and departmental meetings.
- The department included 'What are you saying' information on notice boards, which listed improvements made by the trust in response to queries raised by staff and patients.
- In 2014 57% of all legible staff took part in the NHS staff survey. The results for the trust showed 71% of staff felt satisfied with the quality of work and patient care they were able to deliver and 88% agreed their role made a difference to patients. Negative responses included only 30% of staff felt they had a well-structured appraisal in the last 12 months, 39% suffered work related stress in the last 12 months and 21% experienced physical violence from patients, relatives or the public in last 12 months.

Innovation, improvement and sustainability

- The trust received additional financial resource to enable them to manage the winter pressures as outlined in the winter plan 2014 -2015 presented at the emergency preparedness committee in September 2014. The plan took into account any significant demand for services and pressures such as lack of staffing, increased A&E attendances, admissions and transport problems.
- The trust was waiting for a new hospital to open but due to setbacks was now due to open late. Plans were in place for the new hospital to include an integrated emergency floor with an A&E, a nurse practitioner unit, an emergency assessment unit and the out-of-hours service, Cumbria Health On Call (CHOC). Staff expressed concerns about their ideas and involvement not being listened to for the new build.

Medical care (including older people's care)

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

Information about the service

The medical care services at West Cumberland Hospital are managed by the medical and urgent care business unit and provide care and treatment for a wide range of medical specialities including acute and respiratory medicine, cardiology, elderly care and stroke care. There were 16,700 admissions to medical care services at West Cumberland Hospital in 2013/14, of which 46% were emergency admissions.

We visited Kirkston, Gable and Honister wards and the emergency admissions unit located on Pillar/Patterdale ward. We were unable to visit the discharge lounge as it was closed during our inspection.

We observed care, looked at records for eight people and spoke with 16 patients, seven relatives and 27 staff across all disciplines, including doctors, nurses and health care professionals. We also spoke with members of the divisional management team.

Summary of findings

Following our inspection in April 2014 we found that elements of the medical services at West Cumberland Hospital were inadequate. In the course of this inspection we found that the rating of inadequate remained unchanged.

Medical cover at the hospital remained fragile and was presenting a significant risk to the care of patients. Junior medical staff did not have access to consistent and effective leadership due to the extreme shortages of senior medical staff within the medical specialties. Although nurse staffing had improved it remained a challenge and we found shortages of trained nursing staff on some of the medical wards.

There were also shortages of some essential equipment and the way in which medicines were stored required improvement.

Outcomes for patients were mixed, with outcomes for stroke patients being particularly poor, although action was being taken to improve patient experience and outcomes in this regard. The lack of available of medical beds was very apparent. The high numbers of medical patients placed in areas not suitable to their needs was having a negative effect on the routine review of patients. Patients were not always reviewed in a timely way.

Medical care (including older people's care)

Bed management meetings were disorganized and lacked basic essential information and were not as productive as required in managing patient access and flow within the service.

Are medical care services safe?

Inadequate

Summary

At out last inspection in April 2014 we reported that there were systems for reporting incidents and managing risk within the service. The wards were clean and infection rates were within expected ranges. Medicines were delivered safely but antibiotic usage could be improved. The wards were adequately maintained but equipment wasn't always readily available and was often unfit for immediate use once sourced, and resuscitation trolleys were not equipped with oxygen and suction.

All the wards we inspected within the medical directorate had vacant consultant posts and trained nurse posts. These chronic shortages, when combined with high nursing sickness absence rates, heavy dependence on nursing bank and agency staff, high usage of locum doctors, plus an on-going inability to staff wards within the medical directorate to the agreed safe levels at all times, meant that care and treatment was not always being provided safely. The deanery had raised concern regarding the ability of trainees to be supervised because of the medical staff shortages.

At this inspection systems for reporting incidents and providing staff with feedback had improved since our last inspection. There were shortages of some essential equipment and the way in which some medicines were stored required improvement. Levels of medical cover at the hospital remained fragile and unsustainable affecting the safe and effective service to patients. Nurse staffing had improved since our last inspection but remained a challenge and we noted significant shortages of trained nursing staff on some wards. However the hospital continued to take action to address the recruitment challenges and were using new initiatives to address the problems.

Incidents

- There were robust systems in place for reporting incidents and 'near misses' within the medical business unit. Staff had received training and were confident in the use of the incident reporting system.

- The system for providing staff with feedback from incidents had improved considerably since our last inspection. Weekly governance meetings were held at ward level where outcomes of incidents were discussed, however staff told us that individual feedback was variable, unless they actively sought feedback themselves.
- There was a system in place for reviewing mortality and morbidity. We saw examples of how learning from these reviews was shared throughout the trust, in the form of case studies, in order to improve the quality of patient care. This method of sharing learning was popular with staff.
- Senior clinical staff were aware of their responsibilities regarding the Duty of Candour legislation, but junior staff had little awareness of the legislation.

Safety thermometer

- The medical business unit was managing patient risks such as falls, pressure ulcers, bloods clots, and catheter urinary infections, which are highlighted by the NHS Safety Thermometer assessment tool. The NHS Safety Thermometer 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. Individual ward performance was discussed regularly at staff meetings.
- There had been 42 serious incidents reported.
- There had been 19 pressure ulcers of grade 3 or 4, 12 slips trips or falls, the number of pressure ulcers remained relatively consistent throughout December 2013 to December 2014.
- Rates of catheter urinary infections had shown an overall trend of improvement since October 2014.
- No falls were reported between July and August 2014.
- Between October 2014 and January 2015, Honister, Gable and Kirkstone wards performed below the national average of 95% for harm free care, averaging between 85% and 90%.

Cleanliness, infection control and hygiene

- The wards we inspected were clean. There were cleaning schedules in place and levels of cleanliness were audited regularly.
- The hospital infection rates for Clostridium difficile (C.diff), including the wards within the medical unit, had been below the England average, with only one case reported between April 2013 to November 2014. Methicillin Resistant Staphylococcus Aureus (MRSA) infection rates had been around the England average since May 2013.
- Staff were aware of current infection prevention and control guidelines. We observed staff following good hand hygiene practice on all of the wards we visited.
- Hand towel and soap dispensers were adequately stocked. There was a sufficient number of hand wash sinks and hand gels.
- There were suitable arrangements for the safe disposal of waste. We saw that used linen that presented an infection risk was segregated and managed appropriately. Clinical and domestic waste was segregated in colour-coded bags and managed appropriately. Sharps such as needles and blades were disposed of in approved receptacles.

Environment and equipment

- The hospital did not have an equipment library, which meant that most equipment was stored on wards. Staff on every ward we visited told us there was a shortage of infusion pumps within the hospital. Pumps were either unavailable or had parts, such as electrical leads, missing. This made them unusable. Infusion pumps were needed on a daily basis to deliver essential drug treatment to patients and shortages meant that treatment was delayed while staff sourced a working infusion pump.
- There was insufficient storage for essential equipment on all the medical wards. This meant that corridors and bays within the wards were cluttered with equipment, making it difficult for staff and patients to move freely around the wards.
- Repairs to faulty equipment and the replacement of outdated equipment was slow, which meant wards were sometimes left without essential equipment or were using equipment which had passed the end of its useful life. An example of this was a hoist on Pillar/ Patterdale ward which had to be risk assessed each time it was used.
- We checked the resuscitation equipment on all of the wards we visited and found this had been checked daily by a designated nurse.

Medicines

Medical care (including older people's care)

- Medical care services had access to a ward-based pharmacy service, with dedicated support from pharmacists and technicians. Pharmacy staff visited the wards to check the appropriateness of prescribing and to ensure adequate supplies of medicines were available.
- We looked at the prescription and medicine administration records for five patients on two wards. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed.
- Controlled drugs were stored and managed appropriately.
- Storage of medicines on the medical wards we visited was poor. We found antibiotics for intravenous use stored on the floor under sinks on two wards where there was the potential for contamination. The temperatures of rooms and corridors where drugs were stored were not monitored on any of the medical wards. Manufacturers recommend that most of these drugs should not be stored above 250C, but there was no way of knowing what temperature the drugs had been stored at. Drugs stored outside of the recommended temperatures may not be fit for use.

Records

- During our inspection we reviewed eight sets of patient records. Overall, nursing care records were comprehensive, current and easy to navigate and contained all the information required to support the delivery of safe care. There were instances however, where nursing records were not always consistently completed. For example, documentation in most of the care bundles we reviewed had been completed well for the first day or two and then the documentation was variable as the patient's condition improved, with the exception of the medical assessment unit, where the documentation was consistently good throughout.
- We reviewed six sets of medical records and in all cases found the handwriting to be poor and difficult to read. We also found the designation of the reviewing doctor and their bleep number had not been recorded. This corroborated the findings of a recent local documentation audit within the medical business unit.
- Nursing documentation contained a range of risk assessments covering the major risks for patients. The standardised risk assessments covered risks such as tissue damage, risks of falls and use of bed rails. These had been updated when required, however we found one patient who was detained under section 3 of the Mental Health Act 1983 who had been cared for within the hospital for three days without an appropriate risk assessment being undertaken and appropriate supervision in place. We brought this to the attention of staff at the time of our inspection and appropriate action was taken.

Safeguarding

- There was a system in place 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.
- All frontline staff we spoke with had received safeguarding training and were aware of their individual responsibilities regarding the safeguarding of both children and vulnerable adults.

Mandatory training

- Levels of compliance with mandatory training had improved considerably since our last inspection. Compliance rates for clinical staff on all the wards within the medical business unit were above 90%.

Assessing and responding to patient risk

- The National Early Warning Score (NEWS) was used for acutely ill patients. NEWS is a scoring system that identifies patients at risk of deterioration or needing urgent review. We found that NEWS scores were consistently and accurately completed.
- We found that the response provided by medical staff to a patient whose condition was deteriorating was timely and effective.
- Medical staff were supported, out of hours, by a team of nurse practitioners, many of whom were only partially trained. We spoke with six of these nurse practitioners during our inspection. They told us that they were frequently deployed to wards where there were shortages of trained nurses, which meant the completion of their training had been delayed. They also told us that the responsibilities of their role were unclear as they had no job description.
- Wards within the medical business unit had on-site access to the services of a critical care unit when required.

Nursing staffing

Medical care (including older people's care)

- Nursing staffing levels were reviewed throughout the medical business unit twice each year. Staffing levels had been assessed using a validated acuity tool. There were minimum staffing levels set for medical wards throughout the hospital. Required and actual staffing numbers were displayed on every ward we visited.
- Although nurse staffing levels had improved since our last inspection, there were still high nurse vacancy rates on some medical wards. Of particular concern were the nurse staffing levels on Pillar/Patterdale ward where there were six whole time equivalent vacancies for trained nursing staff, increasing to eight within two weeks of our inspection, against their agreed establishment. A rolling recruitment programme to fill these posts was on-going. Several new initiatives had been implemented, including an increase in the student nurse intake to two per year, with a view to retaining them once qualified and partnership working with other trusts. The trust was in the process of recruiting 50 nurses from the Philippines after recruitment of nurses from Europe had not proved very successful.
- An escalation process was in place to highlight staff shortages to the senior nursing management team. This was only effective if senior staff could access nurses via the nurse bank or redeploy them from wards which were better staffed. In practice, there were frequently times where ward managers escalated staff shortages and the senior nursing team were unable to respond their nurse staffing requirements.
- We also found that when there were no trained nurses available that healthcare assistants would be sent to fill gaps in the rotas. This placed additional pressure on the existing trained staff.
- Staff on medical wards where there were higher numbers of trained staff within their establishment, due to the complexity of the condition of patients within their care, told us they were frequently the first to be moved to cover staff shortages in other areas of the hospital. They told us they were concerned that leaving their designated ward short of a trained nurse while they provided cover on another ward left the ward unsafe for patients.
- The skills and experience of temporary staff differed and it was not always possible to provide care from the same staff. This had an impact on the continuity of care provided.
- Nursing handovers took place at the start of each shift on all the medical wards. Staffing for the shift was discussed as well as any high-risk patients or potential issues. Handovers were detailed and staff on duty were familiar with the needs of patients under their care.

Medical staffing

- Historically the trust has struggled to recruit into consultant and middle grade medical posts at the West Cumberland Hospital. In February 2015, five out of seven consultants in on call positions were filled by locums and all resident medical doctors were locums. At the time of our inspection there were consultant vacancies in specialist posts such as gastroenterology, respiratory, care of the elderly and general cardiology. A medical workforce review produced by the trust, which is dated February 2015, described the nature of medical cover at the hospital as "fragile and unsustainable".
- There was a consultant presence on site between 08.00 and 19.00 on weekdays
- During weekends there was a consultant on site who covered all patients from all specialities, but there was no routine senior medical staff support for the wards at weekends.

Major incident awareness and training

- Plans were in place to deal with the additional pressures on beds and staffing within the hospital during the winter and at other times of peak demand on services. The effectiveness of these plans was reviewed regularly in line with changing demands on the service provided.

Are medical care services effective?

Requires improvement

Summary

At the previous inspection we reported The medical wards had clinical pathways for care in place for a range of medical conditions based on current legislation and guidance. Patients' nutritional and hydration needs were being met. However, the outcomes for patients in some areas needed improvement. Analysis of SSNAP and NADIA data demonstrated that particular improvements were needed in the management of patients with diabetes, especially with regard to foot care and those who had had a stroke, particularly with regard to thrombolysis.

Medical care (including older people's care)

Out-of-hours services were sparse with no routine allied health professional support, no ultrasound service and limited pharmacy service. Only newly admitted patients or those whose condition had deteriorated saw a doctor at weekends. At this inspection national guidelines were used in the treat of patients. Outcomes for patients were mixed, with outcomes for stroke patients being particularly poor, although measures were underway to address this. Thrombolysis remained in the lowest category of the SSNAP audit but a review had been undertaken and the service challenges were to be addressed imminently.

The NADIA audit data showed small improvement in the foot care assessment from the previous year and the number of specialist nurses was slightly above the national average. However, the number of medication and management incidents was higher than the national average.

Medical wards still did not have routine input from allied health professionals out of hours. However, basic emergency imaging services were available out of hours, such as ultra sound scans, but lack of capacity in the system meant that there were frequently delays in accessing emergency imaging.

The requirements of the Mental Capacity Act 2005 were not being met with regard to the application of Deprivation of Liberty Safeguards.

Evidence-based care and treatment

- Staff used a combination of National Institute for Health and Care Excellence (NICE), and Royal Colleges' guidelines to determine the treatment they provided. Local policies were written in line with this and had been updated periodically, as required.
- Clinical guidelines for most conditions were available and accessible via the trust intranet.
- There were specific care pathways for certain conditions in order to standardise and improve the care for patients. For example, care pathways were used for the care of patients with dementia and community acquired pneumonia.
- Specific local audits were undertaken within each of the medical specialities, relevant to the care and treatment provided within the speciality. In addition, more general audits were undertaken across the medical business unit. These included infection control and documentation audits
- Patients on the medical assessment unit were reviewed by a consultant once daily in the morning, with a board round at 5pm, during which a handover was given to the on call team. The handover was verbal only; there was no written medical handover.
- The endoscopy unit does not currently have a Joint Advisory Group (JAG) accreditation. JAG accreditation is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the measures in the endoscopy Global Rating Scale standards. The unit is to be assessed later in 2015, once the endoscopy team have become established within the newly built unit.

Pain relief

- We spoke with seven patients in detail about their pain relief. Everyone told us they had received timely and effective pain relief.
- Medication records demonstrated that patients were prescribed suitable pain relieving medicines and that they had been administered as needed.

Nutrition and hydration

- Appropriate nutritional assessments had been undertaken and were well documented in all the care records we reviewed.
- People were provided with a choice of suitable and nutritious food and drink and we observed hot and cold drinks 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 assistance was given to those patients who needed help. We observed several examples of patients being assisted with meals and drinks in a sensitive and compassionate way.

Patient outcomes

- An analysis of data for West Cumberland Hospital submitted by the trust for April to September 2014 as part of the Sentinel Stroke National Audit Programme (SSNAP) showed that the trust's stroke services remained at an overall score of 'D' on a scale of A to E, with A being the best. Thrombolysis services were

still rated as 'E'. Access to physiotherapy was worse although the discharge process had improved. Only 15% of patients had received an assessment at six months.

- A review had been undertaken of some of the high risk clinical pathways within the trust, which included the stroke pathway. Following discussions with the clinical senate and respected stroke physicians from other trusts, a business case was in the final stages of development to seek board approval for the discontinuation of the thrombolysis service at West Cumberland Hospital from the autumn of 2015. There was evidence to suggest that this would improve outcomes for the largest number of patients.
- An analysis of the data submitted by the trust as part of the Myocardial Ischaemia National Audit Project (MINAP) showed that West Cumberland Hospital achieved a similar or better performance than England averages for the data sets that were large enough to provide reliable data for analysis.
- An analysis of the National Diabetes Inpatient Audit 2013 showed that the hospital was performing below the England average in 11 of the 21 indicators.
- Readmission rates all specialities within the medical business unit were below the England average.

Competent staff

- There was a system in place within the trust to ensure that staff within the medical business unit were registered with the General Medical Council and the Nursing and Midwifery Council and maintained active registration entitling them to practice.
- Nursing and medical appraisal rates across the medical division business unit were good, and were considerably improved since our last inspection.
- Nursing appraisal rates on all of the medical wards we visited were over 90%.
- All the medical staff we spoke with who were directly employed by the trust had received an appraisal during the last year.
- The 2014 NHS staff survey showed that there was a statistically significant positive change in staff reporting that their appraisal was well structured.

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.
- Access to psychiatric input, provided by a local mental health trust, was reported by both nursing and medical staff as "difficult", particularly out of normal working hours. Patient referrals or requests for review of existing patients, made on a Friday would frequently not be actioned until after the weekend, despite patients being otherwise fit for discharge.
- There were few specialist nurses within the trust to support patients, although a stroke specialist nurse had been appointed since our last inspection.

Seven-day services

- There was no routine consultant presence outside of normal working hours.
- Routine ward rounds did not take place at weekends; only patients requiring an urgent review were seen. Urgent reviews were undertaken by the on call doctors who were usually from another specialism with the medical unit.
- Medical wards did not have routine input from allied health professionals out of hours.
- Basic emergency imaging services were available out of hours, such as ultra sound scans, but lack of capacity in the system meant that there were frequently delays in accessing emergency imaging.

Access to information

- The information technology department within the trust were slow to issue access to the trust information systems. We spoke with two doctors who had been employed to work within the medical business unit during the last month. Despite numerous contacts with the information technology team, they had both waited between one and two weeks for access to the hospital information systems. Other doctors we spoke with told us it was not unusual for colleagues to wait over a week for this type of access.

Medical care (including older people's care)

- In order to be able to work effectively, these doctors had used other doctors' passwords in order to access the electronic system. This represents a breach of confidentiality.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were asked for their consent to procedures appropriately and correctly. We saw staff obtaining verbal consent when helping patients with personal care.
- The requirements of the Mental Capacity Act 2005 were not being met with regard to the application of Deprivation of Liberty Safeguards (DoLS). None of the staff we spoke with, including the ward managers, could describe when a DoLS would be required for patients receiving care and treatment at the hospital. We as two examples during our inspection where DoLS applications were required but had not been made.

Are medical care services caring?

Good

Summary

At the previous inspection we reported that 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 patients' wishes into account.

At this inspection services were caring, delivered by compassionate staff. We observed that staff treated patients with dignity and respect. Care was planned and delivered in a way that took into account the wishes of the patients. Patients told us that if they did not understand any aspects of their care that the medical, nursing or allied health professional staff would explain to them in a way that they could understand. The average response rate for the Friends and Family test within the medical division between Dec 2013 and August 2014 was 41%, which was better than the England average of 30%. Wards within the medical division scored better than the England average, with an average of over 90 % of patients reporting they would be likely or extremely likely to recommend these ward to friends and family.

Compassionate care

- Medical services were delivered by 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.
- The average response rate for the Friends and Family test within the medical business unit between Dec 2013 and August 2014 was 41%, which was better than the England average of 30%. Wards within the medical division scored better than the England average, with an average of over 90 % of patients reporting they would be likely or extremely likely to recommend these wards to friends and family.

Understanding and involvement of patients and those close to them

- Patients and relatives said they felt involved in their care.
- They told us they had sufficient opportunities to speak with the consultant and other members of the multi-disciplinary team looking after them about their treatment goals. This enabled patients to make decisions about and be involved in their care.
- Patients told us that if they did not understand any aspects of their care that the medical, nursing or allied health professional staff would explain to them in a way that they could understand.

Emotional support

- The stroke unit had good links with a national charity providing practical and emotional care and support for stroke patients.
- Staff and patients spoke enthusiastically about the chaplaincy service and valued the emotional support it provided. There were arrangements for visits by spiritual advisers from all major faiths.
- There were no dementia nurse specialists at the hospital.

Are medical care services responsive?

Inadequate

Summary

Medical care (including older people's care)

At the previous inspection we reported that 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 for the treatment of their medical condition. 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.

At this inspection the lack of availability of beds allied to the patients' needs was very apparent demonstrated on two adjacent surgical wards where 25 of the 30 beds were occupied by medical patients. This meant patients continued to be regularly cared for on wards outside of the speciality. The high numbers were having a negative effect on the routine review of these patients, some being reviewed only twice a week. Bed management meetings were disorganised and lacked basic essential information. We also found patients who were otherwise fit for discharge were waiting up to a week as an inpatient for angiograms.

Progress had been made in the implementation of improvements regarding the care of patients living with dementia. The Butterfly scheme for patients had recently been introduced, although it had not yet been implemented on several of the medical wards within the hospital.

Service planning and delivery to meet the needs of local people

- There were good links with commissioners and other providers, including the ambulance service, during the planning and delivery of services.
- The average length of stay for patients at West Cumberland Hospital was below the England national average for all medical specialities except cardiology and rehabilitation services.
- 98 medical patients had been transferred to Cumberland Infirmary in the first two months of 2015. This was consistent with the average numbers of transfers of medical patients from West Cumberland Hospital to Cumberland Infirmary throughout 2014.

Access and flow

- Bed occupancy in the trust overall exceeded the England average throughout 2014, with bed occupancy levels for medical patients frequently in excess of 100%. This meant there were usually more medical patients than available beds within the hospital.
- During our inspection the hospital was overwhelmed with medical patients who were occupying most of the beds within the hospital. Medical patients were being cared for on all of the surgical wards. We visited two adjacent surgical wards where 25 of the 30 beds were occupied by medical patients. The impact of the lack of medical beds on surgical patients is discussed within the surgical core service of this report.
- Medical review of these patients varied, depending on the consultant providing their care. Some would visit the ward regularly to review patients, while nursing staff told us they constantly had to remind other consultants that patients needed a review of their care and treatment.
- We reviewed eight sets of records of medical patients who were receiving care and treatment on surgical wards and found that none of them received a daily review during the week, with four receiving a review only twice weekly. We spoke with three of these patients who confirmed this and told us they were unhappy about the frequency of medical reviews.
- Beds were frequently occupied by patients, otherwise fit for discharge, who were awaiting transfer to Carlisle Infirmary for diagnostic tests such as angiograms. An angiogram is an X-ray test that uses a special dye and camera to take pictures of the blood flow in an artery or a vein. During our inspection we reviewed the records of two patients who had been waiting seven and eight days for this procedure. Staff told us that these waits were unusually long, but that a wait of three or four days was normal.
- Bed management meetings were held throughout the day. We found these to be disorganised and lacking basic essential information, such exact patient numbers. The meetings were too focused on the specifics around the care and treatment of individual patients rather than the flow of patients throughout the hospital.
- Referral to treatment times were meeting standards in all medical specialties except dermatology and

rheumatology, which was particularly poor with no patients seen within 18 weeks. There had been a deteriorating trend in the referral to treatment times across the medical specialities throughout the last year.

Meeting people's individual needs

- The discharged lounge was closed during the time of our inspection. We were informed that the discharge lounge could not be opened due to lack of nursing staff. A well run discharge lounge improves the flow of patients throughout the hospital and enables the most effective use of the available beds within the hospital.
- Progress had been made in the implementation of the trust action plan regarding the care of patients living with dementia since our last inspection, which included the introduction of the Butterfly scheme within the hospital. The Butterfly scheme is a national project which identifies those with dementia to staff and describes a range of approaches to help staff meet their needs. A lead nurse for dementia had been allocated on each of the wards we visited and several nurses had attended the training provided as part of the implementation of the Butterfly scheme.
- All of the wards we visited had received a box of Butterfly scheme information and materials for use, but these were in use on only two of the wards we visited. Ward managers told us they were either unclear about when they were expected to begin using the materials or were reluctant to implement it on their wards until more staff had been trained in the use of the scheme. The dementia leads had not been allocated any protected time to undertake these additional duties or oversee the roll out of the scheme on the wards. As there was no designated person or team to provide leadership and drive the initiative forward, it had not been well embedded in the medical wards within the hospital. However, during our inspection we observed some 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 required.
- An adults 'hospital passport' is used for patients with a learning disability and provides vital information to ward and department staff regarding the individual, their support requirements and any adjustments that may be required. The Trust has also recently developed and introduced a comments/complaints leaflet in an accessible format.
- We saw that there was a good range of relevant patient literature displayed in clinical areas covering information about specific diseases and procedures, health advice and general information relating to health, and social care and other services available locally.
- Access to information was good for patients and their families. We saw examples of comprehensive information for patients regarding the management of their health conditions.
- The trust commissioned the services of a diabetes specialist nurse for 12 hours a week, which was insufficient to deal with the demand. As the specialist nurses had to prioritise their time on the basis of patient need, there were patients they were unable to see who would have benefitted from the service they provide each time they visited the hospital.

Learning from complaints and concerns

- Staff could describe trust complaints system and tell us how they would advise patients and relatives to make a complaint, should they wish to do so.
- Large prominently displayed posters and leaflets informing people about how to make a complaint were visible on each medical ward and in corridors throughout the hospital.
- Staff told us that learning from complaints was shared at the weekly governance meetings, where relevant. We saw minutes of governance meetings which confirmed this.

Are medical care services well-led?

Requires improvement

Summary

At the previous inspection we reported 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 lack of connection between the staff providing hands-on care and the executive team.

