University Hospitals of Morecambe Bay NHS Foundation Trust

Royal Lancaster Infirmary

Quality Report

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

Ratings

Overall rating for this hospital	**Requires improvement**
Accident and emergency	**Good**
Medical care	**Inadequate**
Surgery	**Good**
Intensive/critical care	**Good**
Maternity and family planning	**Requires improvement**
Services for children & young people	**Requires improvement**
End of life care	**Good**
Outpatients	**Requires improvement**

Summary of findings

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Overall summary

Context

University Hospitals of Morecambe Bay NHS Foundation Trust became a foundation trust on 1 October 2010. It provides a comprehensive range of acute and support hospital services for around 350,000 people across north Lancashire and south Cumbria, with over 740 beds.

The trust operates from three main hospital sites: the Furness General Hospital in Barrow, the Royal Lancaster Infirmary and Westmorland General Hospital in Kendal. The Queen Victoria Hospital in Morecambe provides outpatient services and Ulverston Community Health Centre provides nutrition, dietetics and breast screening. This inspection report will focus only on the acute services provided at the Royal Lancaster Infirmary.

There have been significant changes to the trust board since 2012. The entire board of Directors has changed since 2012 with 14 new appointments made, including the Chief Executive. In the seven months prior to our inspection four executive directors had taken up post.

University Hospitals of Morecambe Bay NHS Foundation Trust has been selected as one of the early trusts to be inspected under CQC's revised inspection approach. The trust was selected for inspection as a trust where there were known risks to service delivery.

Overall inspection findings at Lancaster Royal Infirmary (RLI)

We found that staff at the hospital were committed to providing safe and effective care for patients. There were good examples of compassionate and person-centred care cross all the core services.

The hospital was clean throughout, however there were instances of staff not adopting best practice in hand hygiene and cross infection practices in both the surgical and paediatric services.

In 2013, net recruitment of nursing staff (recruitment – leavers) showed a positive gain of 135 nurses. Regular updates on nurse recruitment were presented to the Board through the Risk Committee; risks were managed through the daily staffing call and the use of bank and agency staff. However, during our inspection we identified a number of areas where staffing difficulties were having an adverse impact on patient care and safety. This was of particular concern on the medical wards. Staffing levels had been an issue on the medical wards for some considerable time. We inspected the medical wards in October 2013 and found that there were not enough staff to provide appropriate and safe care to patients. As a result, we served a warning notice to the trust.

We visited the trust again in January 2014 to assess its progress against a warning notice issued regarding staffing on Ward 39. Although the nurse staffing levels had improved by the provision of new staff and agency nurse support, we found that there were still concerns regarding the staffing levels and skill mix on the ward, and that some patients were not benefitting from high quality care as a result.

We concluded that the trust had failed to comply with the earlier warning notice.

Staffing concerns were also identified in other clinical areas such as the surgical wards, radiology, dermatology and paediatrics, where there is a shortage of specialist staff.

Staffing issues within the hospital have been recorded on the trust's risk register for some considerable time; however, the trust has been unable to address these concerns effectively.

Specialist support services for people at the end of their life were good and patients spoke highly of the care they were given by the palliative care and oncology teams. However, the specialist service is only available during normal office hours.

Outpatient departments are still experiencing difficulties in obtaining patient records in time for clinic appointments and with scheduling appointments.

Staff are well-led at the frontline and have confidence in their managers to raise issues of concern. However, staff have less confidence in the Executive Team, as management responses and improvement actions are seen as lacking vigour and pace.

The trust's governance and management systems are inconsistently applied across services and the quality of

Summary of findings

performance management information requires improvement. We also found that performance information and learning from incidents was not effectively used to drive changes and improvement.

There have been improvements in both the maternity and accident and emergency services as a result of targeted and focused work by the trust, and patients are positive about their experiences of these services.

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

A number of the services provided require improvements to consistently secure patient safety and protect them from risks. This is often due to shortfalls in nurse staffing and a lack of middle grade doctors. There is still a heavy reliance on bank, agency, and locum staff in a number of specialities. There are particular concerns about staffing levels in some of the medical wards at this hospital.

There were omissions in patient risk assessments and care planning documentation. Patients' records were not always accurately maintained and consequently posed a potential risk to patients.