Medical care (including older people's care)

At this inspection most staff had a clear understanding of the trust vision, values and objectives which had been cascaded across the medical wards. The system in place to communicate risks and changes in practice to nursing staff had improved considerably. It was not possible for junior medical staff to access consistent and effective leadership due to the extreme shortages of senior medical staff within the medical specialties. There was no effective leadership in place for the newly created team of nurse practitioners.

The medical and emergency care business unit was failing to deliver the agreed cost improvements of £3.6 million, with a forecast shortfall in excess of £ 2 million.

Vision and strategy for this service

- The trust had a vision and strategy for the organisation with clear aims and objectives. The trust vision, values and objectives had been cascaded across the medical wards and most staff had a clear understanding of what these involved, although there was less awareness amongst the medical staff than the nursing and allied health professional staff.
- The nursing and midwifery strategy launched December 2014. All the nursing staff were aware of the strategy and could tell us about the impact this might have on them in the future.

Governance, risk management and quality measurement

- Information relating to core objectives and performance targets were visibly displayed in all of the areas we visited. Junior nursing and ancillary staff not understood the newly created performance boards during our last inspection and had not been engaged in the setting of the key objectives specific to their wards. During this inspection we found that staff at all levels now understood the purpose of the performance boards and felt they could directly contribute to setting of specific ward based objectives.
- The system in place to communicate risks and changes in practice to nursing staff had improved considerably since our last inspection. Information was given verbally at staff meetings and reinforced with written minutes of the meetings which were accessed by staff who were unable to attend. Staff we spoke with and minutes of meetings we reviewed confirmed this.
- The Emergency Care & Medicine Business Unit Risk Register contained risks related to medical and elderly care wards. The risks included closed elderly care beds are being opened on a regular basis so that admission to an acute bed is available for patients requiring admission into the organisation. The required staff not always being available when this happens and its affect on the safety and quality of care delivered to patients. Increased numbers of falls with harm. The risk that medical and nursing staff are not being adequately training in the use of Nasogastric tube insertion and feeding in accordance with Trust Policy following a Never Event. Action to mitigate these risks were present and up to date risk ratings were seen.
- A medical dashboard had been developed and was being used to monitor performance and quality against a range of targets.

Leadership of service

- We saw some examples of good leadership by individual members of medical and nursing staff throughout the medical business unit 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.
- It was not possible for junior medical staff to access consistent and effective leadership due to the extreme shortages of senior medical staff within the medical specialties.
- Matrons within the medical business unit had attended a leadership development training programme. Ward managers had either attended leadership training or were scheduled to attend in the near future.
- Information was not always communicated in a timely and effective way between teams within the medical business unit. An example of this was one ward manager who found out about a ward move from the domestic worker rather than through line managgement.
- The team of nurse practitioners were not receiving effective leadership at the time of our inspection, with one nurse practitioner describing their team as "rudderless".

Culture within the service

Medical care (including older people's care)

- Many staff spoke enthusiastically about their work. They described how they loved their work, and how proud they were to work at the trust. There was a culture of "good will" within the medical wards, where many members of staff worked considerably beyond their contracted hours to support colleagues and to provide good patient care.
- Staff spoke of low morale within the hospital which they attributed to low staffing levels and uncertainties about the future of services within the hospital.

Public and staff engagement

- Staff spoke very positively about the levels of nursing staff engagement in the recent nursing and midwifery strategy which had involved staff at all levels.
- The trust, including the medical business unit, scored in the worst 20% on an overall indicator of staff engagement used within the NHS staff survey in 2014, although the score is improved from 2013.

Innovation, improvement and sustainability

- The medical and emergency care business unit was failing to deliver the agreed cost improvements of £3.6 million, with a forecast shortfall in excess of £ 2 million. Weekly meetings to discuss the cost improvement programme (CIP) did not always take place.

Surgery

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

Information about the service

We visited West Cumberland Hospital as part of our announced inspection during 30 March – 2 April 2015.

The hospital carried out a range of surgical services, including urology, ophthalmology, trauma and orthopaedics and general surgery (such as colorectal surgery). There were four surgical wards and five theatres that carried out day case and elective surgery as well as some emergency surgery procedures.

As part of the inspection, we inspected the theatres, Overwater 1 (the emergency surgical ward), Overwater 2 (the trauma ward), Skiddaw 1 (the day surgery ward) and Skiddaw 2 (the elective orthopaedic ward).

We spoke with four patients. We observed care and treatment and looked at care records. We also spoke with a range of staff at different grades including nurses, doctors, consultants, ward managers, the theatres manager, the matron for surgery and the matron for theatres. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Summary of findings

Surgical services had significantly improved since our last inspection. Staffing levels and skill mix was sufficient to meet patients' needs. The staffing levels in the wards and theatres were maintained through the use of bank and agency staff, as well as existing staff working additional hours.

There were no consultant vacancies during February 2015. Locum doctors were used to provide cover for consultant surgeons and anaesthetists. Ward staff were also supported by a team of advanced nurse practitioners.

Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in safe, clean and suitably maintained premises. Medicines were stored and administered appropriately.

The surgical services provided effective care and treatment that followed national clinical guidelines. The surgical services performed in line with similar sized hospitals and performed within the England average for most safety and clinical performance measures.

The majority of patients had a positive outcome following their care and treatment, receiving care and treatment by trained, competent staff. Patients spoke positively about their care and treatment. However, the surgical services had failed to meet 18 week referral to treatment standards across all specialties between July 2013 and September 2014. There was insufficient bed

Surgery

capacity in the wards due to surgical beds being occupied by medical patients. This meant that operations were frequently cancelled. The number of patients whose operations were cancelled and were not treated within the 28 days was worse than the England average between July 2013 and September 2014.

There was effective teamwork and clearly visible leadership within the surgical services. Staff were positive about the trust.

Are surgery services safe?

Good

Summary

At the previous inspection we reported that services were provided by competent staff, although the staffing numbers did not reflect the ideal at all times. The wards and theatres were clean and adequately equipped. Medicines were stored and administered appropriately. There were systems in place for the escalation of patients whose condition was deteriorating.

However, there had been six surgical never events during the period November 2012 to April 2014. Shortages of both nursing and medical staff, together with pressures on bed availability meant there were risks to patient safety. However, the theatre teams were undertaking the 'five steps to safer surgery' procedures, including the use of the World Health Organisation (WHO) checklist at the time of our inspection and this was being audited for consistency but the audit was new, lacked robustness, was non-observational and so the results were not yet reliable. Staff confirmed that learning from incidents was shared, but we could find no evidence to show this, nor could we find evidence of regular staff meetings on the wards we visited.

As West Cumberland Hospital was no longer providing surgery for trauma patients, these patients were transferred primarily to the Cumberland Infirmary. We found a number of protocols in place to facilitate the safe transfer of patients to this location. However, there was a lack of clarity concerning which was the most current version of the protocol and there were delays in transfer because of bed pressures at the Cumberland Infirmary. The lack of clarity among staff about transfer protocols to the Cumberland Infirmary raised concerns about the safety and timeliness of transfers.

At this inspection the staffing levels and skills mix was sufficient to meet patients' needs. There were four whole time equivalent nursing vacancies being recruited to. The staffing levels in the wards and theatres were maintained through the use of bank and agency staff, as well as existing staff working additional hours. The transfer of emergency trauma and general surgical specialties to Cumberland

Infirmary meant the patients admitted to the hospital were less dependent allowing staff the time to provide appropriate care. Some of the surgical wards had moved from operating three shifts to two 12-hour shifts.

There were no consultant vacancies at the hospital during February 2015. Locum doctors were used to provide cover for consultant surgeons and anaesthetists. Ward staff were also supported by a team of advanced nurse practitioners. There were systems in place for the escalation of patients whose condition was deteriorating. Staff followed clear protocols when transferring patients out of the hospital and equipment used for patient transfers was readily available.

There had been no 'never events' reported by the trust relating to the surgical services at the hospital since January 2014. The theatre teams were undertaking the 'five steps to safer surgery' procedures, including the use of the World Health Organisation (WHO) checklist and staff adherence to WHO guidelines between October 2014 and February 2015 showed a high level of compliance (97% to 100%) in key measures.

Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in safe, clean and suitably maintained premises. Medicines were stored and administered appropriately. Staff were aware of how to access guidance in the event of a major incident.

Incidents

- There had been no 'never events' reported by the trust relating to the surgical services at the hospital since January 2014. There had previously been six surgical 'never events' during the period November 2012 to January 2014. A 'never event' is a serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.
- The strategic executive information system data showed there were six serious incidents reported in relation to surgical services at the hospital between February 2014 and January 2015. This included one incident relating to a medical equipment failure, one incident relating to a patient fall, one incident relating to healthcare acquired infections and three incidents relating to delayed diagnosis of patients. We saw evidence that these incidents were investigated and remedial actions were implemented to improve patient care.
- Staff were aware of the process for reporting any identified risks to staff, patients and visitors. All incidents, accidents and near misses were logged on the trust-wide electronic incident reporting system.
- Incidents logged on the system were reviewed and investigated by ward and theatre managers to look for improvements to the service. Serious incidents were investigated by staff with the appropriate level of seniority.
- Staff told us 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 on the wards.
- Patient deaths were reviewed by individual consultants within their surgical specialty area. These were also presented and reviewed at monthly governance meetings within the surgical business unit.

Safety thermometer

- The NHS Safety Thermometer assessment tool measures a snapshot of harms once a month (risks such as falls, pressure ulcers, bloods clots, catheter and urinary infections).
- Safety Thermometer information between December 2013 and December 2014 showed that the trust performed within the expected range for falls with harm, catheter urinary tract infections and new pressure ulcers. The data showed that the number of incidents reported each month was consistent with no was an overall increasing or decreasing trends.
- Information relating to this was clearly displayed in the wards and theatre areas we inspected.

Cleanliness, infection control and hygiene

- There had been no MRSA bacteraemia infections and five Clostridium difficile (C. diff) infections relating to surgery at the hospital between April 2014 and March 2015. The number of infections was within the expected limits for the hospital.
- We looked at the investigation report and action plan for a C. diff incident on Overwater 1 (the emergency

surgical ward) in September 2014. This showed that the incident had been investigated appropriately, with clear involvement from nursing and clinical staff, as well as the trust's infection control team.
- There were no surgical site infections following total hip replacement and total knee replacement surgery reported by the hospital between July 2014 and December 2014.
- The wards and theatres we inspected were clean and safe. Staff were aware of current infection prevention and control guidelines. Cleaning schedules were in place, and there were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. There were enough hand wash sinks and hand gels. We observed staff following hand hygiene and 'bare below the elbow' guidance.
- Staff were observed wearing personal protective equipment, such as gloves and aprons, while delivering care. Gowning procedures were adhered to in the theatre areas.
- Patients identified with an infection were isolated in side rooms. We saw that appropriate signage was used to protect staff and visitors.

Environment and equipment

- The wards and theatre areas we visited were well maintained, free from clutter and provided a suitable environment for treating patients.
- Equipment was appropriately checked and cleaned regularly and the equipment we saw had service stickers displayed and these were within date. Single-use, sterile instruments were stored appropriately and were within their expiry dates.
- Equipment needed for surgery was readily available and any faulty equipment could be replaced from the hospital's equipment store
- 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 and timely support.
- Reusable surgical instruments were sterilised on site in a dedicated sterilisation unit and theatre staff told us they did not have any concerns relating to the sterilisation or availability of surgical instruments used for surgery.
- Reusable endoscopes (used to look inside a body cavity or organ) were cleaned and decontaminated in a dedicated decontamination room. We saw that scopes were decontaminated in accordance with best practice guidelines with a segregated clean and dirty area and use of a coding system for traceability. However, the facility was not accredited by the joint advisory group for gastrointestinal endoscopy (JAG). Staff told us they would seek accreditation during 2015/16 following the planned move to the newly built hospital facilities.
- Emergency resuscitation equipment was available in all the areas we inspected and this was checked on a daily basis by staff.

Medicines

- Medicines, including controlled drugs, were securely stored. Staff carried out daily checks on controlled drugs and medication stocks to ensure that medicines were reconciled correctly.
- We saw that medicines that required storage at temperatures below 8ºC were appropriately stored in medicine fridges. Fridge temperatures were checked daily to ensure medicines were stored at the correct temperatures.
- A pharmacist reviewed all medical prescriptions, including antimicrobial prescriptions, to identify and minimise the incidence of prescribing errors. The ward staff we spoke with confirmed a pharmacist carried out daily reviews on each ward.
- We looked at the medication charts for three patients and found these to be complete, up to date and reviewed on a regular basis.

Records

- The trust used paper patient records and these were securely stored in each area we inspected.
- We looked at the records for three patients. These were structured, legible, complete and up to date.
- Patient records included risk assessments, such as for falls, venous thromboembolism, pressure care and nutrition and were reviewed and updated on a regular basis.

- Patient records showed that nursing and clinical assessments were carried out before, during and after surgery and that these were documented correctly.
- Standardised nursing documentation was kept at the end of patients' beds. Observations were well recorded and the observation times were dependent on the level of care needed by the patient.

Safeguarding

- Staff received mandatory training in the safeguarding of vulnerable adults and children. The staff we spoke with were aware of how to identify abuse and report safeguarding concerns.
- Records showed the target for 80% completion of mandatory safeguarding training for staff within the surgical services had been achieved during 2014.
- Information on how to report adult and children's safeguarding concerns was clearly displayed in the areas we inspected. Each area we inspected also had safeguarding link nurses in place.
- Safeguarding incidents were reviewed by the departmental managers and also by the trust safeguarding committee, which held meetings every three months.

Mandatory training

- Staff received mandatory training in areas such as infection control, information governance, equality and diversity, fire safety, health and safety, safeguarding children and vulnerable adults, manual handling and conflict resolution.
- The surgical business unit governance report from February 2015 showed that overall mandatory training compliance for staff across the emergency surgery and elective care business unit was 81% up to the end of December 2014.
- Mandatory training was delivered on a rolling programme and monitored on a monthly basis. We saw that information on mandatory training performance was displayed on notice boards in each area we inspected.

Assessing and responding to patient risk

- Staff were aware of how to escalate key risks that could affect patient safety, such as staffing and bed capacity issues and there was daily involvement by ward managers and the matron to address these risks.
- On admission to the surgical wards and before surgery, staff carried out risk assessments to identify patients at risk of harm. Patient records included risk assessments for venous thromboembolism, pressure ulcers, nutritional needs, risk of falls and infection control risks.
- Patients at high risk were placed on care pathways and care plans were put in place to ensure they received the right level of care.
- Staff used early warning score systems and carried out routine monitoring based on patients' individual needs to ensure any changes to their medical condition could be promptly identified. If a patient's health deteriorated, staff were supported with medical input.
- Trust data showed that since January 2014, a total of 106 patients had been transferred to Cumberland Infirmary Ward staff told us the majority of patients requiring emergency surgery were transferred out directly from the emergency department.
- Patients were transferred out from the surgical wards their health deteriorated or they developed complications following surgery. There were clear protocols for staff to follow when transferring patients out of the hospital. Equipment required to assist patient transfers was prepared and readily available in the theatres department so patients could be transferred promptly.
- Patient records showed that saw that staff had escalated correctly, and repeat observations were taken within necessary time frames to support patient safety.
- We observed one theatre team undertaking the 'five steps to safer surgery' procedures, including the use of the World Health Organization (WHO) checklist. The theatre staff completed safety checks before, during and after surgery and demonstrated a good understanding of the 'five steps to safer surgery' procedures.
- Staff carried out an audit to monitor adherence to the WHO checklist by observing theatre teams and reviewing the completed checklist records. The audit records between October 2014 and February 2015 showed there was a high level of compliance by staff (97% to 100%) in key measures such as team brief participation and staff conduct during the sign in / sign out phases.

Nursing staffing

- Nurse staffing levels were reviewed against minimum compliance standards, based on national NHS safe

staffing guidelines every six months. The expected and actual staffing levels were displayed on notice boards in each area we inspected and these were updated on a daily basis.
- Nursing staff handovers took place on a daily basis and included discussions about patient needs and any staffing or capacity issues.
- The wards and theatres we inspected had sufficient numbers of trained nursing and support staff with an appropriate skills mix to ensure that patients were safe and received the right level of care.
- The matron for surgery told us there were four whole time equivalent nursing vacancies in the surgical wards. Overwater 1 (the emergency surgical ward) had two nurse vacancies and interviews were scheduled in the next few weeks to fill the vacant posts. The other vacancies had been advertised and were for a nurse on the night shift on Overwater 2 (the trauma ward) and a nurse on Skiddaw 2 (the elective orthopaedic ward).
- Since August 2014, the surgical wards moved from operating three shifts to two 12-hour shifts. Staff spoke positively about this change.
- Staff told us the acuity of patients on the Overwater 1 and 2 wards had reduced since orthopaedic trauma and high risk general surgery was transferred to Cumberland Infirmary, Carlisle. This meant patients admitted to the ward were less dependent allowing staff the time to provide an appropriate level of care.
- The ward managers and matron carried out daily staff monitoring and escalated staffing shortfalls due to unplanned sickness or leave. Staffing levels were maintained through the use of overtime for existing staff, as well as through the use of bank or agency staff.

Surgical staffing

- The wards and theatres we inspected had a sufficient number of medical staff with an appropriate skills mix to ensure that patients were safe and received the right level of care.
- Records showed that during February 2015, there were nine whole time equivalent consultants employed by the hospital, which met the consultant establishment requirement for nine whole time equivalent posts. Additional cover was also provided by one locum consultant during the month.
- Where locum doctors were used, they underwent recruitment checks and induction training to ensure they understood the hospital's policies and procedures.
- There were five vacancies for consultant anaesthetists at the hospital during February 2015. The hospital used a locum consultant anaesthetist to provide additional cover during the month. The clinical business unit director told us they had appointed four anaesthetists during March 2015 to address the shortfall across both hospitals.
- Staff on Skiddaw 2 (the elective orthopaedic ward) told us a consultant or registrar carried out daily ward rounds. Patients on Overwater 1 and 2 wards were sometimes reviewed during 'board rounds' where the multi-disciplinary team discussed patients around a white board but did not see them.
- The wards were supported by a team of advanced nurse practitioners (ANP'S) with at least two ANP's on shift over a 24-hour period. This included at least one that was trained as a nurse prescriber. Ward staff told us they received good support from the ANP's but felt this varied depending on the individual ANP as some were still undergoing training and were not able to carry out specific duties such as prescribing medicines.
- We found there was sufficient on-call consultant cover over a 24-hour period and there was sufficient medical cover outside of normal working hours and at weekends. The on-call consultants were free from other clinical duties to ensure they were available when needed.
- The ward and theatre staff told us they received good support from the consultants and ward-based doctors.

Major incident awareness and training

- There was a documented major incident and business continuity plan in the surgical services, and this listed key risks that could affect the provision of care and treatment.
- Guidance for staff in the event of a major incident was available in each of the areas we inspected and staff were aware of how to access this information when needed.

Are surgery services effective?

Good

Summary

At the previous inspection we reported elective surgery was being provided at the hospital Monday to Friday. A

consultant was available for the surgical directorate between 8am and 10pm and out-of-hours surgical cover was being covered by the on-call team at Carlisle. There was also no pharmacy service out of hours, although advice and support could be obtained from an on-call pharmacist, when necessary. Surgery was managed in accordance with NCEPOD recommendations and the Royal College of Surgeons standards for emergency surgery. Policies were in place, but in ophthalmology were found to be out of date and failed to refer to national guidance. Mortality data did not demonstrate any risks.

Patient reported outcome measures (PROMs) data showed requirements for improvement in meeting all nine standards for care to improve patient reported outcomes for patients undergoing primary hip replacement. Although available, PROMs data was not regularly used or discussed.

At this inspection the surgical services provided effective care and treatment that followed national clinical guidelines and staff used care pathways effectively. The services participated in national and local clinical audits. The surgical services performed in line with similar sized hospitals and performed within the England average for most safety and clinical performance measures.

The majority of patients had a positive outcome following their care and treatment. Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team. Staff sought consent from patients before delivering care and treatment. Staff understood the legal requirements of the Mental Capacity Act 2005 and deprivation of liberties safeguards.

Evidence-based care and treatment

- Surgical care pathways followed National Institute for Health and Care Excellence (NICE) and Royal College of Surgeons guidelines.
- Staff provided care in line with 'Recognition of and response to acute illness in adults in hospital' (NICE clinical guideline 50) and 'Rehabilitation after critical illness' (NICE clinical guideline G83).
- The monthly departmental meetings discussed changes to national and best practice guidance, how it would impact on services and how it would be implemented. Progress against the clinical audit plan and compliance with NICE guidelines was also reported to the safety and quality committee every three months.
- Enhanced recovery pathways were used in a number of surgical specialities. Enhanced recovery is a modern, evidence-based approach that helps people recover more quickly after having major surgery.
- Staff told us policies and procedures reflected current guidelines and were easily accessible via the trust's intranet.

Pain relief

- Patients were assessed pre-operatively for their preferred post-operative pain relief. Staff used pain assessment charts to monitor pain symptoms at regular intervals.
- Staff in the surgical wards and theatres were supported by an acute pain specialist nurse that was based at the hospital.
- Patient records showed that patients received the required pain relief and that they were treated in a way that met their needs and reduced discomfort. Patients told us staff gave them pain relief medication when needed.

Nutrition and hydration

- The patient records included assessments of patients' nutritional requirements. Where patients were identified as at risk, there were fluid and food charts in place and these were reviewed and updated by the staff.
- Where patients did not eat enough, this was addressed by the medical staff to ensure patient safety. Patient records also showed that there was regular dietician involvement with patients who were identified as being at risk. Patients with difficulties eating and drinking were placed on special diets.
- 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.
- Patients told us they were offered a choice of food and drink and spoke positively about the quality of the food offered.

Patient outcomes

- The national joint registry data up to July 2014 showed that hip and knee mortality rates were in line with the national average.
- Performance reported outcomes measures (PROMs) data between April 2013 and March 2014 showed that

the percentage of patients with improved outcomes following groin hernia, hip replacement, knee replacement and varicose vein procedures was either similar to or better than the England average.
- The lung cancer audit 2014, reporting on all of 2013, showed the trust performed better than the England and Wales average for the number of cases discussed at multidisciplinary meetings and the percentage of patients having a CT scan before bronchoscopy. The trust performed worse than the England and Wales average for the percentage of patients receiving surgery in all cases (9.8% compared with the average of 15.1%).
- The national bowel cancer audit of 2014 showed that the trust was performing better than the England average for the number of patients that had a CT scan, the number of patients for whom laparoscopic surgery was attempted, length of stay above five days,
- The trust performed similar to the England average for the number of cases discussed at multidisciplinary team meetings (98% compared with average of 99.1%) and the number of patients seen by a clinical nurse specialist (87.4% compared with average of 87.8%).
- The national bowel cancer audit also showed that the trust was worse than the England average for case ascertainment rate (86% compared with average of 94%), data completeness (79% compared with average of 87%) and the number of patients that underwent major surgery (53.7% compared with average of 63.7%).
- The number of patients that had elective and non-elective surgery and were readmitted to hospital following discharge was similar to or better than the England average for all specialties.
- The average length of stay for elective and non-elective patients across all specialties was better the England average.

Competent staff

- Newly appointed staff had an induction and their competency was assessed before working unsupervised. Agency and locum staff also had inductions before starting work.
- Records showed 68% of nursing staff and 45% of medical staff across the surgical services at the hospital had completed their annual appraisals during the year (April 2014 to December 2014).
- Appraisals were on-going and the staff we spoke with told us they routinely received supervision and annual appraisals.
- Records showed that 100% of surgical medical staff had been positively recommended to the General Medical Council for revalidation.
- The nursing and medical staff we spoke with were positive about on-the-job learning and development opportunities and told us they were supported well by their line management.

Multidisciplinary working

- There was effective daily communication between multidisciplinary teams within the surgical wards and theatres. Staff handover meetings took place during shift changes and 'safety huddles' were carried out on a daily basis to ensure all staff had up-to-date information about risks and concerns.
- Multidisciplinary meetings took place routinely and involved consultants across both hospitals via video link.
- There were routine team meetings that involved staff from the different specialties. Patient records showed that there was routine input from nursing and medical staff and allied health professionals.
- There was effective multidisciplinary working between the two hospital sites so that patients that required emergency treatment or surgery could be transferred to Cumberland Infirmary if needed.
- The ward and theatre staff we spoke with told us they received good support from pharmacists, dieticians, physiotherapists, occupational therapists, social workers and diagnostic support such as for x-rays and scans.

Seven-day services

- Staff rotas showed that nursing staff levels on the wards were sufficiently maintained outside normal working hours and at weekends.
- Skiddaw 1 (the day surgery ward) was open during normal working hours on weekdays. Skiddaw 2 (the elective orthopaedic ward) admitted elective patients during weekdays. The ward manager told us they carried out some elective surgery for privately-funded patients on Saturdays.
- Emergency general surgery was provided between 8am to 8pm. Emergency ophthalmology surgery was provided during Monday to Friday 9am to 5pm.

- Consultants were available between 8am and 10pm, with a consultant on call during out-of-hours service. At weekends, newly admitted patients were seen by a consultant or a registrar.
- Microbiology, imaging (e.g. x-rays), physiotherapy and pharmacy support was available on-call outside of normal working hours and at weekends.
- The ward and theatre staff told us they received good support outside normal working hours and at weekends.

Access to information

- The hospital used paper patient records. The records we looked at were complete, up to date and easy to follow. They contained detailed patient information from admission and surgery through to discharge. This meant that staff could access all the information needed about the patient at any time.
- Notice boards detailed information relating to staffing levels and identified patients with specific needs, such as patients at risk of falls. Information such as audit results, performance information and internal correspondence was displayed in all the areas we inspected.
- Staff told us the information about patients they cared for was easily accessible. Staff could access information such as policies and procedures from the trust's intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood the process for obtaining verbal and written consent from patients before providing care or treatment. Patient records showed that consent had been obtained from patients or their representatives and that planned care was delivered with their agreement.
- Staff understood the legal requirements of the Mental Capacity Act 2005 and received mandatory training in the deprivation of liberties safeguards.
- If patients lacked the capacity to make their own decisions, staff told us they sought consent from the appropriate person (advocate, carer or relative) that could legally make decisions on the patient's behalf. When this was not possible, staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals.
- There was a trust-wide safeguarding team that provided support and guidance for staff for mental capacity assessments, best interest meetings and deprivation of liberties safeguards applications.