There is a lack of clarity about incident reporting in some areas and learning is not systematically shared to prevent reoccurrence. The sharing and maintenance of 'harm free care' information, such as 'safety crosses' (a system used by staff to record and monitor incidents of harm to patients) is also inconsistent and not systematically embedded within the hospital.

Staff were trained to identify issues of adult abuse and neglect. They were able to describe abuse and how they would report and escalate their concerns.

The hospital was clean throughout and, with the exception of the children's ward, staff followed good practice guidance for the control and prevention of infection.

Are services effective?

Requires improvement

Care and treatment was delivered in accordance with national best practice guidelines and there were regular audits to monitor the quality of the services provided to patients.

Where audits had identified service shortfalls, action plans were developed to secure improvement and reported at board level.

However, we found examples where local audits had been carried out that had identified practice shortfalls but action plans were not always implemented and evaluated to see if actions had secured improvement.

Multi-disciplinary teams worked collaboratively to secure effective treatment for patients in their care.

Staff had undertaken appropriate mandatory training.

Are services caring?

Good

We found good examples of compassionate and person-centred care, and many patients and relatives were complimentary about the care they

Summary of findings

received and the way staff communicated with them. Staff treated patients with respect. Patients felt they were involved in their care and that they could make an informed decision about their care and treatment. Staff worked hard to maintain and promote patients' dignity and privacy.

Are services responsive to people's needs?

Requires improvement

Patients' needs were met in a timely way. After targeted improvement work, the hospital was meeting the national target for waiting times in A&E. Patient referral-to-treatment times were within acceptable limits. Similarly, the number of cancelled operations and delayed discharges were within acceptable ranges for a hospital of this size. Although performance had improved over the last year the trust is still experiencing some difficulties in outpatients in relation to appointments and the availability of patient records. The trust was working hard to improve this element of the service.

Are services well-led?

Requires improvement

We found examples of good clinical leadership at service level, and staff were positive about their immediate line managers. There were initiatives in place to engage staff in developing future plans for the hospital. However, staff felt that they were not always listened to and that trust's executive team needed to be more visible. In addition, a greater focus is needed at board level to resolve some longstanding quality and patient safety issues, particularly regarding both medical and nurse staffing levels at this hospital.

Summary of findings

What we found about each of the main services in the hospital

Accident and emergency

Good

Staff were committed to providing patients with a good safe service and patients were cared for in accordance with good practice guidelines. Communication in the department was good, with medical and nursing staff working well together as a team.

Although previously the department had struggled to achieve the national target over the last quarter, 95.3% of patients were seen within four hours. The department had recently been refurbished and this had improved patient experience.

The nurse staffing establishment in the department had been reviewed 2012. As a result of this review an increase of 11.36 Whole Time Equivalent was added to the establishment. A further review in 2013 resulted in an increase of 1.21 Whole Time Equivalent. The increase in staffing establishment within the department since 2012 has been 12.57 Whole Time Equivalent nurses.

However, paediatric staffing levels require improvement as the department could not always provide paediatric nurses over a 24-hour period.

Medical care (including older people's care)

Inadequate

We found that staffing levels, skill mix, systems and processes all required improvement to secure and maintain the safety and effectiveness of the service.

There were particular concerns about nurse staffing levels on Ward 39 at this hospital.

The quality of nursing records required improvement as some patients' records and risk assessments were incomplete.

Patients were looked after by caring and compassionate staff that worked hard to be responsive to their needs, but were often hampered by staffing related issues.

We found that the wards and departments were not always well-led at a senior level and there was a disconnect between the staff providing hands-on care and the Executive Team.

Surgery

Good

There were effective systems and processes in the surgical wards and theatres to provide safe care and treatment for patients. The majority of patients we spoke with across the surgical services expressed satisfaction with the care received and felt that staff were knowledgeable and caring. Integrated care pathways were in use on the surgical wards and patients were making informed choices about their treatment.

Summary of findings

The surgical wards and theatres were clean and well-maintained. There was compliance with the World Health Organisation (WHO) Safer Surgery Checklist. Staff worked effectively as a team within the specialties and across the surgical services.

However, we found that the surgical service was affected by vacancy rates and that staff were working excess hours to maintain staffing levels on some surgical wards.

We also found that medical staff were not regularly undertaking ward rounds on some wards, which made it difficult for staff to plan and arrange discharge arrangements effectively.

Intensive/critical care

Good

Patients received care and treatment according to national guidelines and admissions were prompt and appropriate on both the Coronary Care Unit and Intensive Care Unit. Staff worked well as a team and there was good communication and support between medical and nursing staff. Patients and those close to them felt involved in their care and treatment.

Staff were aware of current infection prevention and control guidelines. There were clearly defined roles and responsibilities for cleaning the environment and decontaminating equipment. Critical care services were clean, safe and well-maintained.

Patient safety information was used effectively to prevent harm and 'safety crosses' (a system for measuring harm-free care) were visible and accurately maintained.

Maternity and family planning

Requires improvement

Maternity and gynaecological services are safe overall, although some improvements are required. The trust needs to continue to monitor the safety and quality of services using a wider range of information relating to performance, incident reporting, workforce, and lessons learned to secure and maintain a safe and responsive service. Services were caring. All women, patients and relatives that we spoke with told us the quality of the care they received was of a high standard and that their needs were well-met.

Services for children & young people

Requires improvement

Paediatric services were caring and child-centred, the wards were well-appointed with a good supply of toys and play equipment. Evidence-based guidance was used in relation to assessing the clinical needs of children admitted to the ward. Medical and nursing staff treated patients with respect and dignity. They took time to listen to children and their parents. We found that staff worked well with other health professionals to best meet children's individual needs. Parents were kept informed and included in decision-making regarding their child's care and treatment.

Summary of findings

Work was required to ensure that cross infection risks were managed effectively as good practice guidelines were not always followed. We found that hand hygiene by staff on the children's ward was poor. Very few staff adhered to proper hand cleansing routines.

End of life care

Good

The trust has a dedicated palliative care team that provided good support to patients at the end of life. Care and treatment was given in a sensitive and compassionate way. Staff worked hard to meet and plan for patients' individual needs and wishes. Staff were very motivated and committed to meeting patients' different needs at the end of life and were actively developing their own systems and projects to help achieve this.

Patients were very positive about the service from the specialist team.

The multi-disciplinary team worked well together to ensure that patients' care and treatment was planned and coordinated. People were positive about the care they received and the support they were given. There were effective working relationships with local hospices to coordinate people's end of life care where the hospice was their preferred place of care.

Patients receiving palliative and end of life care in a hospital setting had limited access to specialist support at weekends and at night.

We found variation in the standard of records in relation to DNACPR documentation as they were not always completed appropriately

Outpatients

Requires improvement

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 professional and caring team.

Staff working in the department respected patients' privacy and treated them with dignity and respect.

However, we found that waiting times for appointments were long in some departments and although performance had improved over the last year the trust was still experiencing some difficulties in outpatients in relation to appointments and the availability of patient records. The trust was working hard to improve this element of the service.

Summary of findings

What people who use the hospital say

Inpatient and accident and emergency Friends and Family test

The trust scored higher than the national average for the family and friends test for A&E services, with 91.0% of patients asked stating they were either 'likely' or 'extremely likely' to recommend the trust's A&E department to friends or family. However, the trust's A&E response rates (since the Friends and Family Test was established) only just reach the national rate from July 2013 onwards and responses to the test have historically been low. Low response rates can affect the results of this performance indicator.

The trust consistently scores above the England average for the inpatient test from August 2013 onwards. However, response rates are low and this can adversely this indicator. Of the 31 wards at the trust, eight scored below the trust-wide average of 70. Four of those wards were part of the medical directorate at Royal Lancaster Infirmary.

Patient views during the inspection

There were very mixed reviews from patients about their experiences while patients were in the hospital. Many patients shared very positive experiences of good and compassionate care from committed and professional staff. However, a number of patients we spoke with on the surgical and medical wards informed us that although staff were very good and caring, they were very busy and that staff shortages meant staff could not spend time with them as they needed or would wish.

Listening event

We held a public listening event on 4 February 2014 and invited local residents to meet with the inspection team to share their experiences of services at the hospital.