Are surgery services caring?

Good

At the previous inspection we reported that 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.

At this inspection patients spoke positively about their care and treatment. They were treated with dignity and compassion. Data for patient satisfaction surveys showed that most patients were positive about recommending the hospital's wards to friends and family. Staff kept patients and their relatives involved in their care and supported their emotional needs.

Compassionate care

- During the inspection, we saw that patients were treated with dignity, compassion and empathy. We observed staff providing care in a respectful manner.
- We spoke with four patients. All the patients we spoke with said they thought staff were kind and caring and gave us positive feedback about ways in which staff showed them respect and ensured that their dignity was maintained.
- The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. The test data between December 2013 and November 2014 showed that all the surgical wards consistently scored above the England average, indicating that most patients were positive about recommending the hospital's wards to friends and family.
- The percentage of patients that completed the survey out of all eligible patients (average response rate) was 22%, which was worse than the England average of 32%. Ward staff told us they routinely encourage more patients to complete the test when they were discharged from the hospital.

Surgery

- A review of the data from the CQC's adult inpatient survey 2013 showed that the trust was about the same compared with other trusts for all 10 sections, based on 414 responses received.

Understanding and involvement of patients and those close to them

- Staff respected patients' rights to make choices about their care. We observed staff speaking with patients clearly in a way they could understand.
- Patient records included pre-admission and pre-operative assessments that took into account individual patient preferences.
- Patients told us they were kept informed about their treatment. They spoke positively about the information they received verbally and also in the form of written materials, such as information leaflets specific to their treatment. The patients we spoke with told us the medical staff fully explained the treatment options to them and allowed them to make informed decisions. One patient commented that "medical treatment well delivered and was told what was going to happen".

Emotional support

- Patients told us they were supported with their emotional needs. Information leaflets were available to provide patients and their relatives with information about chaplaincy services and bereavement or counselling services.
- 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 could also access psychological support for the families of patients who were seriously ill.

Are surgery services responsive?

Requires improvement

Summary

At the previous inspection we reported that locally, staff were responsive to people's needs although there were areas for improvement. There was no evidence to suggest that there were processes that allowed staff to learn from complaints. We noted that booklets were available on wards, but the booklet refers to the Care Quality Commission providing an independent review of complaints, which was inaccurate.

Since June 2013, trauma operative work, high risk general surgery and colorectal cancer work has all transferred to Carlisle Infirmary. This has led to routine elective work being regularly cancelled at Carlisle. The transfer of routine work to West Cumberland has not been systematic, as anticipated, because patients prefer to wait to have their procedure at Carlisle. This had affected referral to treatment times (RTT) which were not being met for admitted patients, particularly in orthopaedics. The trust had a detailed action plan, which included such measures as: additional number of procedures per month to achieve 90%; fully utilising capacity at West Cumberland and recruiting extra consultants. However, there is a clear difficulty recruiting in the North Cumbria area, which was hindering the plan. The distance between the two sites appears to be a major factor in patients' decision-making, rather than the care provided.

At this inspection the surgical services had failed to meet 18 week referral to treatment standards across all specialties between July 2013 and September 2014. There was insufficient bed capacity in the wards due to surgical beds being occupied by medical patients. This meant that operations were frequently cancelled due to the lack of available beds. The number of patients whose operations were cancelled and were not treated within the 28 days was worse than the England average between July 2013 and September 2014.

There were systems in place to support vulnerable patients. The majority of complaints relating to surgical services (78%) were resolved within expected time frames during 2014/15. Complaints about the service were shared with staff to aid learning.

Service planning and delivery to meet the needs of local people

- The hospital provided a range of elective and unplanned surgical services for the communities it served. This included trauma and orthopaedics, ophthalmology, urology and general surgery.
- Hospital episode statistics 2013/14 data showed that 25,477 patients were admitted for surgery across the

trust between July 2013 and June 2014. The data showed that 63% of patients had day case procedures, 17% had elective surgery and 20% were emergency surgical patients at this hospital.
- The hospital had five operating theatres for surgery, including two general surgery theatres, two orthopaedic surgery theatres and an ophthalmology theatre.
- Since 2013, fractured neck of femur (hip) surgery, trauma high risk general surgery and colorectal cancer surgery had been transferred to Cumberland Infirmary. The hospital provided general surgery, such as colorectal surgery and upper gastrointestinal surgery for low risk patients.
- Emergency general surgery was provided between 8am to 8pm. Emergency ophthalmology surgery was provided during Monday to Friday 9am to 5pm.
- The hospital provided elective ophthalmology surgery for adults. Children and patients requiring ophthalmology surgery under general anaesthetic were transferred to Cumberland Infirmary for treatment.

Access and flow

- Patients could be admitted for surgical treatments through a number of routes, such as pre-planned day surgery, via accident and emergency or via GP referral.
- Patient records showed that patients were assessed upon admission to the wards or prior to undergoing surgery.
- Patient records showed discharge planning took place at an early stage and there was multidisciplinary input (e.g. from physiotherapists and social workers). Staff completed a discharge checklist, which covered areas such as medication and communication to the patient and other healthcare professionals to ensure patients were discharged in a planned and organised manner.
- During the inspection, we found that that all available beds were occupied in the surgical wards we visited. Bed occupancy was monitored on a daily basis and patients were transferred to other surgical wards if no beds were available within a specific surgical specialty.
- During the inspection, we saw that there were significant numbers of medical patients admitted to the surgical wards (medical outliers). For example, Overwater 1 and 2 (the emergency surgical and trauma ward) had 30 inpatient beds, of which 24 beds were occupied by medical patients due to a lack of available beds within medical wards.
- Records showed that between September 2014 and December 2014 there were a total of 1,198 instances where surgical beds were occupied overnight by medical patients (medical outliers) at the hospital.
- Staff told us the medical patients were assessed prior to being admitted to the surgical wards and only patients deemed as low risk were admitted on the surgical wards, so they could be appropriately cared for by the surgical ward staff.
- Trust data for operations cancelled on the day of surgery at the hospital showed that there had been a total of 412 operations cancelled on the day of surgery between July 2014 and March 2015 and these accounted for 7.2% of all operations carried out at the hospital. Approximately 58% of the cancellations were due to clinical reasons or patient choice. However, 149 of the 412 (36%) operations cancelled were due to non-clinical reasons.
- Trust data for all operations cancelled across the trust (including prior to admission and on day of surgery) showed that there had been a total of 695 operations cancelled for non-clinical reasons between January and March 2015, and 419 (62%) of these cancellations were due to ward beds unavailable and bed shortages.
- NHS England data showed that between July 2013 and September 2014 the trust performed worse than the England average for the number of patients whose operations were cancelled and were not treated within the 28 days. A total of 88 patients were not treated within 28 days during this period.
- During the inspection, we spoke with two patients that were admitted for day surgery. Both patients told us their procedures had been cancelled on three occasions prior to their surgery that day.
- The hospital measured operating theatre session times (minus time lost through late starts and early finishes). The data between April 2014 and March 2015 showed that the percentage of sessions that were completed within scheduled times across the hospital's operating theatres ranged from 61% to 76%. This meant there were occasions where theatre lists started and finished later than scheduled.
- NHS England data showed national targets for 18 week referral to treatment (RTT) standards for admitted patients were not achieved between April 2013 and November 2014. The data showed that the trust did not meet the waiting time target of 90% for any of the surgical specialties provided.

- There was an on-going action plan to improve performance against RTT standards for each specialty. This included key actions such as improved planning to reduce the back log of patients, improving theatre capacity and use of private sector healthcare organisations to treat patients awaiting surgery.

Meeting people's individual needs

- Information leaflets about services were readily available in all the areas we visited. Staff told us they could provide leaflets in different languages or other formats, such as braille, if requested.
- Staff could access a language interpreter if needed.
- The areas we inspected were compliant with same-sex accommodation guidelines. We saw that patients' bed curtains were drawn and staff spoke with patients in private to maintain confidentiality. Patients could also be transferred to side rooms to provide privacy and to respect their dignity.
- Staff received mandatory training in dementia care. The areas we inspected also had dementia link nurses in place. Staff could also contact a trust-wide safeguarding team for advice and support for dealing with patients living with dementia or a learning disability.
- Staff also used an 'adult passport' document for patients admitted to the hospital with a learning disability or dementia. This was completed by the patient or their representatives and included key information such as the patient's likes and dislikes. The ward staff told us the additional records were designed to accompany the patients throughout their hospital stay. We saw evidence of this in the patient records we looked at.
- Staff could access appropriate equipment, such as specialist commodes, beds or chairs to support the moving and handling of bariatric patients (patients with obesity) admitted to the surgical wards and theatres.

Learning from complaints and concerns

- Ward and theatre areas had information leaflets displayed for patients and their representatives on how to raise complaints. This included information about the Patient Advice and Liaison Service (PALS). The patients we spoke with were aware of the process for raising their concerns with the trust.
- The ward and theatre managers were responsible for investigating complaints in their areas. The timeliness of complaint responses was monitored by the trust-wide complaints team, who notified individual managers when complaints were overdue.
- Staff told us that information about complaints was discussed at weekly staff meetings to aid future learning.
- During 2014/15, the trust received 234 complaints relating to the surgical services, of which 57 complaints related to surgical services provided at this hospital. The trust resolved 45 (78%) of the 57 complaints within the agreed timeframe with three closed beyond the agreed date.
- The most frequent reason for patient complaints (77% of complaints received) related to the treatment and care provided along with the outcomes of the treatment by the clinicians during inpatient and outpatient care.

Are surgery services well-led?

Good

Summary

At the previous inspection we reported the trust had a vision and strategy for the organisation with clear aims and objectives. The trust vision, values and objectives had been cascaded across the surgical wards and departments and some staff had a clear understanding of what these involved. There were differing levels of engagement with the trust's vision and strategy in the areas we visited. Documents provided could not demonstrate that quality improvements were discussed or that the performance dashboard was reviewed for all surgical specialities.

Staff felt well led at ward level but the vacancies in middle management roles within the surgical team had detrimentally affected the leadership above the ward manager. There was lack of consistent presence at the hospital at General Manager level, the shared management approach reduced accountability for the site. The clinical governance system included learning from incidents and risk but there was no specific reference to quality improvements or complaints, and feedback to staff was inconsistent.

Surgery

At this inspection the trust vision and values which had been cascaded across the surgical wards and departments were clear understood. There was no strategic plan specifically for the surgical services but there were plans to develop a service strategy during 2015. Existing plans for improving the surgical services were incorporated into trust-wide strategies, such as the medical workforce strategy 2014-19.

There was effective teamwork and clearly visible leadership within the surgical services. The majority of staff were positive about the culture and support available. Monthly governance meetings reviewed incidents, key risks and monitoring of performance. Risks were documented and escalated by the service appropriately. There was routine public and staff engagement and actions were taken to improve the services.

Vision and strategy for this service

- The trust vision was "to provide person centred world class quality healthcare services" and the values were based on providing safe, caring and responsive services.
- The trust vision, values and objectives had been cascaded to staff across the wards and theatre areas we inspected and staff had a good understanding of these.
- There was no specific strategy document for surgical services across the trust. However, the plans for improving the services were incorporated into trust-wide strategies, such as the medical workforce strategy 2014-19, which included specific objectives such as improving 7-day service provision and plans to centralise surgical services at each hospital in order to improve patient care.
- The trust planned to develop a strategic plan for the emergency surgery and elective care business unit during 2015.

Governance, risk management and quality measurement

- There were monthly governance meetings and monthly staff meetings. There was a set agenda for these meetings with standing items, including the review of incidents, key risks and monitoring of performance. Identified performance shortfalls were addressed by action planning and regular review.
- Risks were documented and escalated by the service appropriately. The risk register for surgery showed that key risks had been identified and assessed.
- In each area we inspected, there were routine staff meetings to discuss day-to-day issues and to share information on complaints, incidents and audit results.
- Information relating to patient safety was displayed on notice boards in each of the areas we inspected. This provided up-to-date information on staff training and appraisal, specific issues and audit performance.
- We saw that routine audit and monitoring of key processes took place across the ward and theatre areas to monitor performance against objectives. Information relating to performance against key quality, safety and performance objectives was monitored and cascaded to ward and theatre managers through performance dashboards.

Leadership of service

- There were clearly defined and visible leadership roles across the emergency surgery and elective care business unit. The services were divided into clinical directorates based on specific surgical specialties and each speciality had a clinical director and an operational service manager.
- The surgical wards were led by ward managers that reported to the matron for surgery. The matron for theatres oversaw the theatres across both hospitals.
- The theatres and ward based staff we spoke with told us they understood the reporting structures clearly and that they received good support from their line managers.

Culture within the service

- The staff we spoke with were proud, motivated and spoke positively about the care they delivered. Staff told us there was a friendly and open culture. They told us they received regular feedback to aid future learning and that they were supported with their training needs by their managers.
- The surgical business unit governance report from February 2015 showed that staff sickness levels across the surgical services ranged between 4.66% and 6.15% between January and December 2014. The sickness levels were higher than the overall trust and national averages during that period. The most frequent reasons for staff sickness were anxiety, stress, depression or other psychiatric illnesses and other musculoskeletal problems.

- Staff sickness levels were reviewed daily in the wards and theatres and staffing levels were maintained through the use of overtime for existing staff and bank and agency staff.

Public and staff engagement

- The patient experience team conducted monthly surveys by speaking with patients on the surgical wards. The surveys asked for patient opinions in nine areas, including respect and dignity, involvement, pain control, doctors, nurses, pain control and medicines. Feedback from patient surveys was displayed in the areas was mostly positive with average scores of nine out of 10.
- The trust also carried out a patient survey between April and December 2014. The survey was based on the national NHS patient survey programme and involved questionnaires being mailed to patients at home shortly after discharge.
- The average score for this hospital's inpatient surgical wards was 82%, based on 301 responses. The average score for the hospital's day case services was 89%, based on 202 responses. This showed the majority of patients were satisfied with the care they received.
- The staff we spoke with told us they received good support and regular communication from their line managers. Staff routinely participated in team meetings across the wards and theatres we inspected. The trust also engaged with staff via email blogs, newsletters and through other general information and correspondence that was displayed on notice boards and in staff rooms.

Innovation, improvement and sustainability

- The surgical services were scheduled to transfer to a newly built hospital on the site in October 2015. The majority of staff spoke positively about the planned move. The new hospital offered newly built wards and theatres with new equipment and facilities to improve the overall patient experience.
- The matron for surgery was confident the surgical services at the hospital were sustainable in the future. The matron told us the hospital was moving towards providing more elective and day case services with emergency surgery services being transferred to Cumberland Infirmary.

Critical care

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

Information about the service

The critical care unit at West Cumberland Infirmary in Whitehaven was commissioned for five level 3 beds or four level 3 beds and two level 2 beds, which were used flexibly as the service demanded. All six of the available bed spaces were equipped to provide level 3 care and treatment. There was also a side room with an atrium or gowning area that was used for patients with specific infection control issues. The side room could provide either positive or negative pressure as required. At the time of our inspection there were four patients on the unit.

The unit is old with limited space and can only be accessed by walking through the endoscopy unit. It falls significantly short of most recent health building note (HBN-04-02) specifications.

For the purposes of governance the unit sits in the emergency care and medicine business unit.

During the inspection we spoke with two medical staff, nine members of the nursing team, two patients and two sets of relatives. We also reviewed patient records, policies, guidance and audit documentation.

Summary of findings

The critical care service had improved since our last inspection and was providing patients with a good service. There were sufficient numbers of suitably skilled nursing staff to care for the patients appropriately. There was access to a consultant and middle grade anaesthetist at all times although out of hours the middle grade anaesthetist had on call responsibilities for other specialities. There were robust systems and processes in place for reporting incidents and there was evidence that learning from incidents was disseminated. National data confirmed that patient outcomes were within the expected ranges when compared with similar units. Critical care was being delivered by caring and compassionate staff. Patients, their relatives and friends were treated with dignity and respect.

Critical care

Are critical care services safe?

Good

Summary

At the last inspection, in April 2014, we reported staff were caring and compassionate, patients and relatives spoke highly of the care and treatment they had received. There was a full complement of nursing staff in place to meet patients' needs. The unit had access to a consultant and an anaesthetist seven days a week. There were daily ward rounds that were consultant-led. Out-of-hours medical cover was provided by a staff grade anaesthetist with an on-call consultant.

Care and treatment was delivered in accordance with national guidance. Staff applied current infection prevention and control guidelines. Cleaning schedules were in place, and there were clearly defined roles and responsibilities for cleaning the environment and cleaning, maintaining and decontaminating equipment.

Multi-disciplinary working was well established and staff worked well together as a team. Medicines, including controlled drugs, were safely and securely stored. At this inspection, there were sufficient numbers of suitably skilled nursing staff to care for the patients. There was access to a consultant and middle grade anaesthetist at all times although out of hours the middle grade anaesthetist had on call responsibilities for other specialities.

There were robust systems and processes in place for reporting incidents and there was evidence that learning from incidents was disseminated. The unit continued to collect and submit data for the intensive care national audit and research centre (ICNARC) for validation. This data showed that patient outcomes were within the expected ranges when compared with similar units nationally.

Critical care was being delivered by caring, compassionate and committed staff. We saw patients, their relatives and friends being treated with dignity and respect and the care being delivered was patient focussed taking their wishes into account. When people required intensive care there were no significant delays in that care being delivered. In accordance with the trust wide reconfiguration of services there has been in reduction in the numbers of surgical and trauma cases being admitted.

Incidents

- All the staff we spoke with were confident in using the trust's incident reporting system. They also felt that they received adequate feedback mainly via the staff huddles held on both daily on both day and nights shifts.
- Incidents were investigated when indicated and the outcome reports were available for staff to read. There was evidence that learning from incidents and near misses was shared and learning applied. For example, since May 2014, longer guide wires had been introduced following the investigations into two previously reported never events involving central venous catheter guide wire retention. In addition two man checks had been introduced alongside revised paper and electronic records.
- There had been no never events reported in critical care since the last inspection.
- The business unit produced monthly incident figures which showed that there had been 47 reported incidents in the West Cumberland Infirmary critical care unit between April and December 2014. These had predominantly (25) resulted in no harm to the patient. Ten had resulted in minor harm with four near misses and eight incidents remaining open and under investigation.
- The monthly incident figures showed that the 'top' incidents in the unit were pressure sores and staffing levels followed by incidents relating to the security of people, documentation and medical equipment. Further analysis showed that of the seven pressure sores reported as incidents, six developed whilst in the North Cumbria trust.

Safety thermometer

- The safety thermometer information on display in the unit gave a quick and simple method for surveying patient harm.
- What was displayed showed predominantly 100% harm free care except in those incidences where pressure ulcer data and venous thromboembolism assessment shortfalls meant a drop to 90%.

Cleanliness, infection control and hygiene

- At the time of inspection the unit was clean, tidy and organised.

- We saw staff adhering to good practice guidance for the prevention and control of infection. There were adequate numbers of hand washing sinks and hand gel dispensers throughout the unit.
- We saw staff using personal preventative equipment appropriately, such as gloves and aprons, when delivering care and treatment.
- All staff including visiting physicians adopted a bare below the elbow approach.
- The unit had an isolation cubicle available with the ability to adjust the airflow independently to provide either positive or negative pressure depending upon the needs of the patient being isolated.
- We saw evidence that infection control audits were undertaken and the results showed high levels of compliance. For example, with care bundle, hand washing and personal protective equipment audits.

Environment and equipment

- Each bed space was capable of managing a level 3 patient.
- The unit was old and unable to meet the current health building note standards (HBN -04-02) for the environment. This is to be resolved with the planned move to the new hospital build in September 2015. For example, access to the unit involved walking through the adjoining endoscopy patient area.
- There was natural light available for the patients and views out over the local countryside.
- Resuscitation and difficult airway trolleys were in place and checked daily and/or after use.
- The transfer kit was also checked daily so that it was ready for use when required.

Medicines

- Allergies were clearly documented in the prescription records that we looked at.
- All patients' medicines were stored securely in a locked cupboard.
- We saw that the controlled drugs were administered in accordance with the Nursing and Midwifery Council standards for medicines management.
- Controlled drug stocks were reconciled daily.

Records

- The unit used paper based records, which were completed by the multi-disciplinary team. They contained a range of assessments and care bundles which were completed, legible and up to date.
- Observations were recorded on a large intensive care record sheet at the foot of the bed space.

Safeguarding

- We saw evidence in the training records that all staff had received safeguarding training.
- There was an internal system for raising safeguarding concerns and staff were aware of the process and could explain what constituted abuse and neglect.

Mandatory training

- Detailed records were kept of the extensive range of mandatory training undertaken for all nursing staff.
- The records clearly showed who was up to date with what mandatory training subject. The hospital wide training figures showed that the 80% standard across mandatory training subjects was not being met.

Assessing and responding to patient risk

- There were tools in place for the early detection of deterioration and we were informed that appropriate medical assistance could be requested at all times.
- The patient's records contained a range of clinical risk assessments. For example, venous thromboembolism, moving and handling and visual infusion phlebitis (VIP) assessments.
- The wards used a national early warning scoring system (NEWS) to facilitate the early detection of the deteriorating patient. The NEWS documentation clearly stated the escalation pathway for deteriorating patients.
- There was a critical care outreach team but they were unable to provide a 24/7 service. The outreach service was prioritised for weekends and nights where it worked as part of the Hospital at Night service.
- Staff on the wards were able to refer directly to the outreach team. We were told that ward staff were encouraged to refer even if they just 'felt' that something was not quite right.
- We were told that on some occasions the outreach team member was used at night to assist on busy or short staffed in-patient areas and undertake transfers. In such circumstances they were unable to provide an outreach

service which included attendance at cardiac arrests. For example, this had occurred 16 times in the period January to March 2015. Staff were unclear if such occurrences had been raised as incidents.
- Daily activity data sets were completed by the outreach team so that their performance and effectiveness could be measured.
- The outreach service did not yet provide any follow up clinic opportunities for ex critical care patients.
- The trust has implemented the training of several cohorts of advanced nurse practitioners (ANPs) who were currently being trained to manage much of the work undertaken by junior doctors on site. The critical care unit at West Cumberland had two ANPs working alongside the nursing and medical teams for three, ten hour, shifts per week each. We were told that it is envisaged that once trained they will have a role in the transfer of patients to the Cumberland Infirmary in Carlisle. We were also told that on occasions the ANP may be called to see patients that have triggered on their NEWS scoring if the outreach team were unavailable.

Nursing staffing

- On the day of inspection there were adequate numbers of suitably skilled and qualified nursing staff on duty to ensure that people received safe care and treatment.
- The unit had high proportion of band 6 and 7 experienced nurses. There were occasions when maternity leave and sickness affected the numbers but the unit operated flexible working arrangements which meant that their own staff often offered to work additional shifts to cover any shortfalls.
- Maternity leave was often covered with temporary contracts.
- Little or no agency nursing staff were used. There had been no agency usage this financial year.
- At times when the unit was not busy staff were moved to help in other in-patient areas. This process was detailed in a staff escalation policy. Understandably staff preferred to stay on the unit and not be moved. Although the escalation procedure stated that they should return to critical care if the patient numbers and acuity demanded.
- We saw that there were two shift handovers per day and in addition a sister to sister handover took place to include any non-clinical issues.
- All new nursing staff were supernumerary until deemed competent to work unsupervised.

Medical staffing

- The trust critical care service had a dedicated clinical director who worked one day per week on the West Cumberland site.
- The unit itself had a consultant of the day who worked from 08.00 until 17.00 assisted by a middle grade anaesthetist until 20.00. This arrangement does not lend itself to the same levels of continuity that having a consultant on for five days would provide.
- Out of hours medical cover was provided by a middle grade anaesthetist with consultant availability on call. It should be noted that the out of hours medical cover for critical care also provided cover for the obstetric unit, cardiac arrests and out of hospital transfers. Whilst no one could remember this level of cover resulting in any actual patient harm, the potential existed for delays in medical attendance even if requested urgently.
- Consultants carried out a ward round daily but this didn't usually take place until late morning. A second consultant ward round wasn't always documented in the medical records. We saw that the middle grade doctor and advanced nurse practitioner undertook a review of patients at the beginning of the shift before contributing to the later consultant led review of patients.

Major incident awareness and training

- The unit had a major incident plan. The hard copy available on the unit was dated 2005 but there was an up to date version on the intranet.
- Staff received training on managing a major incident.
- We did not see any evidence to demonstrate that the major incident plan had been practised.

Are critical care services effective?

Good

Summary

At the previous inspection we reported that the critical care unit was able to demonstrate that the patients who use this service received effective care and treatment through the use of current best practice guidelines by competent staff. The ICNARC data did not identify any issues or concerns

with regard to patient outcomes. Multidisciplinary teams (MDTs) worked well together to ensure coordinated care for patients. Ward rounds took place daily with input from the consultants. At the weekend, cover was provided by the staff grade anaesthetist with an on-call system in place to access the consultant. The unit had the availability of a consultant and a staff grade anaesthetist for seven days of the week up until 5pm and 8pm respectively. Out of hours, the unit had the presence of a staff grade anaesthetist with a consultant available on-call. However, staff we spoke with said that they had not received any clinical supervision or guidance regarding regular personal development. The unit was seeking the thoughts of patients and their families more actively through the introduction of patient diaries.

At this inspection the unit continued to collect and submit data for the intensive care national audit and research centre (ICNARC) for validation. This data showed that patient outcomes were within the expected ranges when compared with similar units nationally. Care was delivered in line with evidence- based, best practice guidance. However, we saw no evidence of best interest decision making processes and currently there was no formal PCA training for nursing staff.

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

Evidence-based care and treatment

- The unit used a combination of national and best practice guidance to determine the care they delivered. These included guidance from the Intensive Care Society and the National Institute for Health and Care Excellence (NICE). For example we saw care bundles for sepsis, ventilator acquired pneumonia, falls and nutrition. We noted that at present the unit had not yet implemented a delirium scoring process although this was 'work in progress'.
- All policies, procedures and guidance were readily available for staff at the bedside via the trust intranet.
- We saw that care and treatment was non-discriminatory.
- The unit demonstrated continuous patient data contributions to ICNARC. This meant the care delivered and mortality outcomes for patients were benchmarked against similar units nationally.