Some participants told us of the difficulties that they or a relative had experienced at the trust. Some of these were still part of ongoing discussions or investigations by the trust. However, some people came to tell us about the good care they had received, and that they were very happy with their care and treatment at the hospital. All the information shared with us was recorded and was used to inform the inspection.

Survey data

The Care Quality Commission undertook a survey of the people who had recently used the services of Morecambe Bay University Hospital NHS Trust (CQC Inpatient Survey 2012). Overall, the trust scored worse than other trusts for the A&E department. However, it scored about the same for similar trusts in the inpatient survey.

Areas for improvement

Action the hospital MUST take to improve

- The hospital must ensure staffing levels and skill mix in all clinical areas are appropriate for the level of care provided.
- The hospital must continue to actively recruit medical and specialist staff in areas where there are identified shortfalls.
- The hospital must improve the nurse record-keeping on the medical wards.
- The hospital must improve its incident reporting. All staff must be aware of their responsibilities to report both incidents and implement remedial action and learning as a result.
- The hospital must ensure that appropriate action is taken in response to audits where poor practice is identified.
- The hospital must ensure that accurate and timely performance information is used to monitor and improve performance in all clinical areas.
- The hospital must ensure the timely availability of case notes and test results in the outpatients department.

Action the hospital SHOULD take to improve

- The hospital should review its staffing investment to ensure that the allied health professional workforce is developed at the same pace as the nursing and medical workforce to meet the growing demand for services.

Summary of findings

- The hospital should consider its investment into the diagnostic and imaging services to respond to increased demand.
- The hospital should improve communication with staff on the wards.
- The hospital should review the opportunities to engage its workforce in the 'better care together' initiative so staff are aware of the future of the services they work in.
- The hospital should review the services provided by the chaplaincy so that patient's spiritual needs are better met.

Good practice

- Maternity and A&E services have improved as a result of targeted and focused work by the trust.

Royal Lancaster Infirmary

Detailed findings

Services we looked at:
Accident and emergency; Medical care (including older people's care); Surgery; Intensive/critical care; Maternity and family planning; Services for Children & Young People; End of life care; Outpatients

Our inspection team

Our inspection team was led by:

Chair: Jane Barrett, Consultant Oncologist.

Head of Hospital Inspections: Ann Ford, Head Of Hospital Inspection, Care Quality Commission (CQC).

The Inspection team had 30 members including medical and nursing specialists, Experts by Experience, lay representatives and eight CQC inspectors.

Background to Royal Lancaster Infirmary

Royal Lancaster Infirmary provides emergency and planned care services, including outpatients, diagnostics, therapies, and day case and inpatient surgery. Key departments and units include a 24-hour emergency department, outpatients department, a comprehensive range of elective and non-elective medical and surgical inpatients, oncology unit, coronary care unit, endoscopy unit, day care unit, intensive therapy unit (ITU), high dependency unit (HDU), maternity unit and special care baby unit.

Other services provided include pathology, radiology and endoscopy, as well as allied health services departments, such as occupational therapy, physiotherapy, nutrition and dietetics, and pharmacy services.

The hospital also has a new minor injuries unit within its emergency department to help improve both service and care for patients.

The hospital has 443 inpatient beds; the emergency department has an average of 42,800 attendances a year.

Why we carried out this inspection

We inspected this trust as part of our new in-depth hospital inspection programme.

We chose this trust as a high risk trust as we knew that there were challenges relating to the delivery of services.

This hospital had also been subject to enforcement action relating to unsatisfactory staffing levels on ward 39 following our unannounced inspection of the trust in October 2013.

How we carried out this inspection

In planning for this inspection we carried out a detailed analysis of local and national data sources that we used to inform our approach and enquiries. The trust was given an opportunity to review the data and comment on its factual accuracy. Corrections were made to the data pack in light of the response.

Detailed findings

We also sought and viewed information from national professional bodies (such as the Royal Colleges and central NHS organisations). We also gathered views from local stakeholders such commissioners of services and the local Healthwatch team.

Our inspection model focuses on putting patients and those close to them at the heart of every inspection. It is of the utmost importance that the experiences of patients and families are included in our inspection of a hospital. To capture the views of patients and those close to them, we held a public listening event prior to the inspection on Tuesday 4 February. This was an opportunity for people to tell us about their individual experiences of the hospital and we used the information people shared with us to inform our inspection.