Pain relief

- As part of their individual care plan all patients in critical care were assessed in respect of their pain management. This included observing for the signs and symptoms of pain.
- The trust provided an acute pain management service led by a band 7 nurse who was assisted by two band 6 nurses. The team operated across both trust sites and we were told currently had no medical lead.
- The unit at West Cumberland Infirmary used a different type of patient controlled analgesia (PCA) delivery system to the one used at the Cumberland Infirmary in Carlisle. We saw that currently there was no formal PCA training for nursing staff.
- There was no epidural pain relief service being provided.

Nutrition and hydration

- Guidelines were in place for initiating nutritional support for all patients on admission to ensure adequate nutrition and hydration.
- People had a choice of suitable food and drinks with hot and cold drinks being available throughout the day and night.
- We saw strict fluid balance monitoring for patients which included hourly and daily totals of input and output.
- Staff had easy access to a dietician who was able to support patients with their individual dietary requirements. The dietician did not routinely join the multidisciplinary ward rounds but would do so on request.

Patient outcomes

- Information was routinely collected about the outcomes of people's care and treatment.
- The results from ICNARC showed that patient outcomes and mortality were within the expected ranges when compared with similar units nationally.
- Since the last inspection the unit had introduced the use of patient diaries. They are often used in cases where people have been sedated and subject to mechanical ventilation. There are completed by the nursing staff and relatives and allow the patient to later reflect on their stay in critical care as they try to evaluate and make sense of the time they were unconscious.

Competent staff

Critical care

- Whilst the unit had a practice educator, the post holder had to work across both trust hospital sites.
- Staff completed an equipment competency evaluation to assess their ability and review the effectiveness of the guidance.
- New nurses went through a supernumerary period and there was a robust mentoring and preceptorship programme. They also attended some training in the unit at Cumberland Infirmary in Carlisle.
- All nursing staff were subject to an annual check of their registration with the Nursing and Midwifery Council.
- We saw that all nursing staff were in receipt of an annual appraisal and staff told us about their personal development opportunities. For example senior nurses had been involved in a leadership programme and one band 6 nurse we spoke with was being supported to undertake a degree.
- Greater than 50% of the trained nursing staff had completed a post registration award in critical care nursing.
- All trained nurses had been trained in intermediate life support with many of the senior nurses also having obtained advanced life support qualifications.
- All the staff we spoke with told us they felt supported and that one of the unit's strengths was its peer support.

Multidisciplinary working

- We saw evidence of positive multi-disciplinary team working. For example, ward rounds would often include relevant professionals like nurses, specialist nurses, physiotherapists, dieticians and pharmacist which helped to improve communication and coordinate patient care.
- The critical care outreach team worked closely with the unit staff and visited the unit every day to establish the likelihood of any discharges. The critical care outreach staff had also assisted in the unit when requested to do so.
- Since the re-configuration of services with emergency surgery and trauma moving to the Carlisle site there was a need to work closely with the neighbouring unit. A joint monthly governance meeting was held but it was not always possible for staff from the unit at West Cumberland Infirmary to attend as the meetings were held on the Carlisle site.
- We saw that the trainee advanced nurse practitioners were integrated into the critical care unit and were well known to the unit staff.

Seven-day services

- A consultant led ward round took place every week day. At the weekend and out of hours consultant cover was via an on-call rota. Out of hours and at weekends the unit relied on medical cover from a middle grade anaesthetist who also had on call responsibilities for obstetrics and if required, patient transfers.
- Out of hours pharmacy, physiotherapy and imaging services were available during the daytime at weekends and then via on call.

Access to information

- All the information needed to deliver effective care and treatment was readily available to staff in the form of paper based records and assessments.
- Formal handover documentation was prepared for ward staff when a patient was discharged from critical care.

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

- The review date has passed for the trust consent policy that we saw.
- The staff we spoke to were able to demonstrate understanding of the issues of consent and capacity for patients in critical care.
- Whilst staff were able to verbalise their understanding of restraint, there was no delirium or restraint pathways in place.
- We saw in one patient's notes that they had consented to a procedure being undertaken.
- We saw no evidence of best interest decision making processes.

Are critical care services caring?

Good

Summary

At the previous inspection we reported ICU services were delivered by a hardworking, caring and compassionate staff. We observed that staff treated the patients with dignity and respect and planned and delivered care in a way that took patients' wishes into account. The evidence seen demonstrated that the trust was good at involving patients, family and friends in all aspects of their care and treatment.

Critical care

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

Compassionate care

- We saw that staff took the time to interact with people being cared for on the unit and those close to them in a respectful and considerate manner.
- Staff were encouraging, sensitive and supportive in their attitude.
- People's privacy and dignity was maintained during episodes of physical or intimate care. Curtains were drawn around people appropriately explanations given prior to care being delivered. We noted that closure clips and do not disturb signs were used to effect.
- Visiting times were flexible to accommodate the varying needs and commitments of people.

Understanding and involvement of patients and those close to them

- We saw that staff communicated with people so that where possible they understood their care and treatment. This was corroborated by the two patients that we were able to speak with during the inspection.
- We spoke with four relatives visiting the critical care unit during the inspection and all spoke highly of the care their relatives were receiving. They confirmed that they were kept informed and updated as to 'what was going on'.
- There were communication records in the medical records that were updated with conversations that staff had with families.
- Since the last inspection the unit had introduced patient diaries for those people who were unconscious during part of their stay in critical care. Intensive care patient diaries are a simple but valuable tool in helping people come to terms with their critical illness experience. The diary is written for the patient by healthcare staff, family and friends. Research has shown that patient diaries often help the patient better understand and make sense of their time in critical care and help to prevent depression, anxiety and post-traumatic stress.
- Language interpreters and sign language interpreters were available on the unit should they be required.

Emotional support

- Staff demonstrated that they understood the impact of critical care interventions on people and their families both emotionally and socially.
- Initial and on-going face to face meetings were implemented by nursing and medical staff to keep people informed about their relatives care and treatment plans.
- There was a senior nurse for organ donation in post who worked closely with the critical team in managing the sensitive issues relating to approaching families to discuss the possibilities of organ donation.

Are critical care services responsive?

Good

Summary

At the previous inspection we reported that 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. The records showed that medical patients were admitted to the unit within the governed time of four hours of being admitted or transferred to a ward. We noted that non-clinical transfers from ITU were low. However, the ITU consultant we spoke with expressed concern that demand for services was increasing and that the unit has recently seen an increase in non-clinical transfers. The trust needs to monitor this to ensure that these types of transfers do not adversely impact on patient care.

At this inspection when people required intensive care there were no significant delays in that care being delivered. In accordance with the trust wide reconfiguration of services there has been a reduction in the numbers of surgical and trauma cases being admitted. There were no issues with delayed discharges where the unit performed better than comparable trusts. One area of risk was the need to transfer ill patients to the Cumberland Infirmary at Carlisle; this was predominantly undertaken for reasons of clinical need.

However, the critical care outreach team on the West Cumberland site prioritised nights and weekends and was not provided 24/7. Physical access to the unit was via the endoscopy unit however this would be rectified once they relocated to the new hospital.

Critical care

Service planning and delivery to meet the needs of local people

- Delivering a full range of acute and critical care services to a relatively rural community on two geographically distant and separate sites is operationally challenging. The trust's long term strategy for the provision of critical care services across the two sites was still under review.
- The relocation of major elective surgical services and all emergency surgery from West Cumberland Infirmary to the Carlisle site had meant that the cadre of critical care patients being admitted to the unit at West Cumberland were predominantly from the medical speciality.

Meeting people's individual needs

- There were a number of structured bed management meetings throughout the day. These were attended by representatives from all the specialties including critical care. The meetings gave an overview of the bed management situation within the trust.
- The unit was funded for five level 3 patients or four level 3 and two level 2 patients. In effect the unit could flex to accommodate a level 2 patient that deteriorated requiring level 3 care and treatment.
- The care records that we reviewed demonstrated that peoples' individual needs were taken into consideration before delivering care.
- The team on critical care were able to meet the cultural needs of patient's in terms of religious beliefs and specialist dietary requirements.
- The unit offered both natural light and views of the surrounding countryside from its elevated position within the hospital
- Facilities situated just outside the unit's main doors were available for visitors.
- Physical access to the critical care unit could only be achieved for any visitors by walking through the adjoining endoscopy unit. Potentially this could impact on the privacy and dignity of those patients receiving care and treatment in the endoscopy ward. This situation would be rectified with the move to the new hospital.
- The relative's room contained a variety of useful information for visitors including how to contact the patient advisory and liaison team (PALS).

Access and flow

- Patients were admitted to critical care within four hours of the decision to admit and were then seen by a consultant within 12 hours of that admission.
- Patients were generally discharged from the unit within four hours of the decision to transfer them to the ward.
- There had been an increase in the numbers of patients requiring transfer to the Cumberland Infirmary at Carlisle. All staff working on the unit had been trained in managing the transfer of critically ill adult patients.
- The unit was also used to stabilise paediatric patients and had specifically trained nurses who would manage those patients whilst they awaited retrieval from the specialist paediatric receiving hospital.
- When discharged from critical care to the wards, the patients would be seen by the critical care outreach team, whose service on the West Cumberland site prioritised nights and weekends and was not provided 24/7.

Learning from complaints and concerns

- We found low levels of complaints about critical care and evidence that the service responded promptly to people's comments and concerns. The unit had received only one compliant during the past year.
- Staff were aware of the trust complaints policies and processes and any complaints were handled in accordance with trust policy.
- In discussions with nursing staff it became apparent that they were aware of the recently introduced requirements concerning Duty of Candour.

Are critical care services well-led?

Good

Summary

At the previous inspection we reported that most staff felt well supported at a local team level, although we identified some staff concerns about the variability of leadership. This was supported by good governance processes, although we noted that identified risks did not always reflect the risks perceived by staff. There was a mixed response to the new hospital as some staff were unclear of their position after transition. The trust had a vision and values for the organisation, which were on display throughout the hospital. Staff found there was a lack of visibility of the trust leads. At this inspection staff felt happy with the level of

engagement with senior staff on the unit, confident to discuss any concerns and felt they would be listened to. Both medical and nursing staff felt the unit was well run and that senior staff and peers were supportive.

Staff questioned the appropriateness of the recent business unit changes, which had seen critical care move from the emergency surgical and elective care business unit to the emergency care and medicine business unit. Critical care was clinically led by anaesthetists who had remained in the emergency surgical and elective care business unit. There was a lack of understanding as to why this move had taken place. Since our last inspection the trust had commissioned a critical care capacity review, which was carried out by the North of England Critical Care Network. They duly published their findings in a report dated July 2014. A key recommendation was that the trust should develop a trust wide critical care delivery group to allow for greater co-ordination and longer term planning of the critical care service across the trust. To date this group had not been established.

At our inspection last year some critical care staff felt disengaged particularly around what the future critical care service would look like following the move to the new hospital build and this position hadn't improved.

Vision and strategy for this service

- There was a clear vision and strategy presented by the trust in that it strove to be 'safe, caring and responsive' but uncertainties were expressed by staff locally as to the future direction of critical care on the West Cumberland hospital site. We found in our inspection of last year that some critical care staff felt similarly disengaged and this position hadn't really improved.
- In 2014 the trust commissioned a critical care capacity review, which was carried out by the North of England Critical Care Network. They duly published their findings in a report dated July 2014. A key recommendation was that the trust should develop a trust wide critical care delivery group to allow for greater co-ordination and longer term planning of the critical care service across the trust. To date this group had not been established.

Governance, risk management and quality measurement

- Governance processes were in place to monitor and review the quality of the service provided in critical care. These included governance and staff meetings where dashboard reports were considered in respect of incidents, complaints and risk. There were some inconsistencies in the documented risks. We saw a critical care risk register for January 2014 that only included one item of risk. This related to the availability of appropriately skilled nurses and anaesthetists to transfer critically ill patients to other hospitals whilst not compromising a safe critical care service at West Cumberland hospital. This issue remained on the risk register at January 2015 with no apparent reduction in the initial risk.
- Staff told us that depending upon the workload; they were not always able to attend governance meetings held at the Cumberland Infirmary in Carlisle.
- The key outcomes from the various staff and governance meetings were shared during a daily 'huddle' within the unit.

Leadership of service

- Senior medical and nurse leaders were committed to providing a safe service for their patients.
- The eight staff we interviewed all said they felt well supported, valued and respected.
- The critical care unit had a designated consultant clinical lead and the nursing team was led by an experienced matron. The matron worked across both trust hospitals and some nursing staff felt that they did not see her enough at West Cumberland although the operational service manager was more visible being based at Whitehaven.
- The clinical director was scheduled to work at the West Cumberland site one day per week.

Culture within the service

- The culture within the unit was one where staff felt supported and they worked as a cohesive team. Though not all staff felt engaged with what the future critical care service would look like following the move to the new hospital build.

Public and staff engagement

- Some staff still verbalised anxieties about the pending move to the new unit, which was due to take place in late summer 2015. These related to being unsure about their role and function on the new unit.

Critical care

- The trust produced a number of staff publications both providing update information on its 'improvement journey' and also inviting staff views on the challenges faced by the trust and the potential options they have to solve them.

Innovation, improvement and sustainability

- The move to the new hospital was generally still seen as a positive move which would improve the experience for critical care patients in a purpose built environment.

Maternity and gynaecology

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

Information about the service

West Cumberland Hospital in Whitehaven provided care and treatment for maternity and gynaecology patients in the west Cumbria area. The maternity services comprised outpatient clinics, a day ward, a ward for post natal and ante-natal care and a delivery suite. Community midwifery services were provided by midwives employed by the trust. For gynaecology patients there was a women's outpatients department, and inpatient beds on a surgical ward. There was a termination of pregnancy service which operated on specific days of the week.

During our visit we spoke with 17 staff and seven patients. We observed care and treatment to assess if patients had positive outcomes and looked at the care and treatment records for seven patients. We reviewed information provided by the trust and gathered further information during and after our visit. We 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.

There had been a review of Cumbria wide provision of maternity services by the Royal College of Obstetricians with the report being published the week before the inspection. Managers and staff were keen to understand how this would affect the service provided at West Cumberland Hospital and this led to uncertainty about the future of the service.

Summary of findings

In the course of this inspection we found that the service had made inspection insufficient improvement to provide high risk patients with an effective service. There was still no dedicated second theatre and the lack of dedicated medical staff and surgical cover out of hours still presented a risk to patients who required surgery. There were however sufficient numbers of midwives to meet patient needs.

There had been an increase in the clinical and quality audits completed however resulting actions for improvement and change were not always articulated and followed up. There were some concerns regarding medicines management and how learning from errors was managed and shared. There had been positive changes made in the gynaecology services to improve the patient's experience.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement

Summary

At the previous inspection we reported 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 the risks had not yet been implemented. The issues identified by the maternity service with the lack of dedicated medical staff cover, locums and regular identified clinics impacted on the services ability to respond in a timely manner and deliver an effective service. There was no dedicated second theatre available for obstetrics; this may impact on foetal/ maternal care due to a delay in accessing theatre. The maternity service had reported on its risk register the risk of suboptimal care due to the lack of permanent middle grade staff and the use of long term locums. The majority of night cover at the location is covered by agency locum staff.

At this inspection lack of medical staff remained the same, specifically out of normal working hours, which led to concerns for high risk patients or those requiring surgical intervention. There was no dedicated obstetric anaesthetist which did not meet national guidance. There was a high reliance on locum doctors due to difficulties in recruiting medical staff. There was a lack of clarity of what to report as an incident. Required actions as a result of learning from incidents were inadequately shared throughout the trust. The women's outpatient department and the ward where gynaecology patients would be accommodated did not provide an environment where staff could ensure their privacy and dignity were protected. The procedures for the safe management of medicines were not always followed. Medical staff in the maternity service were not up to date with their mandatory training.

Clinical risks to patients were identified and actions to reduce them were put in place. The maternity and gynaecology units were clean and tidy and staff adhered to infection control policies. Midwifery staff were trained to do their jobs. Required records were kept correctly. There were measures in place to protect patients from abuse. Midwifery staffing was adequate to meet the needs of the patients.

Incidents

- Staff told us there was a clear incident reporting system which was easy to use.
- There was a "trigger list for incident reporting maternity services" which was on display in in the communal staff areas. This was designed to serve as a reminder for staff of what to report as an incident However the transfer of women on both sites was not included.
- We found staff had not reported a person changing their chosen place of delivery from Carlisle Infirmary to West Cumberland hospital as an incident. This had occurred due to the lack of availability of an epidural service at Carlisle. Senior managers told us this should have been reported on the incident reporting system; however it was not included on the trigger list. This meant there was a lack of clarity of incidents to report which led to incorrect provision of information.
- No never events had occurred at this hospital in the past 12 months. Never events are serious largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.
- The numbers of incidents in the trust reported in the last nine months had remained static. There were three serious incidents in the maternity services reported in the eleven months from January 2014 to December 2014. These incidents had been or were in the process of being investigated. Action plans had resulted where the investigation was completed.
- We saw that whilst there were actions regarding the individual issues identified from a serious incident any wider learning were not evident. Two of the serious incidents were related to errors in the administration of medicines, one at each hospital site within the trust. Whilst the specifics of that medicine had been managed to prevent recurrence the overarching issue of incorrect procedures for checking medicines prior to administration had not been addressed and a further incident had occurred. This meant learning from the incidents was not robustly shared within the trust.
- Monthly risk meetings were held attended by medical and midwifery staff, where specific incidents, the findings and action points were discussed.

- Mortality and morbidity within the maternity services in the trust were included in the "maternity services quarterly integrated governance report." Between October 2014 and December 2014 there were two neonatal deaths and one intrauterine death. The status of investigations were included in the January 2015 report and senior staff discussed the learnings to date.
- A mortality action plan had been developed in response to a Cumbria wide review of perinatal mortality in February 2013 and learnings from a perinatal mortality daylong meeting held in July 2014. These actions included introduction of additional risk assessments, audits and review of care pathways. Of the 29 actions on the plan eight had been completed in January 2015 with target dates of March and April 2015 for the remaining actions.

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 maternity unit and in the female surgical ward and was freely available for patients and staff.
- Staff told us this information was used as part of the ward meetings to discuss clinical performance against these indicators.
- We reviewed the newly introduced maternity dashboard as part of the inspection. This contained clinical data against performance targets set by the trust such as number of births by caesarean section, number of inductions, morbidity and mortality information, rates for health equality measures such as smoking during pregnancy and quality information such as staffing levels and complaints. We found there were strategies for improvement in place for some areas where the indicators were outside of the targets, such as high caesarean section rates. However for others, such as high induction of labour rate for which the target was set at 15% but in November it was 26.1% there were no improvement strategies in place.
- Information from the maternity dashboard was shared with staff in the monthly newsletter. This included data, a summary of achievements against targets and when this information would be discussed further, for example a celebrating normality day to be held in May.

Cleanliness, infection control and hygiene

- Information provided by the trust showed there had been no incidences of MRSA or Clostridium Difficile in the maternity services.
- In the December 2014 report to the Infection prevention and control committee it was documented that the hand washing audit score was 100%.
- During the inspection staff were seen to adhere to infection control procedures including washing their hands between patients.
- We saw the maternity and gynaecology areas to be clean and tidy. Some areas were showing signs of wear and tear, for example cracked plaster around a hand wash sink, which could pose an infection control risk.
- Patients were asked as part of the "Two minutes of your time" survey how clean they thought the hospital ward or room had been. In December 2014 the score for the maternity ward was 9.41 as an average of the responses from a highest score of 10.
- Information provided by the trust showed 52% of medical staff and 71% of midwifery staff had completed training in infection prevention and control. This did not meet the trust's target of 80% and meant not all staff were aware of the correct procedures to follow.
- 99% of midwifery staff had completed training in hand hygiene which exceeded the trust's target of 95%, whilst 88% of medical staff had completed this training which meant the target for this staff group was not reached.

Environment and equipment

- Staff said they had the equipment they required to do their jobs. There were sufficient numbers of necessary equipment, such as Cardiotogography monitors.
- Equipment required to carry out gynaecology procedures in the outpatients department was available. This environment provided privacy for patients undergoing such procedures.
- We saw for one day in the previous month there was no record that one of the resuscitation equipment trolleys, in the maternity unit had been checked. This had been highlighted as an issue at the last inspection. Staff did not know if these checks were audited to assess compliance and take actions for improvement if required. This meant equipment could be unchecked without this being addressed.
- The surgical ward used to accommodate patients who had gynaecology procedures did not provide an

environment in which staff could fully protect their privacy or dignity. These patients were accommodated in an open ward area of eight beds, if a side room was not available, which we were told was often. There were shared bathroom and toilet facilities, with the female bathrooms being next to the male bathrooms. We saw that one of the bays in this ward was occupied by male patients who shared the communal seating area and could view the female area and toilet facilities from their bay.

- There was one waiting area in the women's outpatient department. This meant heavily pregnant women waited with those who had concerns about their unborn baby, those having consultations for a termination of pregnancy and patients having gynaecology procedures. Staff were aware this caused some women distress and were sensitive to it; however the environment did not provide any options for change.
- At the time of the last inspection there was no consistency in how equipment was provided across the two trust sites to manage maternal emergencies. We were told this had been changed so that the equipment held in the emergency trolleys was consistent on both sites.

Medicines

- We saw that medicines were not always stored securely or in line with the trust's medication policy. The medicines on the delivery suite were in an unlocked cupboard, in an unlocked room as the keypad was out of order and no other mechanism for ensuring the security of the medicines had been put in place. This meant there was access to medicines by patients and visitors.
- There was one large container with various strips of medicines stored in it which were not in boxes or identified with labels. This is not secure storage and is not in line with the trust's medication management policy. This was seen to have been removed at the time of the unannounced inspection.
- On the surgical ward used to accommodate gynaecology patients and in the women's outpatient department medicines, including medical gases were securely stored and required records were in place.
- There had been two reported medicine errors in the maternity services across the trust, one in each site, in the past 12 months. We talked with staff regarding the learning from these incidents and found that specific changes had been made, such as the withdrawal of a product which was not a medicine, but was in similar packaging. However both incidents had been due to the correct procedures for checking medicines before administration not being followed and no actions to address this had been taken.
- One further incident had taken place at West Cumberland Infirmary in March 2015 when a 24 hour dose of a medicine was given over 12 hours. Three midwives had been involved in this incident which showed the learnings from the incidents earlier in the year had not improved practice.
- Information provided by the trust showed that 78% of midwifery staff had completed medication management training with 70% having completed training in calculating drug dosages for adults. Of the medical staff working in the maternity services only 44% had completed medication management training with 40% having completed training in calculating drug dosages. This meant that not all staff, including 60% of the medical staff, who prescribed and administered medicines, were trained to do so.
- Both of these training courses were completed once during a staff member's employment with the trust with no regular updates in place. This meant staff that had completed this training could have done so several years ago with no refresher to their practice being completed.
- Staff confirmed there were no observational checks carried out as part of their training or monitoring of their ongoing competence to administer medicines.

Records

- We reviewed 13 sets of patient records. The information was clear, legible and plans of care were evident with a record of the treatment a patient had received.
- Risk assessments were present in the records. These included standardised assessments such as those for venous thrombosis and any additional risks identified such as those associated with a high body mass index.
- In the maternity records a sticker system as a quick easy to read assessment of the maternal and baby well-being had been introduced and used in a patient's notes. These included for the Mother the number of days post-delivery, the status of any wound, emotional state

and any pain. For the baby it included any concerns with their colour, stools, eyes and activity. Staff told us they thought this system was easy to use and identified any issues which required follow up.
- The "Child Health record" (red book) was issued to mothers and advice was available on how to keep the document as a main record of a child's health.
- The gynaecology records we saw were clear and legible. The filing of information in the records was not always accurate.

Safeguarding

- Midwifery and gynaecology staff had received training in the identification of adults and children who may be at risk of abuse or had signs that abuse might be taking place.
- 89% of midwifery staff had completed training in safeguarding children and young people to level 3 which is the required attained standard. 94% had completed the training in safeguarding adults to level 1 with 71% having completed level 2.
- Not all medical staff had completed the training required to ensure they would identify signs of abuse of adults and children. 58% of medical staff in the maternity unit had completed training in safeguarding children and young people with 76% having completed this training for adults. This meant doctors may not offer the support required for patients who were at risk of or were subject to abuse.
- Staff said there were two midwives with a lead responsibility for safeguarding and a registered general nurse to support staff in the gynaecology department. They provided information and support to other staff and we were told they were very helpful and were available to discuss any concerns staff had.
- Midwives and nurses knew how to access support from other agencies outside of the trust if this was required.
- Community midwives assessed any risks to the safety of the Mother and baby, such as domestic violence, as part of their initial and ongoing interventions. Should they have any concerns they would report these to the safeguarding lead midwife.
- At the last inspection in was noted that any safeguarding information was not easily accessible in the notes. We were told this had changed and it was now clearly identified by being colour coded which meant it was easily recognisable by staff.
- Staff had not received any training to aid their understanding of female genital mutilation. This meant they were not aware of how to identify this or support which may be available for patients.

Mandatory training

- Information provided by the trust showed that 65% of medical staff and 88% of nursing staff in the maternity services at North Cumbria University Hospitals trust were up to date with mandatory training. There were no targets set for this overall training performance.
- The majority of mandatory training for the medical staff did not meet the trust targets. This included 68% being up to date with fires safety, 52% for infection prevention and control and 68% for health and safety against the trust target for each of 80%. This meant not all medical staff were up to date with essential training for their role.
- Some training rates for medical staff were below the targets and highlighted as a risk on the information provided. This included 48% of medical staff having completed a self-assessment on the management of medical devices against a target of 95%, 44% had completed training on records management and keeping, with 36% completed risk management training both against a target of 80%. This meant less than half of the medical staff had received training and had the required knowledge and skills in these areas.
- There were no high risks identified in the training data provided by the trust for the maternity nursing staff. Of the 40 required training activities 30 met or exceeded the trust's target. Of the remaining basic adult life support had the fewest people trained with 60 staff members requiring this training. This meant whilst the training for nursing staff was significantly more up to date than for medical staff there remained a significant number who had not completed essential training.
- We were told newly qualified midwives worked for one week in a supernumerary capacity. This had changed from them having several months previously due to them being required to be part of the workforce on the ward. The clinical midwife manager was aware of the additional support they may need however this could result in inexperienced midwives providing care for patients.
- The training data for staff who worked in the gynaecology service were included in the trust wide

information. We saw that managers of individual areas, such as the female surgical ward, kept their own records to ensure they knew when staff were required to complete training.