We also received information and supporting data from the trust and before and during the inspection.

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

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

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

- Accident and emergency (A&E)
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- Children's care
- End of life care

Outpatients

As part of our inspection we spoke with patients in each of the service areas and actively sought their views and the views of those close to them so we could develop a rich understanding of the services provided at the hospital. We held a number of well attended staff focus groups as well as interviews with the Senior Management Team and Board Directors. We looked closely at staffing levels and spent time examining notes and medical records. We also checked departmental records for cleaning and maintenance checks.

We also returned to the hospital unannounced on Sunday 16 February and returned to the medical wards and the intensive care unit.

Good

Accident and emergency

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

Information about the service

The Royal Lancaster infirmary (RLI) A&E department is open 24 hours a day, and provides emergency medical services to the local population. The department has an average of 42,800 attendances a year. The department had been recently refurbished and was clearly divided into different areas for major, minor and trauma casualties. This refurbishment and realignment meant that patients were treated in an area best suited to their needs and helped reduce waiting times. Reception staff receive new patients and begin the patient's pathway.

We talked to 10 patients (and two relatives) six doctors, 12 nursing staff, one receptionist and six ambulance crew.

We observed care and treatment and looked at care records. We received comments from our listening events, from Healthwatch and from people who contacted us to tell us about their experiences. We also reviewed performance information provided by the trust.

Summary of findings

Staff were committed to providing patients with a good safe service and patients were cared for in accordance with good practice guidelines. Communication in the department was good, with medical and nursing staff working well together as a team.

Although previously the department had struggled to achieve the national target over the last quarter, 95.3% of patients were seen within four hours. The department had recently been refurbished and this had improved patient experience.

The nurse staffing establishment in the department had been reviewed 2012. As a result of this review an increase of 11.36 Whole Time Equivalent was added to the establishment. A further review in 2013 resulted in an increase of 1.21 Whole Time Equivalent. The increase in staffing establishment within the department since 2012 has been 12.57 Whole Time Equivalent nurses.

However, paediatric staffing levels require improvement as the department could not always provide paediatric nurses over a 24-hour period.

Good

Accident and emergency

Are accident and emergency services safe?

Good

Cleanliness and hygiene

The department was clean throughout. There were procedures for the prevention and control of infection. Staff were provided with appropriate protective clothing such as aprons and gloves, and there were appropriate hand-washing facilities and alcohol hand gels throughout the department. Staff observed 'bare below the elbow' guidance and the trust's infection control policy was consistently applied.

Initial assessment

We found that all patients reported to reception on arrival and then were seen by a triage nurse. The receptionist had received training to ensure that medical and nursing staff were alerted when patients presented with high risk symptoms, such as chest pains, to make sure that they were seen urgently, otherwise the department aimed to triage all patients within 15 minutes. However, when the department was very busy we saw that patients were waiting up to 45 minutes to be initially assessed.

Staffing

Senior staff told us that the staffing requirements for the department had not been reviewed for some years, However, the trust confirmed the nurse staffing establishment in the department had been reviewed in 2012. As a result of this review an increase of 11.36 Whole Time Equivalent was added to the establishment. A further review in 2013 resulted in an increase of 1.21 Whole Time Equivalent. The increase in staffing establishment within the department since 2012 has been 12.57 Whole Time Equivalent nurses.

There are three paediatric nurses based in the A&E department. However, the department was unable to provide 24-hour paediatric nurse cover seven days a week without requesting additional assistance from staff on the paediatric ward.

Equipment

Equipment within the department was well maintained and it had been regularly checked and serviced to ensure it was safe to use.

Incident reporting

Staff used the trust's electronic system to report incidents, which were sent automatically to senior managers. There was a serious incident last year relating to how the department looked after patients who had died within the A&E department. We found that new procedures had been put in place to ensure that previous incidents were not repeated and that learning from incidents was shared across the whole department through weekly emails. The emails also cover 'classic' cases from other departments if there are no specific incidents relating to the department.

However, staff also informed us that they did not always report incidents as they often did not receive feedback or a managerial response. Staff told us that there was 'no point' and that the electronic system was cumbersome and that they did not have the time to report incidents as they were so busy. One example of this was how, following several cases of missed spinal fractures in the department, staff had been told that they should report further similar incidents. However, three members of staff told us that these were not always being reported. This means that the trust may not be aware of all missed fractures and is therefore unable to implement required changes to prevent reoccurrence.

Mandatory training and safeguarding

Staff were supported to undertake mandatory training and training relating to their roles. Staff were communicating effectively and handovers were well managed and informative. Staff felt that they were well informed about the care, treatment and condition of their patients. 100% of reception staff and 91.7% of A&E staff had completed safeguarding training and there were systems for raising and escalating child and adult safeguarding concerns.

Monitoring safety and responding to risk

There was an electronic system for monitoring a patient's progress through the department that included how long patients had been waiting as well appropriate equipment to monitor their heart rate, oxygen levels and blood pressure. This equipment was fitted with alarms that would alert medical and nursing staff if a patient's condition deteriorated. Patients who required extra monitoring were cared for near the nurse's station with easy access to nursing and medical support should their condition deteriorate.

Good

Accident and emergency

Anticipation and planning

During our visit to A&E the department became very busy. At one point there were several ambulances waiting for their patients to be seen. We saw that waiting times began to steadily increase, with at least one ambulance crew waiting for over half an hour before they were allowed to hand over the patient.

A written escalation process was in place that outlined procedures for dealing with increasing levels of pressure within the department. This enabled staff to alert senior managers to pressures within the department and secure additional support to maintain safe practice within the service.

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Using evidence-based guidance

Care and treatment was managed in accordance with national guidance. There was good practice for the assessment and treatment of head injuries and paediatric care.

The department responded well to a trauma call with care provided in accordance with international standards (ATLS). Appropriate spinal precautions were put in place upon arrival (they had not been applied by the ambulance service) and there was a swift transfer to radiology for appropriate investigations.

Benchmarking performance

Since 2009, the College of Emergency Medicine has encouraged trusts to contribute to 16 national audits, benchmarking the performance of their department. The Royal Lancaster has contributed to 12 out of 16 of these.

The trust provided us with their individual summaries from the College for two of the audits – Severe Sepsis and Septic Shock (Adult) and Renal Colic (Adult). The department was in the lowest quartile for measuring and recording vital signs and evidence of crystalloid being given within one hour. It was also below the national median for the percentage of patients being given antibiotics in A&E (i.e. before moving on to another ward). It was around the national median for the percentage of patients having their lactate measured and lactate taken. In the Renal Colic audit, it was in the lowest quartile for whether pain was recorded and the third quartile for the time taken to give patients pain relief. It was also in the bottom quartile for recording whether patients' pain was re-evaluated.

Are accident and emergency services caring?

Good

The trust scores higher than the national average for the family and friends test for A&E services, with 91.0% of patients asked were either 'likely' or 'extremely likely' to recommend the trust's A&E department to friends or family. However, the trust's A&E response rates (since the Friends and Family Test was established) only just reach the national rate from July 2013 onwards and responses to the test have historically been low. Low response rates can affect the results of this performance indicator.

Compassion, dignity and empathy

We spoke with patients and those close to them throughout the day of our inspection. We also case-tracked patients who had been admitted to the hospital following their assessment in A&E and spoke with them about their care. We heard from patients that they felt safe and comfortable and were being treated with compassion, dignity and respect. One person told us, "They're professionals but resources seem stretched to the limit." Another mentioned, "I've nothing but good things to say about the hospital."

Staff dealt with patients in a dignified and respectful manner. Staff kept patients informed about their care and treatment, apologies were given and delays explained. Care was taken to ensure that patients with dementia were treated in a sensitive and supportive way, and staff supported patients on a one-to-one basis when required.

Involvement in care and decision making

Patients felt that they were involved in their care and treatment; they told us that, "They checked everything with me." Another added, "Yes I had two doctors looking after me who were both very good."

Staff were clear and open with patients about proposed care and treatment, explaining what was happening in a

language that patients could understand. Where appropriate, staff sought appropriate consent from patients, taking care to ensure the patient and those close to them understood what they were consenting to.

Trust and communication

Communication with patients was friendly, warm and professional. Patients felt well supported and informed. Staff were committed to giving patients a positive experience even when they were pressured by increasing service demand.