Assessing and responding to patient risk

- Staff told us that an assessment of the risks to the patient and baby were carried out as part of the ante-natal screening programme. We saw records of assessments which included past medical and maternity history and social risk which may impact on the mother or baby.
- Should a high risk factor be recognised at this stage the required support would be made available. We were told this could include multi-disciplinary specialists including medical personnel such as those to advise about diabetes in pregnancy.
- There were guidelines for the risk assessment of venous thromboembolism and staff were aware of their responsibilities to assess and reduce this risk.
- We saw equipment for managing obstetric emergencies, such as post-partum haemorrhage was available and easily accessible.
- Staff said they carried out skills training in the management of maternity emergencies.
- Staff used an early warning score system to assess if a patient's condition was deteriorating.
- Midwifery staff were reminded of the need to assess maternal and neonatal risk factors in the monthly newsletter. This included guidelines for group B streptococcus in the new-born where there was learning for staff following a missed opportunity for early diagnosis of infection.
- The number of admissions to the intensive care unit from the maternity unit was five between July 2014 and December 2014. This was higher than the trust's goal of four per six months. Each case was investigated however there were no general learning from this.
- We saw the World Health Organisations guidance for 5 steps to safer surgery was in use as part of the routine of surgical procedures.
- One consultant told us that their transportable pager system, which would alert them if there was an emergency they needed to attend, did not work in some parts of the hospital. This meant they may not be aware they were required to assist in an emergency situation. This had been reported however no actions had been taken.

Midwifery staffing

- An assessment of the midwifery staffing numbers using the birth-rate plus assessment tool had been completed in January 2015. The final report had been presented to the trust board, however no decision on the actions to be taken had been finalised. We were told that it was hoped staff numbers would increase.
- The trust provided information during the inspection that the midwife to birth ratio was 1 to 24. This was better than the England average which was 1 to 28. We were told 100% of patients had one to one care during labour.
- Staff told us there were times when the wards and delivery suite were very busy and they used the escalation procedure to ensure patients received the correct level of care. This included community midwives working in the hospital and specialist midwives and managers working on the wards. We were told the escalation procedure was used frequently however the report for this on the maternity dashboard was blank.
- Staff told us they did not have time to take their allocated breaks on most shifts. It was unclear why staff were so busy when the staffing numbers were adequate on the records we saw. Managers told us they met with the director of nursing every week to discuss staffing; however there was no analyses of workforce utilisation or future planning. We were told this would be done following the birth-rate plus assessment. The use of current staffing resources, such as the community midwives, was not evaluated.
- Information provided by the trust was that during the past six years midwives had been employed on an integrated basis to work in both the hospital and community. This rotation was to be on a monthly basis however staff we spoke with said this was not the case. Several people told us they did not work in the community whilst one was doing some shifts in the community and others in the hospital. There was no clear strategy for this integrated working and no plan to ensure midwives in the community maintained their skills.
- The current sickness rate was 4.6% and we were told the majority of this was staff based in the community.
- The delivery suite co-ordinator was supernumerary unless the escalation procedure was in place. This provided for good support for less experienced midwives.

- Midwifery care assistants were used and staff told us they were an invaluable part of the team.
- Staff in the women's outpatients department told us there were an adequate number of staff to meet the needs of the patients.
- On the surgical ward where gynaecology patients were accommodated there was a high number of medical patients also on the ward which increased the workload of the staff.
- Verbal handover of information with a written record took place between each shift. Staff reported the details of any patient they had provided care for during their shift, including any risks which may be present.

Medical staffing

- The trust discussed the issue of not being able to recruit medical staff to West Cumberland Hospital, despite recruitment initiatives. This had resulted in the removal of emergency consultant surgical cover out of hours in order to focus this provision on Cumberland hospital in Carlisle. This had led to a lack of immediate surgical cover and doctors told us they were concerned about patient safety due to this.
- The one doctor available out of hours for obstetrics and gynaecology emergencies was a locum middle grade doctor, with a consultant on call. It was on the risk register that the on call consultant could also be a locum. Whilst where possible the locums were consistent there was concern that they were not part of the established workforce of the trust with the inclusion and involvement in changes, improvement policies and decisions this would bring, such as reducing the caesarean section rates.
- At the time of the last inspection there were concerns raised that there was no dedicated anaesthetist for the maternity services and one consultant anaesthetist during the night who was available for both maternity services, general surgery and intensive care. This remained the same at this inspection. This meant should a patient in labour require an emergency caesarean section and the anaesthetist was engaged in theatre with a general surgical patient there may be a delay which could put the mother and unborn baby at risk of harm. This does not meet with the Association of anaesthetists of Great Britain and Ireland (AAGBI) and the Obstetric anaesthetist association (OOA) "Guidelines for obstetric anaesthetic service 2013." This has a joint recommendation which states that "the duty anaesthetist should be immediately available to attend the obstetric unit 24 hours per day, and therefore must have no other responsibilities outside obstetrics." The measures in place involved cancellation of other surgical procedures, however this was insufficient to ensure patients were safe at all times.
- The number of consultants had increased since the last inspection and there were now no vacant posts. Those recruited had a variety of interests including gynaecology oncology, foetal medicine and minimal access gynaecology. This had led to an increase in the services offered, such as laparoscopic surgery.
- There should be seven middle grade doctors employed by the trust however there were five locum middle grades working at the time of the inspection. This meant there was a shortage of this grade of doctor, none of whom were permanent.
- There were now surgical assistants, which were qualified nurses who had completed additional training for this role. They assisted in operating theatres should there be a need for an emergency caesarean section out of hours or when a team of theatre personnel was not available.

Major incident awareness and training

- Staff were aware there was a major incident policy and knew how to access it should they be required to do so. They had not been part of a drill.

Are maternity and gynaecology services effective?

Requires improvement

Summary

At the last inspection we reported 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). The department had developed some clinical care pathways to ensure that patients received care appropriate to their needs. However, we found that the guidance was not always followed. Staff told us, and records showed, that some staff were not following the policy for induction of labour on the maternity unit. The trust's 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 of elective and emergency caesarean sections when compared nationally. We did not find evidence of a clear strategy or plan to reduce the number of caesarean sections.

At this inspection a programme of audit was underway however it was in its infancy and procedures to change practice as a result were not embedded. There was a lack of shared practice between the two trust sites although there had been some improvement since the last inspection. Caesarean section rates were higher than the trust's target. A strategy for reducing them had been introduced although some required actions had not been formalised. Patient's pain was well managed with clear pathways in both the gynaecology and maternity services. Gynaecology services had been improved and audited to assess patient satisfaction.

Some staff had a poor understanding of the mental capacity act and how it may affect patients in their care. There were some issues regarding correct procedures for consent for termination of pregnancy although staff were aware of it and working towards improvement. The breastfeeding rates were low and there was no clear strategy for improvement. There was a lack of formal multi-disciplinary working. There was no seven day service in gynaecology or early pregnancy assessment.

Evidence-based care and treatment

- Policies we saw were based on NICE and Royal College of Obstetrics and gynaecology guidelines. Those such as the induction of labour guideline had been updated in line with reviewed NICE and RCOG guidelines.
- Guidelines and policies were reviewed within a cyclical process, and also as part of the audit process. The work was managed through the trusts Maternity Guideline and Information Group (MAGIG).
- There was an audit programme based on Clinical Negligence Scheme for Trusts (CNST) Medical records had been audited against 40 high-risk clinical standards by the end of February 2015. This work was at an early stage and the plans for actions to improve practice, as a result of the audits, were not yet embedded.
- The rates of post-partum haemorrhage were greater than the trusts' target of less than 1% of total births during 10 of 11 months between January and November 2014. An audit across the trust had been completed in July 2014 however this contained no conclusion or recommendations. This meant whilst audits were being completed they were not being used to improve practice.
- The induction of labour rates were higher than the trusts' target for eleven months from January 2014 to November 2014. The trust set their target at 15% of the total births per month and the highest was 32.4% with the lowest 18%. An audit of inductions had been carried out in 2013 and recommendations made however there had been no continuous measures in place to reduce the rate and meet their own target.
- In the gynaecology service an audit of outpatient hysteroscopy had been completed which reviewed 82 cases. This included the clinical outcomes and patient satisfaction. The clinical outcomes were 100% rate of accessing the cavity and in only three of 74 cases there was a failure to remove the pathology. This showed the introduction of this laparoscopic procedure was successful.
- Medical and nursing staff stated there was a lack of sharing of knowledge and experiences between the two hospital sites in the trust. This meant opportunities to learn and change practice as a result of good or poor practice were missed.
- Staff were aware of the relevant guidance their practices must meet. This was both midwifery, nursing and medical staff on both the maternity and gynaecology wards.
- Where policies or procedures did not meet guidance, or posed a risk these were on the risk register and staff were aware of them. An example was the standard procedure developed due to the lack of a dedicated second theatre for obstetrics.

Pain relief

- Midwives discussed how the expected pain relief was available to patients. This included oral, injectable, medical gases and epidural. They said this was discussed with the patients from their ante-natal appointment and the choices were discussed with them.
- Patients told us they had their pain relief administered when it was required and did not have to wait. However there was no formal assessment of pain during labour which meant there was no procedure to ensure a patient's pain was monitored and recorded.

- We saw that staff discussed the pain relief a patient had received during handover.
- Staff said the birthing pool was used for pain relief. The numbers of patients giving birth in water was low at 10 between October 2014 and March 2015, however staff said patients used it for pain relief but did not stay in the pool to deliver their baby.
- In the gynaecology services staff were very aware of the need for a variety of pain relief to be available dependant on the type of procedure being performed. This included oral, injectable and medical gases for laparoscopic examinations and procedures. The care pathway for laparoscopic hysterectomy included a pain relief regime.

Nutrition and hydration

- The trust had achieved the Baby Friendly Initiative, however had not maintained the standard for this and lost it several years ago. This is a recognised United Nations International Children's Emergency Fund UK initiative which consists of three stages of assessment including, parents feedback with regard to support for breast feeding. An action plan was in place to regain this award which was to be assessed by Baby Friendly representatives in early May.
- Staff said they encouraged breast feeding where this was appropriate, but accepted and supported a mother's choice.
- Breastfeeding rates had been below the trusts target of 68% for 11 months from January 2014 to November 2014 being at 56.2% in that month. There was no action plan to increase breastfeeding.
- Patients could eat and drink in the communal dining room and said the food provided was good. They said staff provided hot and cold drinks and snacks like toast at any time of day or night, which they very much appreciated.

Patient outcomes

- Information from the trust is that they expected 1400 births at West Cumberland Hospital consultant led unit in 2014. The Royal College of Obstetrics and Gynaecology define a consultant led unit with less than 3000 births per year as small. There are six consultant led units in the UK with less than 2000 births per year and therefore a comparable unit is used by the trust to benchmark their performance.
- The caesarean section rates were higher than the trusts' target during six months between January and November 2014. The trust set their target at less than 25%. The highest was 34.4% with the lowest 19.8%. A strategy for the reduction of caesarean sections had been introduced and the rate had reduced from 30.8% in December 2014 to 27.8% in January 2014.
- One of the strategies for reducing the rate further was the development of VBAC clinics (Vaginal birth after caesarean section). These were still in the planning stage despite having been discussed for the past 12 months. Staff said they were unaware of plans to introduce a formal clinic and currently one of the lead midwives was counselling women with regard to VBAC in their own time.
- Information provided by the trust showed a higher than target rate of unexpected admissions of babies to the neonatal unit. Staff said they believed this was due to accepted clinical practice of the midwives and no investigations into the reasons for it or the possibility of reduction had taken place.
- In the gynaecology department the patient satisfaction review of 82 cases of laparoscopic hysteroscopy were that 76% of patients were very satisfied with a further 21% being satisfied. This showed the introduction of this service provided a good outcome for patients.
- A review of the termination of pregnancy service in the trust following the last inspection took place in January 2015. This resulted in a standardisation of practice in both sites with regard to the medicines used in a medical termination.
- Although there was limited access to the termination of pregnancy service as the outpatient clinics ran on Thursdays only and treatment was provided on Saturdays only, this service was specific to these patients on these days. This had the advantage that the service was not cancelled, they did not have to wait for an inpatient bed to be available and there was additional privacy for the patients. Alternatives had been investigated, however the advantages above would be lost and the decision to maintain the current arrangement was made.
- Staff said that when the doctor who managed the termination of pregnancy clinic was on holiday there was no other doctor to run this service. This meant at these times patients could be waiting up to three weeks for an appointment following referral by their GP. The

current recommendation is that patients should be seen within five working days and actions to develop the service further in order to reduce the waiting times were ongoing.

Competent staff

- 100% of midwives and other clinical staff on the maternity unit had received an appraisal of their work in the past 12 months. 1 staff member told us that the emphasis was on achieving this target, rather than the quality of the discussion and theirs had lasted no more than 10 minutes. This meant the process was not robust and did not give staff the opportunities they needed to discuss their performance and development.
- PROMPT (PRactical Obstetric Multi-Professional Training) was provided to midwives and medical staff to ensure they had practical experience of obstetric emergencies. 80.9% of midwives, 70.5% of healthcare assistants and 44% of medical staff had completed this training. We were told skills and drills training within the clinical area was adhoc dependant on the workload. This meant that not all staff were up to date with this training.
- The local supervising authority had completed an audit of the trust in October 2014. The number of supervisors to midwives was one to eleven which was acceptable. The role of the supervisor is to protect the public through good practice. They monitor the practices of midwives to ensure the mothers and babies receive good quality safe care.
- At that audit two of the four areas of practice audited had been met with the remaining two partially met. An action plan had been developed to work towards meeting the shortfall.
- Staff in the gynaecology department said there had been a recent initiative to encourage staff to attend their appraisals as previously the completion rate had been poor. Work was on-going to achieve 100%.

Multidisciplinary working

- Midwives discussed how there was some access to multi-disciplinary colleagues, such as diabetic specialists, should a patient require additional treatment or assessment. There were no multi-disciplinary clinics scheduled.
- Midwives and other staff working in the maternity services discussed how they worked well as a team, supporting each other and working together for the patients. We saw evidence of good team work with staff of all grades working outside their role when necessary for patient care.
- Staff such as the sonographer on the assessment unit said they had a good working relationship with the doctors who attended quickly if they were needed and provided support and advice to ensure patients received an efficient service.
- There was a lack of clarity from the managers regarding the role of the community midwives and communication with them. We were told some midwives were now working between the hospital and the community, spending some time in each setting. The way this was going to work was unclear as we were given conflicting information.
- We were told throughout the inspection that patients with a high body mass index were increasing and presented as potentially high risk care through their pregnancy. There were no additional measures in place to manage this patient population, including from the ante natal stage.
- Staff in the gynaecology outpatient services said they could access doctors when they were required.
- On the female surgical ward where gynaecology patients would be accommodated staff said they could have a high number of patients who required medical care on the ward at any time. When this was the case they could be waiting for medical doctors to come to the ward and see their patients as they did not come onto the ward daily. To reduce this issue and improve care to patients nurse practitioners were available who could attend the ward and manage the care of patients more quickly.
- We were told throughout the inspection that communication between the two hospital sites within the trust was poor and there was little cohesion with care pathways and guidance. This had been acknowledged and some work was underway to improve it with joint meetings for various grades of staff taking place monthly.

Seven-day services

- The early pregnancy assessment unit in the women's outpatient department was a Monday to Friday service. Outside of these hours patients could attend the emergency department for a scan should this be necessary.

- Discussions with regard to extending the hours had taken place, however currently there was not the staffing resource to do this.
- Midwifery staff said there was an obstetric consultant resident on call 24 hours per day and they felt well supported by this. The lack of an anaesthetist and general surgical doctors out of normal working hours concerned both doctors and nurses due to the risk this posed if a patient required surgical intervention.
- The termination of pregnancy service was available on a specific day each week. There were no other services in the area, such as private facilities, for patients to attend. This did limit their access to the service and could cause a delay in them obtaining treatment. Discussions to expand this service had taken place and although medical staff were willing to extend their working hours to facilitate it, there was no availability of ward space or nursing staff to accommodate this.

Access to information

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- 93% of midwives had received training about the mental capacity act and 94% in the deprivation of liberty safeguards. Despite this those we spoke with and nurses in the gynaecology service had a limited understanding of the mental capacity act and deprivation of liberty safeguards. They knew that patients were required to have mental capacity to consent to treatment but not how this might be assessed or the measures to take if patients lacked capacity. This could mean patients may not be given the opportunity or information to help them make a decision to decline or accept treatment.
- We saw that consent forms for caesarean sections were correctly completed.
- Consent forms for termination of pregnancy were correctly signed and completed. However doctors said that at times it was difficult to obtain a second signature on the necessary documentation as there were not many doctors available who were willing to do this but no TOP went ahead without the appropriate signatories. In the future this should improve as a newly recruited doctor was prepared to be a second signatory.

Are maternity and gynaecology services caring?

Good

Summary

At the previous inspection we reported 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.

At this inspection staff provided care which was respectful, kind and protected the privacy and dignity of patients. We were told by patients that they received "excellent" care from the staff and liked the relaxed and informal atmosphere of the maternity service.

Staff in the gynaecology services had a good understanding of the need to provide additional emotional support to some patients. They were aware of the inadequacy of the environment to provide privacy and dignity and had developed some temporary strategies for improvement.

There was recognition of the need for informal carers or family members to be part of the care for some patients and this was accommodated where necessary. There were systems in place to help patients through potential emotionally upsetting events.

Compassionate care

- Patients told us they received "very good care" in the maternity unit of the hospital. They said they had good support from the staff who kept them informed, gave them choices and treated them with dignity and privacy.
- We saw staff protecting the privacy and dignity of patients, by closing doors, using privacy notices and keeping information confidential.
- Staff interacted with patients in a friendly but respectful manner. There was an informal and relaxed atmosphere on the wards and units.
- In the friends and family test the trust scored better than the England average in the December 2013 to November 2014 survey. 89% of respondents stated they would recommend the ante-natal care and 81% the care in labour.
- The results of the CQC survey of women's experiences of maternity services in 2013 were comparable to other trusts.

- Staff on the surgical ward where women recovering from gynaecology surgery would be accommodated were aware of the potential lack of privacy and dignity for them due to the layout of the ward. They were unable to take action to address this in the current environment but discussed that when the ward was moved to the new building, in October 2016, there should be a number of beds allocated for the use of gynaecology patients only. These would help them to provide an environment where they could protect their dignity.
- The service for termination of pregnancy was organised so as to provide the optimum privacy for the patients who used it. All patients were seen in the outpatients department on a Thursday and the day ward was used, on a Saturday, to provide care for these patients only. This meant their privacy was protected from patients and visitors unless they were present for the same procedure.

Understanding and involvement of patients and those close to them

- Midwives explained how they involved patients in their own care, giving them choices, explanations and where necessary written information.
- They said partners, husbands or anyone else who the patient required to help them during their birth would be welcome to be present through the labour.
- If a person required additional support due to mental health issues or learning disabilities midwives said they would be encouraged to have an informal carer with them if they wished. Staff said this would be part of the care throughout a person's pregnancy from the ante-natal to the post natal services.
- Patients told us the doctors were very attentive and listened to their opinions, concerns and choices, explaining things clearly.

Emotional support

- Staff in the women's outpatients told us how they would use a different exit door for patients who may have received bad news, to prevent them needing to walk through a full waiting room. This showed an understanding of the need for emotional support.
- A postnatal listening service had been introduced to provide an opportunity for patients to talk to staff, following the birth of their baby, in case of any issues they wished to discuss. Staff provided this service in their own time and it was run on the goodwill of the staff as they recognised the need for it, and money from the trust was not available.
- There was a lead midwife for bereavement and staff talked about how they used this midwife to offer support to parents who had lost a baby.
- Staff who supported patients through a termination of pregnancy told us there was a lack of provision of on-going community support in the area. There was nowhere to guide patients to should they feel they needed this support.

Are maternity and gynaecology services responsive?

Good

Summary

At the previous inspection we reported the Maternity Services Liaison Committee had not met for two years. There were concerns that the lack of an agreed service specification made it difficult to assess the delivery of the service against the needs of the local population. Services were supported by staff working over their hours to support service delivery.

We were told there was a high incidence of obesity in the area and the service had started to audit its service for this population of patients At this inspection the Maternity Services Liaison Committee meetings had been reinstated. Minutes from the past four meetings were seen and an on-going action plan had been developed with progress documented. Staff recognised the shortfalls in the service provision and where possible ensured patients' needs were met even if this resulted in them working outside of their normal working hours. There was a lack of support from the trust for some of these services. Staff recognised the limitations of the environment with regard to providing privacy and dignity in some areas. They had strategies in place to manage this. The termination of pregnancy service was designed so as to protect vulnerable patients and staff offered a high level of professional support.

At this inspection no multi-disciplinary clinics had been developed for people with obesity. There was no formal measurement of the cancellation of some services, no

mechanism for investigation or plans for improvement. There was an effective escalation policy in place for when the maternity service was short of staff. There had been no complaints in the maternity or gynaecology services in the past 12 months.

Service planning and delivery to meet the needs of local people

- The geography of the area where the hospital is situated meant patient's journeys could be long to reach the hospital services. Staff in all departments were aware of this and tried, where possible to ensure few journeys were necessary for consultations and treatments. For example they would carry out pre-operative procedures at the consultation visit if a surgical procedure had been deemed necessary.
- There were systems in place to manage patients with complications. We were told transfers between the two hospital sites would take place as seldom as possible due to the transfer time which was over one hour. If a baby had specific undiagnosed complications at birth they would be transferred to Newcastle specialist unit.
- We were told there was a high incidence of patients with a high body mass index in the area. There was no multi-disciplinary clinic for this although one consultant anaesthetist saw these patients in case of general anaesthesia being necessary.
- There were no private termination of pregnancy services in the area, including any emotional aftercare service or on-going advisory service. Staff recognised this and part of their pathway of care was to provide long term contraception at the time of the termination to assist patients who may have difficulty returning to a doctor.
- At the time of the last inspection the Maternity Services Liaison Committee had not met for two years. At this inspection the meetings had been reinstated. Minutes from the past four meetings were seen and an on-going action plan had been developed with progress documented.

Access and flow

- There was a system of 12 appointments per day being booked into the day assessment ward. The midwife sonographer worked 9am to 5pm but said they stayed longer if necessary. If patients were seen by their GP or community midwife and needed a scan they would be additional to the patients already booked in. This could cause them to wait as could the need for them to see a doctor when the wait could be up to two hours. There was only one midwife sonographer employed in the hospital which we were told added to the waiting time.
- If the one midwife sonographer was off work there would be no designated person to carry out scans and any emergencies would need to be done by a doctor. This meant patients would have to wait and may not get a same day scan.
- Two patients per day were booked in for induction of labour. If the activity on the maternity unit was high due to spontaneous labour or emergency caesarean sections patients could have their induction postponed. One patient told us they had their induction of labour postponed on three consecutive days due to high activity on the unit. If possible patients would be offered the choice of having their labour induced at Carlisle hospital. On this occasion they were also at full capacity.
- The number of cancelled inductions was not part of the maternity dashboard information. We were given conflicting information that it was or not reported on the incident reporting system. Therefore there was no understanding of the scope of this issue and no plans to improve this patient experience.
- There was an escalation plan when staff numbers on the unit were insufficient, due to sickness or increased activity. We saw this worked in practice. This was blank on the dashboard, however staff told us it did happen "frequently."
- The average length of stay was within recommended guidance at 24 to 48 hours.
- In the past six months 58 gynaecology operations had been cancelled. 21 were due to bed shortages with 15 of these being on the same day as the operation. This meant these patient's treatment was delayed and they had to re-schedule for a new date.
- The introduction of gynaecology procedures carried out in the outpatients department meant patients did not need to remain in hospital. They were seen quickly with one visit for both diagnostic and surgical procedures such as removal of polyps.

Meeting people's individual needs

- Staff said they could obtain help with specific religious or cultural needs of patients from advisory services should they need this.
- They were aware there was a translation service available, but staff we spoke to had not used it as they

said the patient was usually accompanied by a family member if they needed help with their use of the English language. This could mean a family member was explaining clinical procedures in order to obtain consent.
- Staff said if a patient needed additional support due to mental health needs or learning disabilities they would accommodate this from family members or informal carers.
- There was a midwife with a lead interest in mental health and staff said they would provide support and advice if it was required.
- The rate of normal births, that is those without medical or surgical intervention, was in line with the England average.
- The maternal readmission rates were in line with the England average.
- Information leaflets for patients were present in the waiting rooms and communal areas.
- Patients told us they had access to the information they required. This included that given in writing, such as what to expect from a gynaecology procedure, and that given verbally when they attended clinics or a ward.
- As part of the "Two minutes of your time" survey patients were asked if they received timely information about their care and treatment. In the results we saw for January 2015 an average score of 9.8 out of 10 was achieved for this standard.
- A quiet room for breaking bad news or allowing patients to sit alone had been provided in the women's outpatient department.

Learning from complaints and concerns

- The maternity service had received six complaints between January and November 2014. Staff said the learning from these was shared during ward meetings, informal discussions and the monthly newsletter.

Are maternity and gynaecology services well-led?

Requires improvement

Summary

At the previous inspection we reported the midwifery staff felt positive about their clinical leadership, but felt that the roles were not yet embedded. They did not fully understand the roles of the clinical leads and the role of the business manager. 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 location, and they had anxieties about the provision of care. 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.

At this inspection there was no clear vision for the future of the maternity services due to the recent review of the Cumbria wide provision and managers awaiting the outcome. There was no strategy for increasing the cohesive working of the two hospital sites for maternity services although some improvements had been made since the last inspection. There were some concerns by medical staff regarding a lack of enthusiasm for change and improvement in the maternity services. There was a lack of financial resources in the maternity services to promote innovation and change. There had been increased activity in the auditing of clinical practice and quality of service since the last inspection. However the outcomes and actions as a result were not clear. Staff were now aware of the maternity dashboard and it's use to measure clinical and quality performance.