Patients told us that they felt that staff were doing a "fantastic" job and were "second to none". One person said, "They were fairly busy but I got straight into a cubicle." Another told us, "They were pleasant and very kind." We observed staff interacting with patients and relatives in an open, honest and professional manner.

Emotional support

Staff offered emotional support to patients who were frightened or anxious about their admission and did their best to reassure them. Staff also spent time explaining to people close to patients what was happening and why, staff offered reassurance and support to people accompanying patients receiving care and treatment within the department.

There was support available for the bereaved from the chaplaincy and the bereavement office located within the hospital.

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

(for example, to feedback?)

Good

Access

Historically the trust has struggled with the levels of demand in its A&E and as a result waiting times and patient experience was adversely affected. Since CQC's investigation of the trust's urgent care pathway in 2012 and the follow-up visit in 2013, the trust has been focusing on managing capacity, demand and performance in A&E, and as a result performance around the A&E target has improved steadily. In the last quarter, 95.3% of patients were seen within four hours. While this is very positive for the trust, it must be able to sustain this level of performance over long periods before it can be assured that performance consistently meets the standard required.

Environment

The department had been recently refurbished and was clearly divided into different areas for major, minor and trauma casualties. This refurbishment and realignment meant that patients were treated in an area best suited to their needs.

More care was required in the facilities and services provided in waiting rooms. These rooms were sparse with little literature and information available. There was little evidence of facilities to inform, divert or support people waiting to be seen or who were waiting for news regarding their relative's care and treatment. There was no display screen that indicated how long people would be waiting. The triage nurse kept people informed and apologised on several occasions for people having to wait.

The A&E department also provides emergency care for children and young people and although there was a separate room in the department it had large glass windows that meant that children were visible and able to look into the main waiting area.

There was a separate private area for bereaved relatives.

Vulnerable patients and capacity

Patients with dementia were sensitively managed, often on a one-to-one basis to promote the patient's safety.

Patients with mental health needs were risk assessed using a recognised suicide risk assessment tool at triage to ascertain the level of risk they may present to themselves. There was a specially adapted cubicle which had had all unnecessary equipment removed to prevent people harming themselves or others. Staff explained that if someone required extra support because of their vulnerability a member of staff would be allocated to sit with them until specialist support was available.

There were no mental health liaison staff, as this service was provided by the local crisis team who were employed by a different trust. We spoke with a mental health practitioner and they informed us that they were one of three staff who provided mental health liaison support to the RLI. Staff in A&E were not clear how this service

Good

Accident and emergency

worked nor were they clear about the range and nature of the support available. Staff gave examples of how patients waited for over four hours to receive mental health support.

The trust is aware of the difficulties in securing timely mental health support and has recorded this issue on its risk register. It is working with the CCG and the trust providing the support to formalise a Service Level Agreement (SLA) with a view to improving response times for mentally ill patients who present at A&E. The SLA has yet to be finalised and implemented.

Information leaflets in languages other than English were not available and there was a lack of accessible information for those with impaired vision or learning difficulties. The reception staff explained that they were able to access interpreters for people whose first language was not English and that they would personally assist anyone with hearing or sight impairment while in the department.

Leaving hospital

We found that people's discharge plans were robust and had been agreed with the patient and their carers prior to their discharge from the department. Information was accurately shared in a timely manner with the patient's GP. Senior staff explained that there were occasional difficulties with arranging appropriate adult social care to enable people to leave hospital safely. However, the trust was continuing to work closely with the local authority to ensure that discharges are better managed and social care packages were provided in a timely way.

Learning from experiences, concerns and complaints

We were unable to establish if any improvements had been made as a result of patient feedback or patient complaints. This is a missed opportunity for the trust to respond positively to patient experiences and improve services accordingly.

Are accident and emergency services well-led?

Good

Vision, strategy and risks

Front line staff were unaware of the strategic plans for the service and knew little of the proposed clinical strategy 'Better Care together'.

The service monitored the safety and quality of care, and action was taken to address immediate concerns. However, in the absence of a clear strategy for the ongoing development of the service, staff were unclear about future plans and developments and the lack of response from managers meant that staff did not always record and escalate risks appropriately.