Staff spoke highly of their immediate managers. There was an open and informal but professional culture in both the maternity and gynaecology services. Improvements in public and staff engagement had taken place since the last inspection.

Vision and strategy for this service

- Staff were concerned about the future of the maternity services at West Cumberland Hospital, in light of the many reviews which had been conducted. They said open discussions had taken place and they felt as aware of the future as they could be because no final decisions had been made.
- Midwives were positive they were providing a good and necessary service to the area and the current strategy was to improve the service they provided.
- The Royal College of Obstetrics and Gynaecology had published their options appraisal: "Reconfiguration of Obstetric and Maternity Services in Cumbria" the week

before our inspection. Medical staff discussed how they had hoped this would help shape the future services they provided and expected some managerial discussions regarding any impact it may have on the future of the service.
- Staff in the gynaecology services were looking forward to improving the range of services available and having increased capacity to do so in the new building.
- Managers in both maternity and gynaecology stated there needed to be a cohesive strategy for the future which involved both hospital sites within the trust as they must improve working together. Some improvements had been made since the last inspection in this regard and cross site meetings and sharing of information was taking place.

Governance, risk management and quality measurement

- Monthly meetings of the Maternity Governance Group were held. This was attended by clinical managers, lead midwives and consultants. Topics discussed ranged from actions required as a result of new guidance, monitoring of the maternity dashboard and discussion following meetings of other groups such as the guideline group. Action points were documented and followed up at the subsequent meeting.
- In the maternity services quarterly integrated governance report published in January 2015 the trust stated "initial analysis of the first round of audits are showing poor results of compliance as measured against the Maternity Service's own clinical guidelines and the record keeping standards in the medical records. Initial findings have also highlighted inconsistencies in practice across sites." As a result multidisciplinary workshops were carried out for the areas of clinical practice showing poor results. Clinical guidelines were to be clarified and checked against national guidance.
- There was a maternity risk register which contained all risks identified, with control measures and gaps in the control. Where gaps were identified assurance actions were documented. The risks were reviewed within an identified timescale and none had been present over 12 months.
- There were some measures on the maternity dashboard which were blank. These included the infection rate and the midwife to birth ratio. A senior manager told us this dashboard was in "embryonic form" and may be subject to change.
- Individual risk assessments were carried out for equipment and the environment in the gynaecology services. They would be a part of the surgical services in terms of risk register, but they were aware of what was included in relation to gynaecology
- Individual audits for specific clinical procedures took place in the gynaecology services and all staff were included in the findings and any subsequent changes to practice.
- There were monthly gynaecology governance video conferences held between the two hospital sites. This meant ideas, action plans and outcomes could be shared between the two services

Leadership of service

- Midwifery staff were very positive about their immediate line managers who they said were supportive and approachable. They praised the clinical midwife manager who was available to support them at all times including when they were not on duty.
- In order to increase the visibility of managers since the last inspection there were now 2 "walk rounds" per week by the supervisors of midwives and the unit coordinator. These were designed to illicit the views of patients and staff and monitor the progress of actions planned from the last inspection. Staff saw this as positive as it made them accessible.
- The current head of midwifery was due to retire in the near future and staff were positive about having a new appointment that could bring fresh ideas to the service.
- Some concerns regarding the medical leadership were discussed in terms of a negative approach to the future of the maternity services and therefore a lack of enthusiasm for change and improvement.

Culture within the service

- On the maternity unit there was an open, informal and friendly atmosphere. Staff were very positive about their work and despite the high number of reviews and the perceived threat to the services they were very enthusiastic about the future and proud of the service they provided.

- Staff in the gynaecology services were positive about the improvements which had been made and additional future plans, especially moving to the new building. They

Public and staff engagement

- The executive trust board walk around the maternity unit on a weekly basis and sometimes out of normal working hours. Staff said the director of nursing was visible and approachable for staff.
- Both midwifery and medical staff told us the medical director had openly and publically stated that the maternity unit would close and they find this unsettling.
- Maternity staff expected further meetings and communications to take place following the publication of the RCOG review the week of the inspection.
- Public engagement had been reinstated in the form of the maternity services liaison committee and one to one discussion with patients at the managers walk rounds.

Innovation, improvement and sustainability

- There had been improvements in some policies, practices and procedures since the last inspection. However some of the progress the trust told us it had made was in its infancy or had not produced robust results. This included the standard operating procedure for use of a second theatre which the trust said had "not necessitated any cancellations of elective obstetric or gynaecology cases." However the trust provided data for cancellation of gynaecology surgery where seven were due to a lack of anaesthetist and eleven to lack of theatre time.
- There was a lack of encouragement of innovation in the maternity services and staff were thwarted by lack of financial resources to progress their ideas.
- Medical and nursing staff in the gynaecology services were innovative and had introduced new ways of working to improve the patient's experience.

Services for children and young people

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

Information about the service

West Cumberland Hospital children's services comprised of a 15-bed children's ward (Fairfield) and a 10-cot special care baby unit (SCBU) (Thirlmere).

There was one six-bedded bay used to medically assess children who attended the unit following direct referral from their GP or from the hospital's accident and emergency department. There were eight side rooms.

Facilities included a lounge area and small kitchen for parents and visitors; bathrooms, shower and toilet facilities; treatment rooms and other clinical areas; a kitchen area used by staff to prepare snacks and drinks for patients; a large well equipped play room and a staff room.

There were seven patients on the ward and we talked with three of the parents and the parent of a baby in the SCBU.

We reviewed the records and information available on the ward. We also spoke with medical doctors, including the consultant on duty and the nurses in charge on the ward and SCBU.

Summary of findings

Following our last inspection it was evident that the service had made some improvements to prevent avoidable patient harm. It was evident at this inspection that these improvements had been maintained. Children and young people received their care in a visibly clean environment. Child Safeguarding was well understood and supported by staff training.

Nurse staffing levels were appropriate to meet the needs of Children and young people. However there was still a shortage of medical staff that meant consultants were filling in gaps in the rota and there was a reliance on locum staff at both junior and middle grades.

Consultant paediatric cover was provided out of hours by a consultant on call. Care and treatment was delivered in accordance with NICE guidance. The service participated in the national audit programme including the paediatric diabetic and asthma national audits. Where shortfalls were identified, action plans were completed and implemented to secure improvement. There was a positive, child centred culture within in the service. Staff were motivated and offered care that was kind, sensitive and supportive.

Governance arrangements had been strengthened and cross site working with the children's service in Carlisle was providing good opportunities for the sharing of information and good practice.

Services for children and young people

Are services for children and young people safe?

Good

Summary

At the previous inspection we reported the trust needed to take more action to make children's services safe and protect children from avoidable harm. The trust did not ensure that care and treatment was always provided in keeping with good practice guidelines. There was appropriate security in accessing the ward, but the security of rooms once on the ward was inadequate.

The service for children at the hospital was at risk because although the hospital ran a 24-hour Accident and Emergency service, experienced paediatric doctors are only available on site to provide high quality paediatric medical intervention Monday to Friday from 9am to 10pm.

At this inspection it was evident that the service had made some improvements to prevent avoidable patient harm. Children and young people received their care in a visibly clean environment. There was good practice in relation to the prevention and control of infection. Incident reporting was better managed and learning from incidents shared and applied. Child Safeguarding was well understood and supported by staff training.

Nurse staffing levels were appropriate to meet the needs of Children and young people. However there was still a shortage of medical staff that meant consultants were filling in gaps in the rota and there was a reliance on locum staff at both junior and middle grades. Speciality doctors were available until 10pm and although junior doctors felt consultants provided good support, there were times when the junior medical staff found their role stressful and would have preferred the on call consultant to remain on site out of hours. Consultant paediatric cover was provided out of hours by a consultant on call. However, consultants often remained on site out of hours to support the care and treatment of sick children where required.

Incidents

- Incident reporting had improved and staff were making better use of the electronic reporting system to report incidents and events requiring investigation.
- Staff were more confident in reporting incidents and demonstrated a better understanding of the criteria relating to the classification of a minor, moderate and serious incident.
- Staff were provided feedback about the outcomes of incident reviews, learning from the incidents was shared, implemented and evaluated.

Cleanliness, infection control and hygiene

- The inpatient areas and departments were visibly clean and tidy
- There were ample supplies of hand washing facilities and personal protective equipment to support good infection control practice.
- Hand hygiene and cleanliness was audited monthly January February and March 2015 audits demonstrated 100% compliance.
- Infection rates were lower than the national average.
- There had been no cases of Cdiff or MRSA in the service.

In the Special Care Baby Unit (SCBU)

- Improvements had been made to the storage of expressed breast milk that was now stored securely and risks of cross-contamination or tampering had been reduced.
- Single use pacifiers (dummies) were now discarded appropriately.

Environment and equipment

- Equipment and drugs required for paediatric cardiopulmonary resuscitation were checked in accordance with the Resuscitation Council (UK) 2013 guidance.

Medicines

- Medication across the children's service 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 Special Care Baby unit.

- Controlled drugs and other medication on the Special Care Baby unit at the hospital were stored and administered in accordance with the Royal Pharmaceutical Society guidance.

Services for children and young people

Records

- There had been a significant improvement in the quality of record keeping since our last inspection.
- In the Special Care Baby Unit Patient assessments; care plans; daily records were accurate well maintained, dated and signed.
- Case notes were accurate and well set out.
- Diagnostic tests and results were readily available and stored securely in the patients notes.
- On the children's ward (Fairfield) record keeping had also improved and assessments, care plans and daily records were comprehensive and well maintained.
- New documentation had been introduced that was supporting improved record keeping. The audit of care records in March 2015 indicated 94% compliance in relation to record keeping.

Safeguarding

- Staff better understood their roles and responsibilities in relation to safeguarding children and young people. There were good relationships with other child related services. Communication focussed on the safety and well-being of the child.
- Referrals were now made in a more timely way and staff had received safeguarding training.
- The (trust wide) database tracked children and flagged up those who had already been referred when they returned to the service. This approach supported early intervention and prompt review of the condition of the child.
- Appropriate safeguarding training had been provided. All relevant staff had now completed level 3 training. This was an improvement since our last inspection. The majority of ancillary staff had also received safeguarding training.
- Staff were competent in recognising and escalating 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

- Mandatory training levels were currently at 90% against a service objective of 100%. Staff were able to access eLearning sessions.
- Mandatory training was both generic and role specific.
- Staff were positive about the range of training provided.

Assessing and responding to patient risk

- The service used the paediatric early warning score (PEWS) for recording the vital signs of children so that early signs of deterioration could be identified and appropriate action taken promptly.
- The PEWS audit showed that the children's ward had achieved improvements in completing these observations for children. Pews records were better maintained and included appropriate observation and escalation.
- Staff 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 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.
- However, transferring high dependency patients with the services own staff did apply additional pressure on staffing levels.
- All relevant staff had received Basic or Advanced Paediatric Life Support training.

Mortality and Morbidity

- There were monthly mortality and morbidity meetings. Lessons learnt were discussed with clinical staff at a variety of meetings within the Business Unit. All child deaths were subject to the CDOP (child death overview process) that analysed in detail mortality data.

Nursing staffing

- Planned and actual staffing levels were displayed in the ward area. The information displayed confirmed that nurse staffing levels were appropriate to meet the needs of children on a consistent basis. The wards were very rarely full, average occupancy ranged from 40-50%.
- Sickness and absence was covered by staff working bank and overtime shifts. There was a good escalation plan in place to support safe staffing levels.
- The escalation policy gave staff guidance about requesting additional staff from managers who then sought to address the shortfall appropriately.
- Care in the SCBU was nurse led with support from medical staff as required.

- The SCBU was not always able to meet national standards in relation to the number of nurses on duty. Staff appropriately sought managerial support to address shortfalls. Bank and overtime shifts were used to provide adequate staffing levels.

Medical staffing

- The service did not provide 24-hour paediatric consultant presence on the hospital site. Consultant paediatric cover was provided from 9am until 10pm with a consultant on call. This remained a concern as the service still offered a 24 hour emergency service for children and young people.
- In addition there was still a shortage of middle grade doctors and this meant that consultants were covering gaps in the medical rotas to provide appropriate medical cover.
- Junior medical staff felt well supported by consultants who were seen as accessible and responsive. However they would have preferred to have senior colleagues on site rather than on call.
- Consultants would remain on site if required to support the care and treatment of a very ill child.

Major incident awareness and training

- Staff had received relevant training to support the management of major incidents.

Are services for children and young people effective?

Good

Summary

At the previous inspection we reported innovative plans of care and treatment were not in use. The service had a high rate of emergency readmissions and there was no evidence that the trust had investigated this issue. We found that the trust's response to improving services for children and adolescents with mental health needs has been slow and did not reflect the seriousness of the risk to children with mental health needs who accessed the service.

At this inspection care and treatment was delivered in accordance with NICE guidance. Staff had access to evidenced based guidelines via the intranet. Pain relief was well managed and staff made good use of distraction techniques to allay children's fears and anxieties.

Staff used a nutritional screening assessment tool called STAMP to support and guide the meeting of each individual child's dietary and nutritional requirements. .

The service participated in the national audit programme including the paediatric diabetic and asthma national audits. Where shortfalls were identified, action plans were completed and implemented to secure improvement.

Doctors, nurses and Allied Health Professionals (AHPs) worked well together for the benefit of children in their care.

Evidence-based care and treatment

- Care and treatment was delivered in accordance with NICE guidance.
- Staff had access to guidance and reference material via the intranet.
- Bed side guidance was also available for the management of childhood conditions including asthma.

Pain relief

- Young people confirmed that pain relief was well managed.
- Staff monitored children's pain levels and pain assessments were recorded on the reverse of the paediatric early warning assessment record. This was an improvement since our last inspection.
- 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 to minimise children's fears and anxieties.

Nutrition and hydration

- Staff used a nutritional screening assessment tool called STAMP to support and guide the meeting of each individual child's dietary and nutritional requirements.
- The menu offered a good variety of hot and cold meals that included fresh vegetables, salads, pasta bakes and age appropriate food choices.
- Additional menus were available and utilised for patients with special dietary needs.

- Snacks and cold drinks were provided throughout the day.
- The ward kept a number of different brands of baby milk in stock so that individual preferences could be met.

Patient outcomes

- The service participated in the national audit programme including the paediatric diabetic and asthma national audits. Where shortfalls were identified, action plans were completed and implemented to secure improvement.
- The service also participated in the National Neonatal Audit Programme (NNAP). The 2013 NNAP audit (published in Sept 2014), the 2014 audit has not yet been made available. However the data available indicated that the service was not meeting 3 of the 5 standards measured. Work was on going to address the identified shortfalls.
- In addition, the service participated in a range of local audits including PEWS and hand hygiene, the results of the local audit demonstrated high levels of compliance with good practice guidance.
- Readmission rates were within national averages for a service of this size.

Competent staff

- All staff had received an annual staff appraisal.
- 90% of staff had completed CWILTED Training (related to the new care documentation).
- Staff had also received child mental health training and there were planned developmental days for staff who worked in the SCBU via the neonatal network.

Multidisciplinary working

- The service worked well with a range of other disciplines. Doctors, nurses and Allied Health Professionals (AHPs) worked well together for the benefit of children in their care.
- There was work underway to improve transition services for young people moving into adult service provision.
- Transition arrangements were subject to a CQUIN target, the 'Ready Steady Go initiative' was aimed at transferring young people into adult services in a seamless and timely way.
- Young people with diabetes had formal transition diaries to support transition; arrangements were also in place to support the transition of young people with asthma.
- There were local arrangements in place with a neighbouring mental health trust for young people with neurological conditions.
- Communication had improved with the children's service based on the Carlisle infirmary site. Regular meetings were held to share information, good practice developments and management information to support service improvement.
- The Child and adolescent Mental Health Service (CAMHS) was provided by a neighbouring trust. Working relationships were positive although the out of hours and weekend services provided by the CAMHS team required improvement in terms of response times. This issue had been raised with commissioners and was highlighted on the services risk register.
- The service had access to two specialist diabetic nurses who provided support and guidance to children and young people with this condition.

Seven-day services

- The service had not yet fully implemented 7 day working.
- Emergency x-ray and pharmacy services were available out of hours but not as matter of routine.
- Consultant medical cover was provided via an on call system outside normal working hours. Although it was not unusual for consultants to be available until 9-10pm.

Access to information

- Staff had access to readily available patient information and reports, including at weekends and out of hours.

Consent

- Staff understood their roles and responsibilities seeking appropriate consent for care and treatment.
- The admission assessment forms included information about the level of consent given by a parent, child or young person.
- Training information confirmed that the majority of staff had completed Mental Capacity Act and Deprivation of Liberty Safeguards training level 1 in respect of young adults.

Services for children and young people

- Young people on the ward confirmed that the doctors and nurses always explained procedures to them in a way that was easy to understand. Parents were positive about the way procedures and treatment where described so that there was informed consent.

Are services for children and young people caring?

Good

Summary

At the previous inspection we reported the patient satisfaction surveys indicated that parents and patients were satisfied with the conduct of staff and felt the service was caring. Observation of the interaction between staff and patients confirmed that staff were attentive and treated patients and their parents with dignity and respect. Staff took action to provide information that would offer reassurance to parents.

At this inspection there was a positive, child centred culture within in the service. Staff were motivated and offered care that was kind, sensitive and supportive. We observed many interactions that showed how caring the staff were.

Staff recognised and respected children's needs, fears and anxieties and provided both physical and emotional support on an individual basis.

Staff recognised that having a sick child was a worrying and anxious time for parents and carers. Staff were keen to support parents and carers emotionally and include them as partners in the care of their child.

The children and young people we spoke with were positive about their interactions with staff.

Compassionate care

- Children and young people, their families and carers felt well cared for and supported by staff. Children and young people were treated sensitively and kindly.
- Patients confirmed that nurses were always available and children didn't have to wait for nurses to attend them.
- Children's needs were met in an individualised way, care planning took into account the child's needs and preferences as well as recognising and supporting the child's wider religious or cultural needs.
- Parents were positive about staff and there approach to the care of their child.
- Children were positive about their interactions with the staff and the family and friends test indicated that parents and children were 'extremely likely' to recommend the service to others.

Understanding and involvement of patients and those close to them

- Parents confirmed that staff included them in the decision making process and that they were well informed as to their child's condition and treatment.
- When children and young people did not have family support available in terms of involvement in decision making. Best interest meetings were held to ensure the child or young person's needs were central to the decision making process.
- Play therapy services included preparation for invasive/ non-invasive procedures, distraction therapy, emotional support and pain management.

Emotional support

- Staff recognised that having a sick child was a worrying and anxious time for parents and carers. Staffs were keen to support parents and carers emotionally and include them as partners in the care.
- Children and young people's emotional needs were considered as part of the care planning process. Staff provided good emotional support to children and young people and were open and honest in their communication with patients to establish and foster a relationship build on trust and empathy.

Are services for children and young people responsive?

Good

Summary

At the previous inspection we reported that children treated as inpatients were attending the ward following referral from 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 demonstrated that the admissions process was flexible and responsive.

Services for children and young people

Evidence confirmed that the systems in place for responding to foreseeable concerns, such as short-term staff shortages, were flexible and effective. Information from the trust demonstrated that although the service responded to complaints or concerns raised by patients or their relatives, there was no evidence that the outcomes were, as yet, routinely analysed and used to influence the development of the service at ward level.

At this inspection the children's and young peoples service was under view and a number of service models were being considered and evaluated in order to better meet the needs of children and young people living in the area and to maximise the effective use of resources. A decision about the future model of paediatric care had not been reached at the time of our inspection.

The service was responsive to the needs of children and young people and there were facilities and support services in place to meet their individual needs.

Although the numbers of complaints about the service were low, complaints were managed in a timely way, and lessons were learned and shared.

There were good examples of staff responding well to feedback provided by children and those close to them.

Service planning and delivery to meet the needs of local people

- The children's and young people's service was under review and a number of service models were being considered and evaluated in order to better meet the needs of children and young people and maximise resources effectively. A decision had not been reached at the time of our inspection.
- In the interim, the service continued to meet patient's needs under the existing model of care.

Access and flow

- Children were admitted to the ward following referral from either the A&E department, through direct access from GP referrals or through direct access agreed as part of a discharge plan.
- There were also times due to a shortage of medical staff that patients on the ward could wait for long periods of time before seeing a doctor.
- Plans were in place to transfer children requiring specialist support to other hospitals in a timely way.

Meeting people's individual needs

- There was an ample supply of play equipment available to accommodate a variety of ages and needs in both inpatient and outpatient areas. Toys could be provided at the bedside as well as age appropriate games and books.
- Parents were supported and encourage to remain with their child and there were facilities to allow parents and carers to stay overnight if they wished to do so.
- There was a comprehensive range of information leaflets available including post-operative tonsillectomy care, asthma action plan , wheeze action plan , isolation care, and transfer information that gave patients and those close to them information about care and treatment in a way they could understand.
- Children with learning difficulties were managed in a sensitive and person centred way.
- The service provided a translation service for children and those close to them whose first language was not English.
- The service had good links between children and young people's services and the child and adolescence mental health service (CAMHS). However staff felt that due to the demands in this service there was sometimes a delay in children and young people being seen after being referred at weekends and out of normal working hours.

Learning from complaints and concerns

- The service did not receive high numbers of complaints.
- Complaints, where possible, where resolved locally, staff were familiar with the complaints procedure and there where leaflets in the service to help me people make their complaints and concerns known.
- Staff would also refer patients to the PALs service when appropriate to do so.
- Learning from complaints was shared to support improvements in the service.
- The service also displayed a 'You said, We did ' board that highlighted the actions taken by the service in response to feedback

Are services for children and young people well-led?

Services for children and young people

Good

Summary

At the previous inspection we reported the leadership on the paediatric ward and special care baby unit at West Cumberland hospital required improvement. There was no comprehensive and robust strategy in place to identify all the areas that required improvement so that good quality and safe care and treatment was consistently provided on the children's ward or SCBU. This meant that processes in place did not inter-relate so that comprehensive and sustained improvements could be achieved. The trust had not taken sufficient steps to engage staff with the changes required to promote good quality and safe care and treatment.

At this inspection the service had faced a number of local leadership challenges, there had been some recent management changes and a new ward manager had not yet been appointed. In addition the service lacked oversight from a matron. Staff were keen to improve the service they offered but had felt there had been a lack of direction in the absence of these two key roles.

Staff were sighted on the trusts vision and values and were aware that work regarding the longer term strategy for children's services was under discussion and a decision had not yet been made.

Risk management had improved and there were regular reviews of the departmental risk register, mitigating actions and controls.

Performance against an agreed set of indicators was monitored monthly and actions taken to secure performance improvement where appropriate.

Governance arrangements had been strengthened and cross site working with the children's service in Carlisle was providing good opportunities for the sharing of information and good practice.

Vision and strategy for this service

- Staff were cognisant of the trusts vision and values and were aware that work regarding the longer term strategy for children's services was under discussion and a decision had not yet been made. They were also aware that the review of the future of the service may result in some service reconfiguration and there was a mixture of support and anxiety regarding the future of children's services in the hospital and across Cumbria as a whole.
- Staff were keen for a decision to be made so that they understood the implications of the decision both for the service and themselves.

Governance, risk management and quality measurement

- There had been improvements to risk management and governance processes.
- The risk register better articulated risks, mitigating actions and was regularly reviewed at the monthly child health business unit governance meetings.
- The meetings also considered results and actions from audits, current performance, new developments, incidents and complaints.
- Actions agreed were recorded and followed up. Opportunities for learning were identified and shared.
- There was improved working with the children's service in Carlisle infirmary, improved and shared governance and risk management systems were providing good opportunities for the sharing of information and learning.

Leadership of service

- Staff were positive about their colleagues and felt supported to share concerns openly.
- The changes in the management team at the current leadership vacancies had left staff feeling that the service lacked direction at the present time.
- As the service did not have a Matron, staff felt that this was a missed opportunity to drive changes and improvements in timely way.

Culture within the service

- There was an encouraging culture in the service.
- Staff were keen to improve the service and were proud of the work they did.
- Staff demonstrated a commitment to providing children and those close to them with a good service.
- There was however some anxiety about the future of the service and the implications of a service reconfiguration.

Public and staff engagement

Services for children and young people

- Although staff were aware of the vision and values of the trust and the plans to take the hospital forward. They were less sighted on the plans although they were aware that discussions were on-going.
- Staff actively sought feedback from patients and those close to them about the service provided. Responses to the family and friends test were positive with most recommending the service as a good place to receive care and treatment. However, response rates were low.
- The 'you said we did' initiative demonstrated positive changes made as a result of patient feedback.

Innovation, improvement and sustainability

- Plans for the future of the children's service were still under discussion at the time of our inspection with a number of service options under consideration. No decision had yet been made. Although staff were aware that it was unlikely that the service would remain as it was.

End of life care

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

Information about the service

Care for patients at end of life was provided on individual medical wards in the West Cumberland Hospital. We visited three wards where end of life care was being provided. We also visited the hospital mortuary, chapel of rest and the chaplain service.

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

The Specialist Palliative Care Team (SPCT) in the hospital comprised of one 0.8 whole time equivalent (WTE) consultant post shared with the community and the Loweswater Suite with two sessions per week of hospital support. One 0.8 WTE staff grade doctor who mainly works in the Loweswater Suite, and one WTE Macmillan nurse which was a job share to cover both hospital sites. There was one anaesthetist who provided two sessions per week on the Loweswater Suite.

The SPCT worked collaboratively with clinical teams to support end of life care and there were good working relationships throughout the two hospitals particularly with the acute oncology services. The SPCT offered a five-day a week service. Cover after 5.30pm and at weekends was provided via telephone advice by the local Eden Valley Hospice, this was an ad hoc arrangement without a service level agreement.

The number of patients referred to the SPCT had increased in recent years. During 2013/2014, approximately 635 new patients were referred to the service in comparison to approximately 500 in the previous year.

As part of this inspection we visited three wards looking specifically at end of life care and we reviewed the medical records of eight patients and eight "do not attempt cardiopulmonary resuscitation" (DNACPR) records.

We observed care being delivered on the wards and spoke with five patients, who were identified as requiring end of life care. We also spoke with three sets of relatives.

We observed a weekly multi-disciplinary patient review meeting. We met and spoke with 20 members of staff including doctors, nurses, porters, specialist nurses and ward managers. We met the chaplain and the mortuary manager and were shown the resources and facilities they had available to them.

We carried out focus group meetings for doctors, nurses, allied health professionals, administration and clerical staff.

End of life care

Summary of findings

There was evidence of improvement in this service since our last inspection; We found that space to develop bereavement offices on the site had been identified. There were plans in place to develop a Bereavement Support Team. A Bereavement Information booklet was near completion.

In response to the national withdrawal of the Liverpool Care Pathway, a new End of Life Care Plan had been developed. This was in a draft format and had been piloted in the hospital. Senior staff were more aware of how the service should be developed and were active in taking the service forward.

We saw eight DNACPR forms which were inconsistently completed. This was supported by the Trusts annual audit figures for DNACPR which showed 54 of 276 forms (19%) were not fully completed.

An End of Life and Bereavement Group had commenced in July 2014 which included representation from the chaplaincy service, medical, nursing, administration, porters and other external providers of care. Its remit was to review how standards for end of life care could be enhanced. A draft strategy for end of life care had been developed and would be overseen by the group reporting to the Safety and Quality Committee.

Formalisation of the governance mechanisms was within the service was still required .For example a structured service level agreement with a neighbouring trust so that clear collaborative working using specific parameters to measure performance and delivery was formally agreed and understood.

Are end of life care services safe?

Good

Summary

At the previous inspection we reported people at the end of life were assessed and care delivered safely including medicines. Ward staff received training from the specialist palliative care team and from the local hospice.

The mortuary adhered to infection control procedures and a risk assessment was undertaken on all patients who had died from blood borne diseases. DNA CPR forms were appropriately completed and we saw that the decision had either been discussed with the patient themselves, or where that was not appropriate, it had been discussed with the patient's relatives. Patients who did not have capacity to consent to end of life care were treated appropriately.

At this inspection Staff who cared for patients at the end of their life and staff working in the mortuary were aware of their responsibilities to raise concerns and report incidents. The SPCT however were unclear if incidents should be reported to the North Cumbria University Hospitals Trust or to their employing Trust. In practice they would copy reports to both Trusts.

Ward areas where patients at the end of their life were cared for were clean and we saw staff regularly wash their hands. The mortuary adhered to infection control procedures and a risk assessment was undertaken on all patients who had died from blood borne diseases.

Anticipatory prescriptions were utilised and discussed at the weekly multi-disciplinary team meetings within the Loweswater Suite.

We saw eight DNACPR forms which were inconsistently completed. This was supported by the Trusts annual audit figures for DNACPR which showed 54 of 276 forms (19%) were not fully completed.

Patients were referred to the SPCT by staff on the wards by telephone or a FAX. Nursing staff told us that if they were unsure they could ask for advice from the team and they were always helpful and supportive.

Incidents

End of life care

- All staff who cared for patients at the end of their life and staff working in the mortuary were aware of their responsibilities to raise concerns and report incidents. SPCT were unclear about lines of accountability for incident reporting.
- Staff spoke about receiving feedback from incidents being shared through regular team meetings and monthly newsletters.
- Staff used Root Cause Analysis in order to reduce subsequent incidents happening and enhancing learning from incidents.
- Between October 2014 and January 2015 there were four incidents reported for patients receiving end of life care. One incident related to the delay in transfer of a patient between the West Cumberland Hospital and the Cumberland Infirmary which resulted in a delay in the patient receiving their medication. The other three incidents were related to pressure area care.

Cleanliness, infection control and hygiene

- Ward areas where patients at the end of their life were cared for were clean and we saw staff regularly wash their hands.
- The Trusts bare below the elbow policy was adhered to.
- The mortuary adhered to infection control procedures and a risk assessment was undertaken on all patients who had died from blood borne diseases.
- Staff on the ward would inform mortuary staff if there was a patient being transferred with a hospital acquired infection and if the patent was being transferred out of working hours porters would complete a form to notify the mortuary staff of the infection.

Environment and equipment

- The National Patient Safety Agency recommended during 2011 that all Graseby syringe drivers (a device for delivering medicines continuously under the skin) should be withdrawn by 2015. The Graseby syringe driver had been withdrawn from the hospital and all the nursing staff were using the McKinley syringe driver.
- However, we saw different documentation to support the use of the syringe drivers being used.
- Staff raised concerns that syringe drivers were often in short supply. At the time of the inspection the Trust had 33 syringe drivers, five were new. The Trust had recently ordered 15 additional syringe drivers.
- The mortuary was clean and tidy but looked in need of refurbishment. We were told a new mortuary was being built.
- The viewing area in the mortuary was light and pleasant with religious neutrality. There was a waiting area with toilets for visitors and in the waiting room there was a curtained window for viewing their loved ones when it may not be appropriate to touch them.
- At the last CQC inspection 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 told by senior staff, space to develop bereavement offices on both sites had now been identified.

Medicines

- Staff told us patients who required end of life care medicines were written up for anticipatory medicines. We examined the records of two patients receiving end of life care and found that anticipatory medication was appropriately prescribed.
- Anticipatory prescribing is designed to enable prompt symptom relief at whatever time the patient develops distressing symptoms. This is based on the grounds that although each patient is an individual many acute events during the palliative period can be predicted and measures can be put in place to reduce these events in advance.
- We also noted that anticipatory prescriptions were discussed at the weekly multi-disciplinary team meetings within the Loweswater Suite.
- We also observed medication for a newly admitted patient, on to Honister ward, for end of life care. This had been completed by the admitting medical team. We were told by nursing staff that this medication chart would be reviewed by the SPCT. This demonstrated good working relationships with the SPCT and the Trust staff working at West Cumberland Hospital
- We observed staff witnessing, checking the identity of the patient and recording the administration of pain medicines to a patient at end of life.

Records

- Following the national withdrawal of the Liverpool Care Pathway, the Trust piloted new documentation to support their new priorities of care for both hospitals. The pilot only took place at the Cumberland Infirmary, Carlisle. 19 patient case notes had been taken for audit

at Cumberland Infirmary but only one had used the new end of life care plans the results were collated and would be presented at the next End of Life and Bereavement Group in April 2015.

- We were told the newly revised care plan would be used throughout the North East and North Cumbria University Hospitals Trust and Morecombe Bay Trust. Staff were currently working across all areas to develop a variety of teaching methods including video's, e-learning, face to face teaching to support the implementation of the new documentation.
- We saw eight DNACPR forms which were inconsistently completed. This was supported by the Trusts annual audit figures for DNAR which showed 54 forms out of 276 forms (19%) were not fully completed.

Duty of Candour

- The Duty of Candour regulation requires being open with patients when things go wrong and providers should establish the duty throughout their organisations, ensuring that honesty and transparency are the norm in every organisation.
- In consultations with patients and relatives, we found evidence of staff being open and transparent.
- We saw effective systems in place to report and learn from mistakes which had occurred in their service.

Safeguarding

- Staff who cared for people receiving palliative care understood their safeguarding responsibilities and were aware of the policies and procedures to follow.

Mandatory training

- As there was no specialist end of life care team the mandatory training attendance is reported under the other core services.
- We were told by senior staff, the palliative care end of life communication training (Sage and Thyme) was to be classed as mandatory training as of the 1st April 2015.
- Sage and Thyme training included advanced communication skills training.

Nursing staffing

- The Cumbria Partnership Trusts' Specialist Palliative Care Team (SPCT) provided nursing services to North Cumbria University Hospitals NHS Trust through the Northern England Strategic Clinical Network (NESCN) agreement.
- There was one full time Macmillan nurse post which was a job share. The two part time Macmillan nurses covered both the hospital sites. There was no cover for annual leave or sickness.
- Palliative care link workers for end of life care had been identified on each ward at West Cumberland Hospital. These link nurses had yet to meet for the first time, roles and responsibilities had yet to be agreed. Training was also being discussed at the newly formed Task and Finish Group.

Portering staff

- Porters play a big part in looking after patients across all areas in the hospital.
- Porters were concerned at the lack of privacy which will be available to them in the new hospital building for discussing sensitive information and for staff support and counselling if required.

Medical staffing

- The recruitment process for the post of specialist palliative care consultant was carried out in November 2014 but the post was not filled. This means the effectiveness and quality of care and education and training for medical staff remains a concern.
- However, two Palliative Care Consultants had been appointed permanently by Cumbria Partnership NHS Foundation Trust to provide the Trust with structured clinical leadership. There were only two sessions per week dedicated to the West Cumberland Hospital, though in practice the consultant often spent more than this in direct clinical care on the wards of the West Cumberland Hospital.

Assessing patient risk

- Patients were referred to the SPCT by staff on the wards by telephone or a FAX. Nursing staff told us that if they were unsure they could ask for advice from the team and they were always helpful and supportive.
- We were told the SPCT could respond to deteriorating patients quickly and told us ward staff usually telephoned if a referral was urgent.

End of life care

Major incident planning

- Staff were aware of emergency planning processes and staff told us about what was expected of them if there was a major incident.
- The mortuary had its own major disaster plan and has in the past received high volumes of patients following major incidents and disasters.

Are end of life care services effective?

Requires improvement

Summary

At the last inspection we reported staff followed the guiding principles of the Liverpool Care Pathway but following a review the trust no longer formally followed the processes and protocols of this pathway. The trust was in the process of developing alternative documentation to use for people who were at the end of life, which must be in place by July 2014.

All staff reported excellent multi-disciplinary working between the Loweswater Palliative Care Suite and the palliative care team operated by Cumbria Partnership NHS Foundation Trust, and patients in the medical wards. Telephone advice was available on a 24-hour basis.

At this inspection in response to the national withdrawal of the Liverpool Care Pathway, a new End of Life Care Plan had been developed. This was in a draft format and had been piloted on two wards but not was not fully embedded. Wards had new palliative care and end of life care resource folders available containing advice and guidance. Training to support the implementation of the new end of life documentation had been discussed and was part of the Bereavement and End of Life Groups Task and Finish working group agenda. A roll out of further nurse training was planned.

Palliative Care Link Nurses for each ward were in the process of being identified but had not had any training Medical staff and allied health professionals received training although it was sometimes inaccessible to staff at West Cumberland as it was delivered at Carlisle.

Palliative care cover after 5.30pm and at weekends was provided via telephone advice operated by Cumberland Partnership Foundation Trust and telephone support was also provided by the Eden Valley Hospice. These were ad hoc with no service level agreements in place.

Staff recognised the complexities of pain management for this group of vulnerable people and they used a range of pain assessment and management strategies to address this by using pain management interventions ranging from simple analgesics through to the use of opioids.

We noted at the weekly multi-disciplinary meeting that most patients referred to the SPCT also had a referral to the speech and language therapy service, occupational therapy and the discharge coordinator as required.

Thirty one nurses had undertaken palliative care end of life communication skills training (Sage and Thyme) and as of the 1st April 2015 this was to be classed as mandatory training.

Staff could describe to us what mental capacity assessment (MCA) meant and understood the procedure to use if a patient did not have capacity to make choices. We were told nurses did not undertake MCAs as they would call the mental health crisis team. This team ran an on call system and would respond in a timely manner.

Evidence-based care and treatment

- In response to the national withdrawal of the Liverpool Care Pathway, a new End of Life Care Plans had been developed. This was in a draft format, had been piloted in two wards but was not embedded. This is part of a Trust wide pilot which will review results and plan for Trust wide implementation and training through a Task and Finish Group which will report to the End of Life and Bereavement Group.
- Staff were unclear about this documentation and the palliative care resource folder which had appeared on the wards the week prior to the CQC inspection. Some staff we spoke with had not seen the documentation.
- Some staff were unable to articulate the End of Life quality goals.
- Most of the supporting documentation and care plans for End of Life care we saw had been developed by the Northern England Strategic Clinical Networks. These included; End of Life Core Nursing Care Plan, Agitation and Restless Core Care Plan, Pain Core Care Plan and many more.

End of life care

- The Northern England Strategic Clinical Networks were created in 2013 to drive improvement in the quality and equity of health care for its 3.1 million population. This covers the North East, North Cumbria and Hambleton and Richmondshire.
- The Trust had an organ donation policy, which adhered to national guidelines. The framework process made reference to specialist nurses, clinicians and nursing staff supporting the family throughout the process.

Pain relief

- For end of life care, staff recognised the complexities of pain management for this group of vulnerable people and they used a range of pain assessment and management strategies to address this by using pain management interventions ranging from simple analgesics through to the use of opioids.
- Some staff described how they would assess pain in patients who couldn't communicate such as; through observations of behaviour, facial expressions and movements.

Nutrition and hydration

- Staff told us about explaining to some relatives how a person's nutritional needs can change when they were coming to the end of their lives. This included why sometimes food and water was not always appropriate due to the physiological changes that took place.
- Patients told us they were happy with the quality and quantity of the food and felt they had plenty to drink.
- We noted at the weekly multi-disciplinary meeting that most patients referred to the SPCT also had a referral to the speech and language therapy service and occupational therapy and discharge coordinator.
- We saw patients being offered drinks at regular intervals and patients commented that the food was nice.

Patient outcomes

- The Trust had not participated in the Care of the Dying National Audit. However, we were given assurances by some members of the executive team that the Trust would participate in 2015.
- A local audit of End of Life Care had taken place as a base line for the pilot of the new End of Life Care plans. This showed that patients had access to anticipatory medications for pain and distress at the end of life.
- There were no systems in place to monitor that all patients received good end of life care. However, we did see evidence from patient's notes that good care was given.

Competent staff

- All staff received appraisals.
- Thirty one nurses had undertaken palliative care end of life communication skills training (Sage and Thyme) and as of the 1st April 2015 this was to be classed as mandatory training.
- Training to support the implementation of the new End of Life Care Plans documentation had been discussed and was part of the Bereavement and End of Life Groups Task and Finish working group agenda.
- We were told link palliative care nurses had been identified on each ward but had not had any training as yet, and once the training was ready to be presented, the link nurse and matron from each ward would be the first to receive this training.
- Further training at ward level would then be cascaded via the link nurses and matrons. We were told medical staff would receive this training.
- Other training for nurses included use of syringe drivers.
- Allied health professionals such as; Radiographers, Occupational Therapists and Physiotherapists received training in end of life care and communication training.
- End of Life training for junior medical staff (Foundation Year1) was delivered by the SPCT in March 2015 and Foundation Year 2 doctors were due to receive further training from the SPCT in June 2015. One junior doctor commented that it was difficult to access this training if working in West Cumberland Hospital as training was delivered in Cumberland Infirmary.
- There were also formal seminars for medical students, Foundation Year1, Foundation Year 2 and Specialist Registrars on a variety of topics such as symptom control, communication skills including 'breaking bad news'.

Multidisciplinary working

- We were told about good multidisciplinary (MDT) working arrangements with the SPCT and consultant's within the hospital.
- There was a weekly SPCT MDT attended by an occupational therapist, discharge coordinator, chaplain

and SPCT medical and nursing team. We noted that patients had good holistic assessment and there was evidence of emotional support and anticipatory prescribing.
- Consultant staff from the SPCT attended some of the MDT meetings such as oncology, colorectal and respiratory meetings.
- We were told that the palliative care consultants on the West Cumberland and Cumberland Infirmary sites used a video conference MDT based in the community for complex cases and peer support.
- The Trust had two GP Registrars two sessions per week who were supervised by the SPCT. We were told this had improved the sharing of information about patients and had improved the referrals between services.

Seven-day services

- The SPCT based on Loweswater Suite offered a five-day a week service.
- Cover after 5.30pm and at weekends was provided via telephone advice operated by Cumberland Partnership Foundation Trust. This was ad hoc with no service level agreement
- Out of hours telephone support was also provided by the Eden Valley Hospice. This was ad hoc with no service level agreement

Access to information

- We asked for information relating to the number of patients referred to the SPCT, the number of patients who died at their place of choice and the number of patients who were currently identified as using an end of life pathway. This information could not be supplied to us at the time of the inspection.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff could describe to us what mental capacity assessment (MCA) meant and understood the procedure to use if a patient did not have capacity to make choices.
- Nurses did not undertake MCAs as they would call the mental health crisis team. This team ran an on call system and would respond in a timely manner.
- One nurse told us about a recent occasion where they cared for a patient where a DoLS had been applied. The crisis team and the mental health consultant supported the ward staff throughout this period.
- Staff we spoke with had all undertaken MCA and Deprivation of Liberty Standards (DoLS) training.
- The Trust wide figures for attendance at MCA training were; Level 1=91% and Level 2=76%.

Are end of life care services caring?

Good

Summary

At the previous inspection we reported 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. The bodies of deceased patients were treated with dignity when going from the wards to the mortuary.

At this inspection staff cared for patients in a compassionate manner with dignity and respect. Relatives we spoke with told us their loved ones had all their care needs met by dedicated staff and they were involved with their loved ones care and felt supported in making decisions as a family.

Staff could use rooms on the wards such as the MDT room or an office for breaking bad news.

The chaplaincy team worked with ward staff and other professionals for patients receiving end of life care and attended the Bereavement and End of Life Group meetings being instrumental in developing the end of life strategy and documentation.

Compassionate care

- A manual to explain about last offices had been developed by the Bereavement and End of Life Group. Ward staff had the opportunity to make suggestions on the content of the manual. Last offices relate to the care given to a deceased patient and their family or carer from the time of death in hospital until the body is released to the Funeral Director.
- The manual was now used on the wards and staff told us they frequently ring the mortuary staff for examples and advice about preparing the body prior to transferring to the mortuary.
- Mortuary staff confirmed that the use of the manual and increased communication with ward staff had resulted in patients being better presented at the mortuary.

End of life care

- Due to the high number of road traffic accidents and incidents with mountain climbers, we were told by senior staff about how compassionate and skilled the mortuary technician was in reconstructing deceased bodies so that they look as peaceful as possible prior to families viewing the body.
- Porters told us about how they were trained to transfer deceased patients from the ward to the mortuary. We were told; 'we treat them as if they were our own family and we move them as if they were living patients. Such as putting a hand under the head to protect them. We make sure all the curtains are closed on the ward before we move the patient'.

Patient understanding and involvement

- We spoke with patients who told us they were informed about their care and understood the treatment and choices open to them.
- One patient told us; 'I know exactly when I can expect to go home and they have told me I will need carers at home and they are sorting this out with my daughter'.

Emotional support

- At the last inspection concerns were expressed that the patients' panel had raised funds for patients to have a separate room for the delivery of bad news.
- At this inspection, there were no specific rooms for 'breaking bad news'. However, we were told staff could use rooms on the wards such as the MDT room or an office.
- The chaplaincy team worked with ward staff and other professionals for patients receiving end of life care.
- The chaplain attended the Bereavement and End of Life Group meetings and was instrumental in developing the end of life strategy and documentation.
- The chaplain worked 25 hours across both sites from Monday through to Friday and is on call during the evenings.
- There were two Roman Catholic chaplains who worked five hours per week and two bank chaplains were used to cover the weekends and time off.
- Referrals to the chaplain had increased over the last year.

Are end of life care services responsive?

Requires improvement

Summary

At the previous inspection we reported palliative care was offered on all wards and supported by the Loweswater Suite. Service support was available 24 hours a day. Wards were using the AMBER care bundle, an alternative communication method to highlight when there was clinical uncertainty about whether a patient may recover and to ensure that their preferences and wishes around end of life care could be identified and met.

Where possible, side rooms were prioritised for patients at their end of life and when appropriate, patients were transferred to the Loweswater Suite for palliative care where all rooms were single. However, staff felt there were insufficient palliative care beds. Patients often had to be cared for on busy medical wards. This situation should be improved when the new unit is built, which will offer 30 beds with ensuite cubicles.

All faiths were able to use the chapel. A prayer room and prayer mats were available and the chaplaincy was available 24 hours a day, seven days a week.

At this inspection the contract with Cumberland Partnership Trust was for provision of hospital support through the SPCT and access to the four palliative care beds in the Loweswater Suite.

There were no dedicated facilities for relatives but there were quiet rooms which ward staff would use in similar circumstances. A Bereavement Team has yet to be established, along with Bereavement Officers to support this.

There was little provision for relatives who visit their loved ones from a distance. We were told relatives could be offered a reclining chair or a 'Z' bed if they wanted to stay overnight. Drinks were supplied by the nursing staff along with sandwiches when necessary.

Staff told us they worked closely with the discharge liaison nurse and this nurse also attended MDT meetings with the SPCT in order to enhance early discharge where possible.

End of life care

We were told about how complaints were used to make improvements with their services such as a complaint about a particularly complex issue which resulted in improving how different members of staff communicate with each other.

A full report showing trends, themes and learning from complaints has yet to be developed.

Service planning to meet the needs

- The current contract with Cumberland Partnership was to provide hospital support through the SPCT and access to four palliative care beds in the Loweswater Suite.
- There were no dedicated facilities for relatives but there were quiet rooms which ward staff would use in similar circumstances.
- A Bereavement Team has yet to be established, along with Bereavement Officers to support this.
- Work continues with the chaplaincy teams to ensure spiritual needs of patients were met and chaplaincy expertise continues to influence service provision.
- Information for families on end of life care was seen when visiting some of the wards.

Meeting people's individual needs

- There was little provision for relatives who visit their loved ones from a distance. We were told relatives could be offered a reclining chair or a 'Z' bed if they wanted to stay overnight. Drinks were supplied by the nursing staff along with sandwiches when necessary.
- When a patient had died staff would transfer them to the mortuary as soon as possible. We were told the deceased patient would never be left more than half an hour to be transferred.
- The Trust had just appointed a second mortuary technician at the hospital which would ensure a more responsive and comprehensive service and would also free up the current technician who had been working in isolation for some time.
- As a result of the external review of end of life services, relatives or carers would be taken to view the body in the mortuary by the mortuary technician to ensure this was done in a timely manner.
- Patient's belongings would be sent directly to the families Funeral Director so that when families came to view their loved ones they were not given the patients valuables and belongings.
- There was access to translation services for people whose first language was not English.
- A Bereavement booklet for families was in the process of being developed

Access and flow

- At the last inspection staff felt there were insufficient palliative care beds and patients often had to be cared for on busy medical wards.
- At this inspection this was still the case. However, staff tried to ensure patients at the end of their lives would be given a side ward if possible, though this was not always possible.
- Staff told us that patients at end of life could die in A&E while waiting for a bed on the wards.
- We observed discussions about a patient's discharge plans and referral back to the patients' GP. Pre populated handover sheets were used to cover these plans and referrals. There was access to electronic GP records but only through Cumberland Partnership computers in the Loweswater Suite.
- Staff told us they worked closely with the discharge liaison nurse and this nurse also attended MDT meetings with the SPCT in order to enhance early discharge where possible.

Learning from complaints and concerns

- The service received a low number of complaints about end of life services.
- People we spoke with knew how to raise a concern or make a complaint.
- Complaints were used to make improvements with their services such as a complaint about a particularly complex issue which resulted in improving how different members of staff communicate with each other.
- A full report showing trends, themes and learning from complaints has yet to be developed.
- As part of the pilot, the 'supporting care in the last hours of life' document 'Guidance for care of dying patients' was being used for information for family or carers. This was a communication sheet which was given to patients, relatives or carers to collate their views on the care being delivered.

Are end of life care services well-led?

End of life care

Requires improvement

Summary

At the previous inspection we reported there was a lack of trust and local vision and strategy for end of life care and a lack of clarity of organisational structure to develop the service for the future. There appeared to be a lack of ownership about end of life care at trust level. Staff said that there was a lack of an End of Life Care strategic group operating within the trust. Since the national withdrawal of the Liverpool Care Pathway, the trust had not yet developed a formal End of Life Care standard framework. 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 or dedicated leadership for end of life care. There was no substantive consultant in post for specialist palliative care, giving a lack of consultant continuity. Verbal feedback from patients and visitors was very positive.

At this inspection we found the Trust had reviewed how it was going to provide and enhance the way in which they cared for patients at the end of their life. An End of Life and Bereavement Group had been initiated in July 2014 which included representation from the chaplaincy service, medical, nursing, administration, porters and other external providers of care. Its remit was to review how standards for end of life care could be enhanced. There were arrangements for the Trust Board to receive a report annually outlining progress against key priorities within the strategy, including audit findings, themes from complaints and incidents, evidence of learning and compliance with end of life training requirements. This was still being embedded and needed time to mature.

At this inspection the Executive Director of Nursing had taken the executive lead for end of life care, along with a Non-Executive Director to ensure issues and concerns were raised and highlighted at board level.

However, further work is needed to formalise and cement the governance mechanisms such as; a structured service level agreement with Cumbria Partnership Trust which makes clear how work will continue together, using specific parameters to measure performance and delivery.

Vision and strategy for this service

- The Cumbria Healthcare Alliance chose Cumbria Partnership Foundation Trust as the lead organisation for end of life care for the county and so they employed and managed the Loweswater Suite and the Specialist Palliative Care Team (SPCT) who provided hospital support for end of life care for the North Cumbria NHS Trust.
- At the last inspection this had led to: the lack of a Trust wide vision and strategy for end of life care; a lack of clarity regarding the organisational structure to develop the service for the future; cross provision adding to the complexity of leadership and engagement at senior management and board level and lack of ownership about end of life care within the Trust
- At this inspection we found the Trust had reviewed how it was going to provide and enhance the way in which they cared for patients at the end of their life. An End of Life and Bereavement Group had been initiated in July 2014 which included representation from the chaplaincy service, medical, nursing, administration, porters and other external providers of care. Its remit was to review how standards for end of life care could be enhanced, developed and fit for purpose.
- We were told the End of Life and Bereavement Group would oversee delivery of the priorities within its strategy and the Safety and Quality Committee would receive minutes of its monthly meetings.

Governance, risk management and quality measurement

- Arrangements were being put in place so the Trust Board receive a report annually outlining progress against key priorities within the strategy, including audit findings, themes from complaints and incidents, evidence of learning and compliance with end of life training requirements. This was still being embedded and as yet needs time to mature.
- At the last inspection the Trust had not developed a formal End of Life Care standard framework to assure safe effective care at the end of life. There were also no training packages to support the new framework once it had been developed.
- The Trust commissioned an external review of the bereavement and end of life service which was reported to the Bereavement and End of Life Group in November 2014. An End of Life improvement Plan was developed

which was led by a sub group of the Bereavement and End of Life Group. A number of actions have been completed with some areas needing further work. This was being monitored by the Bereavement and End of Life Group.

- At this inspection, we saw a draft End of Life Strategy. This had recently been disseminated across both hospitals and all wards. It should be recognised the work needed to accomplish this work taking into account the complexity of how this service was provided. Foundation work had been accomplished which set the basis to build future direction for this service.
- However, further work now needs to take place in order formalise and cement the governance mechanisms such as; a structured service level agreement with Cumbria Partnership Trust which makes clear how work will continue together, using specific parameters to measure performance and delivery.
- The SPCT were unclear of Risk Register arrangements for End of Life Care due to the complex provider arrangements
- The SPCT were also unclear about the incident reporting structure due to the complex provider arrangements. This was mitigated by copying incidents to both Trusts and starting to review all End of Life Care Adverse Incidents at the End of Life care and Bereavement Group.

Leadership of service

- At the last inspection we were told there was a lack of leadership at senior and board level, staff did not appear to be aware of who in the Trust had responsibility and leadership for end of life care.
- At this inspection the Executive Director of Nursing had taken the executive lead for end of life care, along with a Non-Executive Director to ensure issues and concerns were raised and highlighted at board level.
- However, we were told none of the executive team had visited the mortuary at West Cumberland Hospital. The mortuary is an integral part of the pathway for a patient at the end of their life and as such staff need to feel they are part of this service.

Culture within the service

- Staff were passionate about providing good quality care to patients at the end of their lives. Staff told us about the support and advice offered by the SPCT and talked about responding quickly, managing pain effectively and communicating well with the family.
- Staff we spoke with told us about how the new Director of Nursing was changing the culture within the service. Staff felt more positive about their roles and were proud to work for the Trust.
- However, further work is needed to be in communicating with operational staff. We were told by junior staff about their lack of knowledge relating to the new hospital at White Haven. It was evident there were discussions and decisions made by senior staff which could have been better communicated.

Public and staff engagement

- At the last inspection staff were seeking direction as felt they were not engaged in the wider development of the service.
- We found at this inspection senior staff were more aware of how the service should be developed and we were told by senior staff how they were included in influencing how the service should be developed.
- Arrangements were being made to ensure there was patient and public representation on the End of Life and Bereavement Group

Innovation, improvement and sustainability

- At the last inspection staff felt that end of life care did not have a high profile within the Trust and was not recognised as a specialism. We were told by staff at this inspection, there had been an increase in the raising the profile of this speciality and medical staff told us they felt the profile of this speciality had improved.

Outpatients and diagnostic imaging

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

Information about the service

The hospital's outpatients department provides services across a wide range of medical and surgical services. It offers a one-stop clinic in urology. NCUH provided approximately 280,000 outpatient appointments per year of which 82,715 are seen at the outpatients department at West Cumberland Hospital.

The radiology department provided main x-ray, ultrasound and CT scanning and there was a mobile MRI scanner.

We visited six clinics including gynaecology, hysteroscopy, termination of pregnancy (TOP), ophthalmology, maternity and fracture clinics. We also visited radiology, nuclear medicine, plaster room and the records departments.

We observed care, looked at records and spoke with 16 patients, five relatives and 33 staff across all disciplines, including doctors, nurses, health care professionals and department managers.

Summary of findings

At the previous inspection we found and reported a serious concern regarding the management of systems for patient records, which impacted on both staff and patients. At this inspection the availability of records had significantly improved with 98% of patient records available at the start of clinics. The storage of records had also significantly improved with off site storage in place.

There were challenges with consultant recruitment. There were a number of consultant vacancies in ophthalmology. The lack of an ultrasound radiologist had resulted in patients waiting over six weeks for vascular and musculoskeletal scans. A full time manager had been recruited and an outpatient's improvement group had been established.

An Intensive Support Team (IST) had been commissioned from July to December 2014 to develop capability and support the development of robust demand and capacity plans to deliver sustainable 18 week Referral to Treatment Times (RTT). However, RTT in most specialties were below the target rate and patients could wait for longer than average for diagnostic tests. Morale had improved and staff were motivated and positive about the management changes.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good

Summary

At the previous inspection we reported 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, there was a serious issue/safety breach regarding the management of systems for patient records, which impacted on both staff and patients. This has already been flagged as high risk on the trust risk register.

At this inspection the availability of records was significantly improved with a rate of 95% available at the start of clinics. A new hub had been developed where notes were screened and checked. The storage of records had also significantly improved with off site storage in place.

However, one never event had been reported (a radiology/ scanning incident) from February 2014 to January 2015. In ophthalmology air flow problems restricted which procedures could be performed however this would be rectified once they move in to the new hospital.

Plaster room staff reported concern on the lack of access to a medic unless orthopaedic clinics were running. They also reported the inconsistency of information regarding the follow up care required. These had been reported to the manager.

The quality of the notes remained a concern to staff with some loose filing but this was being audited and addressed. We reviewed five sets of notes and found one set was large and had loose pages and identification sheets were incomplete in four of the five sets.

Within the radiology department they were challenged in the recruitment of senior radiologists in particular a senior MRI radiologist for the new hospital. In ophthalmology there were five of eight consultants in post. Locums were used to cover however there were inconsistencies in the quality of the locums.

A full time manager had been recruited to promote compliance with national standards. Local audits had commenced with case note availability and clinic start and finish times having been completed. The clinics in orthopaedics and ophthalmology were being improved through use of the "Perform" improvement programme. There continued to be some cancelled clinics but these were reduced from the last inspection.

Staff continued to demonstrate a committed and caring attitude with a sensitive approach to patients and relatives.

Intensive Support Team (IST) had been commissioned by the trust from July to December 2014 to develop capability and support the development of robust demand and capacity plans to deliver sustainable 18 week RTT standard. Referral to treatment times (RTT) had improved but overbooking of clinic slots was reported as improving RTT but extending the follow up appointment times for example in orthopaedics where 6-8 week follow up appointments were not possible for 4 months.

The lack of an ultrasound radiologist had resulted in patients waiting over six weeks for vascular and musculoskeletal scans.

An outpatients improvement group had been established. The outpatients department had moved directorate and staff felt they had clearer support since the change. We spoke with 33 staff across the service, morale was better than at the last inspection although there remained concerns about the future move to the new hospital which had been unforeseeably delayed.

Incidents

- Senior staff were aware of how to escalate incidents.
- The diagnostic imaging department operated a clear error reporting system.
- One never event reported radiology/scanning incident from February 2014 to January 2015.
- Outpatient staff meetings were in place and working well to disseminate information and learning.
- Serious incident investigation learning was shared with staff

Cleanliness, infection control and hygiene

- Although the building is aged all clinic areas were clean and in good repair.
- There were cleaning schedules in place and levels of cleanliness were audited regularly.

Outpatients and diagnostic imaging

- Staff were aware of current infection prevention and control guidelines. We observed staff following good hand hygiene practice on all of the areas we visited.
- There was a good supply of hand gel in all areas.
- The recent hand hygiene audit was 100%

Environment and equipment

- The environment was appropriate and there was provision for children in the waiting area of main out patients department. However in the ultrasound waiting area it was very cold.
- Storage space remained limited but we saw all equipment stored safely.
- The physical environment for the storage of medical records was improved from our last inspection. All records were stored appropriately.
- The x-ray department was a distance from the outpatient departments and some patients had to be escorted. It was noted that the new hospital layout would provide a better lay out.
- In the plaster room there was no hoist although one could be accessed if required.
- Radiology equipment was checked one to two monthly in line with recommendations.
- IR(ME)R checks had been completed on 16 July 2014 and were due again in 2017. staff dosage checks were in place and increased dosages were rare.
- The angiography room is no longer used as these procedures are now all completed at Cumberland Infirmary, Carlisle.
- In ophthalmology air flow problems restricted which procedures could be performed however this would be rectified once they move in to the new hospital. Eye injections were performed in the treatment room.
- Staff were positive about the design of the department in the new hospital.

Medicines

- The department sister informed us there was a very limited use of medicines in the department.
- Medicines were handled appropriately when used.
- The fridge in ophthalmology outpatients did not have a log for temperature checks.

Records

- Medical records were available at the start of 95% of clinics.
- New processes and staff had resulted in major improvements in the provision of notes at the start of clinics.
- Medical records were being archived and stored at an external facility. This meant the records department on site was able to work more efficiently.
- Temporary sets of notes were prepared if necessary and collated two years of electronically held information although this was infrequent.
- The quality of the notes remained a concern to staff with some loose filing but this was being audited and addressed.
- We reviewed five sets of notes and found one set was large and had loose pages and identification sheets were incomplete in four of the five sets.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent was obtained for the small number of procedures undertaken in outpatients.
- Staff were aware of the Mental capacity Act and deprivation of Liberty safeguards.

Safeguarding

- Up dates regarding safeguarding were received via a safeguarding newsletter.
- All nursing staff dealing with children had level 3 child protection training.

Mandatory training

- In radiology some mandatory training was outstanding, it was noted that nine staff (20%) had not completed their annual basic life support training and five (11%) had not completed infection prevention and control annual training.
- Outpatient staff attendance at mandatory training was good.

Management of deteriorating patients

- Plaster room staff reported concern on the lack of access to a medic unless orthopaedic clinics were running. They also reported the inconsistency of information regarding the follow up care required. These had been reported to the manager.
- There were processes in place to call emergency support if required.

Nursing staffing

- Nurse staffing was appropriate to the department and the retention of staff was very good.

Outpatients and diagnostic imaging

- There were challenges in providing cover for maternity leave.
- The skill mix was appropriate.
- Agency/bank use was minimal in the department.

Radiology staffing

- Within the radiology department they were challenged in the recruitment of senior radiologists in particular a senior MRI radiologist for the new hospital.
- No locums had been used in the radiology department as they had managed to cover internally.
- We were told there were not enough radiographers to release any to go to Carlisle Infirmary for CT training.
- There were 13 radiology helpers who supported the department.

Medical staffing

- In ophthalmology there were five of eight consultants in post. Locums were used to cover however there were inconsistencies in the quality of the locums.
- The gynaecology consultant was currently in a dual role as obstetrician as well.

Major incident awareness and training

- The trust had a major incident plan and staff were aware of their role.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Summary.

At the previous inspection we reported there was evidence of practice being supported by best practice guidance. There was good continuity of nursing staff in the department and they received favourable patient feedback. The team was supported by specialist nurse roles. Staff appraisal and supervision was not received consistently. Although patients we spoke with did not complain about the waiting times staff said that additional weekend clinics were needed to meet demand.

At this inspection a full time manager had been recruited to promote compliance with national standards. Local audits had commenced with case note availability and clinic start and finish times having been completed.

The clinics in orthopaedics and ophthalmology were being improved through use of the "Perform" improvement programme.

There continued to be some cancelled clinics but these were reduced from the last inspection.

Evidence-based care and treatment

- A full time manager had been recruited to promote compliance with national standards.
- Audit of case note availability and clinic start and finish times had been completed.
- Local audit of the quality of outpatient services had commenced.
- Policies based on NICE/Royal College guidelines
- Staff were aware of and adhered to local policies and procedures for example, hand washing and bare below the elbow.

Pain relief

- Pain relief was available if required.
- There was some use of sedation when required.

Patient outcomes

- There had been daily audit of the availability of records for each clinic since September 2014.
- The clinics in orthopaedics and ophthalmology were being improved through use of the "Perform" improvement programme.
- There continued to be some cancelled clinics but these were reduced from the last inspection.

Competent staff

- Radiographer appraisals were up to date. However staff felt that the move of trauma to the Carlisle site meant they did not get that experience.
- Nurse appraisals were undertaken but not all had been entered on to the database.
- Mandatory training was up to date and additional training was being completed by a number of staff including NVQ qualifications, orthopaedic plaster work certification and one nurse was studying for a foundation degree.

Multidisciplinary working

- Multidisciplinary working relationships were observed to be good between out patients, radiology and other professionals .

Outpatients and diagnostic imaging

Seven-day services

- In radiology there was an on call rota covered by the level 8a leads on a one in six rotation.
- There was a resident radiologist overnight and a CT radiographer on call.
- There was a mobile MRI scanner six days a week.

Are outpatient and diagnostic imaging services caring?

Good

Summary

At the previous inspection we reported 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 caring and worked to achieve the best outcomes for patients.

At this inspection we spoke with 16 patients and five relatives who were positive about their experiences. Some had been using the hospital service for some time. Staff continued to demonstrate a committed and caring attitude with a sensitive approach to patients and relatives.

Compassionate care

- Outpatient staff were observed to treat patients with respect and compassion.
- Radiology staff were observed to be very polite and helpful.

Patient understanding and involvement

- Patients were kept up to date when clinics ran late and there had been no patient complaints at the time of our visit. Staff apologised to patients.
- Patients in the gynaecology clinic spoke highly of the staff sensitivity and the speed of response to referrals.
- Patients reporting a good or excellent service was 95% and those who rated their experience as satisfactory was 97% as shown on the department board.

Emotional support

- The play therapist was involved in the clinics for children with cystic fibrosis and individual play packs were used to prevent cross infection.
- Access to the Patient Advice and Liaison (PALS) service was evident in the waiting area, although they were only on site two days per week.
- Clinical nurse specialists

Are outpatient and diagnostic imaging services responsive?

Requires improvement

Summary

At the previous inspection we reported although some additional outpatient clinics had been arranged we saw that clinics were stretched. This was compounded by the required six weeks' notice of cancellation of clinics by consultants, which quite often did not happen, resulting in a high level of short notice clinic changes. Problems with consultant recruitment also affected clinics. This was particularly noticeable in gastroenterology, respiratory, dermatology and cardiology.

The general manager had taken action to mitigate this by placing a ban on overbooking and focusing on correctness of clinic template. 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 and overbooking of clinics was masking the overall picture. This was resulting in long waits for patients. Patients were verbally informed of waiting times at their clinic appointments.

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.

At this inspection the main outpatient department was very quiet as clinics had been cancelled due to planned leave and another due to another clinical priority.

Intensive Support Team (IST) had been commissioned by the trust from July to December 2014 to develop capability and support the development of robust demand and capacity plans to deliver sustainable 18 week RTT standard. Referral to treatment times (RTT) had improved but overbooking of clinic slots was reported as improving RTT but extending the follow up appointment times for example in orthopaedics where 6-8 week follow up appointments were not possible for 4 months.

Outpatients and diagnostic imaging

Referral to treatment rates in most specialities were below the target rate and up to December 2014 in the trust the percentage of patients waiting longer than 6 weeks for diagnostic tests in the trust was almost 12% against a target of less than 1%.

Up to December 2014 in the trust Cancer 2 Week Waits were at 89% against a target of equal to or greater than 93% and in breast cancer the 2 week wait was 92.9% against a target of 93%. The Cancer 62 Day Waits was 83% against a target of 85%.

The lack of an ultrasound radiologist had resulted in patients waiting over six weeks for vascular and musculoskeletal scans.

The nuclear medicine department was only small but was meeting the six week threshold for appointments with the exception of myocardial scanning. This was being actively monitor and actioned.

Service planning and delivery to meet the needs of local people

- An improvement group had been established which was meeting weekly to address the delivery of services.
- A central contact centre had been set up at the Carlisle site and there had been some "teething problems" for example an extra clinic had been arranged but the letters sent to patients gave the wrong location. Despite follow up one patient attended the wrong hospital and some orthopaedic patients were booked on to the wrong clinic e.g. someone with a knee problem booked on the hip clinic.
- Staff spoke positively about the move to the new hospital later in the year as they would all be together and this would make team working and support easier to manage.
- Due to recruitment issues the UVB therapy service had been discontinued. Patients now received the service at Wigton or Carlisle.

Access and flow

- On the day of our visit the main outpatient department was very quiet as clinics had been cancelled due to planned leave and another due to another clinical priority.
- Intensive Support Team (IST) had been commissioned by the trust from July to December 2014 to develop capability and support the development of robust demand and capacity plans to deliver sustainable 18 week RTT standard.
- Up to December 2014 the trust 18 week RTT (Referral to treatment) objective for admitted pathways was 78% against a target of 90%, non admitted pathways was 93% against a target of 95% and incomplete pathways was 89% against a target of 92%.
- Up to December 2014 in the trust the percentage of patients waiting longer than 6 weeks for diagnostic tests in the trust was almost 12% against a target of less than 1%.
- Up to December 2014 in the trust Cancer 2 Week Waits were at 89% against a target of equal to or greater than 93% and in breast cancer the 2 week wait was 92.9% against a target of 93%. The Cancer 62 Day Waits was 83% against a target of 85%.
- The trust cancer 31 Day Waits were being met in all areas.
- In trauma there had been some challenges with rotas to cover clinics as the trauma service moved to Cumberland Infirmary. This had resulted in some clinics being cancelled but this was improving.
- In orthopaedics there had been occasions of local patients asked to fast before attending Cumberland Infirmary for treatment to be sent home due to lack of beds and have to wait 2/3 days to return to Cumberland Infirmary and still not receive their surgery.
- The consultant in the gynaecology clinic informed us that a hysteroscopy clinic had been commenced in June 2014 but they aspired to provide a one stop clinic.
- We were informed that certain consultants consistently arrived late to clinic which had a knock on effect on patients and staff. This was being addressed by the business manager.
- Outpatient rates of "Did not attend" were low at 4.5%.
- Referral to treatment times (RTT) had improved but overbooking of clinic slots was reported as improving RTT but extending the follow up appointment times for example in orthopaedics where 6-8 week follow up appointments were not possible for 4 months.
- Clinic cancellations were approximately one per month.
- There was no formal system for triaging urgent appointments.

Outpatients and diagnostic imaging

- The lack of an ultrasound radiologist had resulted in patients waiting over six weeks for vascular and musculoskeletal scans.
- The nuclear medicine department was only small but was meeting the six week threshold for appointments with the exception of myocardial scanning. This was being actively monitor and actioned.

Meeting people's individual needs

- In the hysteroscopy clinic structural changes had been made in order to improve confidentiality, privacy and dignity.
- The two week clinic for patients with suspected cancer in gynaecology was run separately to the main clinic. They are consultant led. Half the patients would receive their scan on the day of their appointment.
- Termination of pregnancy clinics were run appropriately so that they did not run concurrent to early pregnancy clinics.
- Clinics for children with cystic fibrosis were well managed with appropriate adjustments made.
- The reception was manned until the last patient left but there had been occasions when this had not been possible and nursing staff covered particularly when patients were waiting for transport.
- There was access to translation services.

Learning from complaints and concerns

- Complaints were minimal in the department and often resolved at local level.

Are outpatient and diagnostic imaging services well-led?

Good

Summary

At the previous inspection we reported there was a positive view about the role of the new tier of management, General Managers, they were felt to be effective, but also that they had a very large remit. The Chief Executive was felt to be a strong leader and the staff felt it was good to have stability at the top. The CE was said to be visible with a genuine desire to find out what was going on/ answer questions/ find out what the issues are and how to resolve them.

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 secure the required improvements.

Staff felt valued and well-led. There were some exceptions to this. A few staff felt the organisation was not well-led and there was low morale.

At this inspection an outpatients improvement group had been established. The outpatients department had moved directorate and staff felt they had clearer support since the change. We spoke with 33 staff across the service, morale was better than at the last inspection although there remained concerns about the future move to the new hospital which had been unforeseeably delayed.

Vision and strategy for this service

- An outpatients improvement group had been established and met weekly.
- There was an improvement plan in place for outpatients .

Governance, risk management and quality measurement

- Radiology held monthly team meetings to cascade information.
- The outpatients department had moved directorate and staff felt they had clearer support since the change.
- Policy folders were available in outpatients and accessible to staff.

Leadership of service

- The radiologists told us they had seen the CEO more since our last inspection and received more feedback.
- There is use of video links to provide updates form the executive team.
- The CEO had shadowed teams in outpatients and the records department
- Lines of accountability were clear and senior staff could escalate concerns.

Culture within the service

- We spoke with 33 staff across the service, morale was better than at the last inspection although there remained concerns about the future move to the new hospital which had been unforeseeably delayed.

Outpatients and diagnostic imaging

Public and staff engagement

- The department was involved in the Family and Friends test in which

Innovation, improvement and sustainability

- Dressings clinics regularly over ran so the managers were looking at running clinics from West Cumberland to address this.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Urgent and Emergency care

- Ensure equipment is stored correctly, decontaminated effectively and all single use items are within expiry date. (Reg.12(2)(f))
- Provide safe and secure storage for medication with access limited to qualified staff only. (Reg. 12(2)(g))

Surgery

- Improve compliance against 18 week referral to treatment standards for admitted patients. (Reg. 9(1)(b))
- Improve number of patients whose operations were cancelled and were not treated within the 28 days. (Reg. 9(1)(b))

Medicine

- Improve medical staffing levels. (Reg.18(1))
- Increase numbers of trained nurses. (Reg. 18(1))
- Improve the way in which medicines are stored. (Reg. 12(2)(g))
- Provide sufficient infusion pumps so that there are pumps always available for patient use. (Reg. 12(2)(f))
- Ensure the requirements of the Mental Capacity Act 2005 are followed with regard to the application of Deprivation of Liberty Safeguards. (Reg. 12(2)(a))
- Improve the routine review of medical patients receiving care and treatment on wards outside their speciality. (Reg.12(2)(a))

Maternity

- Ensure out of hours surgical cover to protect the safety of patients in a surgical emergency. (Reg. 18(1))
- Ensure a dedicated obstetric anaesthetist is available at all times. (Reg. 18(1))
- Ensure that resuscitation equipment is appropriately checked in order to that it is suitable for use at all times. (Reg. 12(2)(e))
- Ensure the safe management and storage of medicines in the maternity unit.(Reg.)12(2)(g))
- Ensure medical and midwifery staff are up to date with the training necessary for their role. (Reg. 18(2)(a))
- Improve the governance arrangements to include investigation of the higher than target rate of unexpected admissions to the neonatal unit; the potential wait for patients requiring a termination of pregnancy from referral to procedure, especially when medical staff were absent from work; the necessary measures to adequately manage patients with a high body mass index, multi-disciplinary clinics which should be routinely available for patients with complex needs or multiple health needs; possible extension of the early pregnancy service to a seven day service, the standardisation of the post natal listening service across the trust and introduction of mechanism for monitoring the number of cancelled inductions of labour. (Reg. 17(2)(f))

Services for Children

- Review the consultant paediatric cover provided out of hours. This was a concern as the service still offered a 24 hour emergency service for children and young people. (Reg. 18(1))
- Recruit a ward manager and ensure oversight from a matron. (Reg. 18(1))

Outpatients and diagnostics

- Recruitment of senior radiologists in particular a senior MRI radiologist and ultrasound radiologist. (Reg.18(1))

End of Life

- Improve the accurate completion of DNACPR forms. (Reg.12(2)(a))

Action the hospital SHOULD take to improve

Urgent and Emergency care

- Improve the four hour wait target results.
- Improve the mandatory training completion rate.

Medicine

- Ensure that medical staff document information in patient records appropriately.
- Work towards JAG accreditation in endoscopy.
- Improve access to psychiatric review.
- Improve access to information systems for newly appointed doctors and locums.
- Continue with plans to improve outcomes for stroke patients.
- Implement the Butterfly scheme on all medical wards

Outstanding practice and areas for improvement

- Review and improve bed management.

Surgery

- Improve bed capacity on the surgical wards.

Maternity

- Systems to protect the privacy and dignity of gynaecology patients accommodated on a mixed sex ward should be in place.
- Improve incident reporting, monitoring and mechanisms for sharing learning across the whole staff team on both sites.
- Complete the actions identified on the mortality action plan within the agreed timescales.
- Improve the level of staff with up to date with training in the prevention and control of infection.
- Medical staff should be up to date with practical obstetric multi-professional training.
- Staff should have information and advice regarding the management of patients who may have received female genital mutilation surgery.
- Make sure the emergency pager system works in all parts of the hospital for all staff.
- Audits of clinical practice should included recommendations and actions where a shortfall in provision is assessed.

Services for Children

- Progress work regarding the longer term strategy for children's services.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Maternity and midwifery services Nursing care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider was not always assessing the risks to the health and safety of of service users of receiving the care and treatment with regards to: the requirements of the Mental Capacity Act 2005 and the application of Deprivation of Liberty Safeguards; the accurate completion of DNACPR forms. and the routine review of medical patients receiving care and treatment on wards outside their speciality. (Reg.12(2)(a) ensuring that resuscitation equipment is appropriately checked in order to that it is suitable for use at all times. (Reg. 12(2)(e)) ensuring equipment is stored correctly, decontaminated effectively and all single use items are within expiry date and the provision of sufficient infusion pumps so that there are pumps always available for patient use. (Reg. 12(2)(f)) the provision of safe and secure storage for medication with access limited to qualified staff. Reg.12(2)(g))

Regulated activity	Regulation
Nursing care Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider has not always provided care that meets the patients needs through reduced compliance against 18 week referral to treatment standards for admitted patients and the raised number of patients whose operations were cancelled and were not treated within the 28 days. (Reg. 9(1)(b))

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Nursing care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider has not ensured sufficient numbers of qualified, competent, skilled and experienced persons with regards to: medical staffing levels; the numbers of trained nurses; out of hours surgical cover, consultant paediatric cover out of hours; lack of a paediatric ward manager and oversight from a matron; vacancies for senior radiologists in particular a senior MRI radiologist and ultrasound radiologist and a dedicated obstetric anaesthetist available at all times. (Reg. 18(1)) medical and midwifery staff not being up to date with the training necessary for their role. (Reg. 18(2)(a))

Regulated activity	Regulation
Maternity and midwifery services Termination of pregnancies	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have robust governance arrangements within midwifery with regards to the higher than target rate of unexpected admissions to the neonatal unit; the potential wait for patients requiring a termination of pregnancy from referral to procedure,; the necessary measures to adequately manage mothers with a high body mass index; the early pregnancy service not providing a seven day service, the post natal listening service not being standardised across the trust and the lack of mechanism for monitoring the number of cancelled inductions of labour. (Reg. 17(2)(f))