Governance arrangements

The A&E Department is part of the Acute and Emergency Medicine Division. "Each Clinical Division is headed by a Clinical Director, supported by a Divisional General Manager and an Assistant Chief Nurse. Each Clinical Specialty has a Consultant with dedicated management time to act as Clinical Lead. Each Division also draws on dedicated support from Finance, Human Resource and Governance.

Risks are escalated and recorded on the risk register; the two key risks relating to A&E were the recruitment of medical staff and mental health support to patients attending A&E. Actions are assigned and owned by a senior manager and progress is reported to the Board quarterly".

Leadership and culture

The team was motivated, with good team working and good communication between all grades of staff. Staff felt supported by their line managers and departmental colleagues. Staff felt able to raise concerns and challenges and able to share ideas and practice within the department.

Learning, improvement, innovation and sustainability

Staff were given opportunities to learn and develop professionally. They were keen to learn and improve the service for patients. However, there was little evidence of cross-departmental working with the A&E service at

Good

Accident and emergency

Furness General Hospital (there are no A&E services at Westmorland General Hospital). There was a sense that the department was working in isolation, which meant opportunities to share learning and good practice may have been lost.

Inadequate

Medical care (including older people's care)

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

Information about the service

Medical care is provided on four wards (22, 23, 37 and 39) at the Royal Lancaster Hospital and care for people with a wide range of medical conditions. At the beginning of November 2012, the trust opened a new temporary ward block as part of a larger re-organisation of the medical wards. The new building is situated adjacent to the Centenary Building and accessed through the Centenary Building corridors.

We visited all of the medical wards during our inspection and looked at the personal care and treatment records of people who use the service. We observed how people were being cared for and talked with people who use the service. We spoke with patients and those close to them and talked with medical and nursing staff.

Summary of findings

We found that staffing levels, skill mix, systems and processes all required improvement to secure and maintain the safety and effectiveness of the service.

There were particular concerns about nurse staffing levels and skill mix on Ward 39 at this hospital.

The quality of nursing records required improvement as some patient records and risk assessments were incomplete.

Patients were looked after by caring and compassionate staff that worked hard to be responsive to patients' needs but were often hampered by staffing-related issues.

We found that the wards and departments were not always well-led at a senior level and there was a disconnect between the staff providing hands-on care and the Executive Team.

Inadequate

Medical care (including older people's care)

Are medical care services safe?

Inadequate

Cleanliness and hygiene

All of the wards we inspected were clean. Alcohol hand gel was available in several places on the wards we inspected, and we saw that staff used this regularly and washed their hands. There were adequate hand washing facilities available on each ward, the liquid soap and hand towel dispensers we checked were adequately stocked. Staff adhered to safe practice guidelines in relation to hand hygiene and the control and prevention of infection.

A ward manager told us the infection control team were "Very active within the trust, they will come and speak with us on the ward but they don't always recognise we are doing our best within the constraints of the ward".

Staffing

There were insufficient numbers of suitably qualified, experienced nursing and support staff on some of the medical wards. In particular we had significant concerns regarding the nursing staffing on Ward 39, which is a 50-bedded general ward which primarily received patients straight from the A&E department.

No acuity tool had been used to accurately assess the number of trained and non-trained nurses that were required on the ward, although concern over the staffing ratios was significant enough for it to score 20 on the divisional risk register and 16 on the corporate risk register. Of note it was first placed on the risk register in November 2011. We looked at the rotas for the month of November 2013 and found that during the day there were on average seven trained staff (including one band 6) and five or six untrained. We discovered it was not unusual for there to be only four trained and two untrained. Overnight this dropped significantly to four or five trained and three to four untrained. We looked at the improvements made in the staffing numbers since November and found that the trust had provided three additional trained nurses however, this ward is very busy with a high turnover of patients and it often had patients with more intensive medical (especially intravenous medication) needs or acuity. As such many similar wards in other hospitals aim to staff their units to ratios of one trained nurse to five patients, which would require higher numbers than the current establishment. We also discovered that several senior nurses had recently resigned, which meant there were more newly-qualified nurses on the ward who required managerial support.

We were able to assess the impact of the current staffing during both the unannounced and announced visits, and were concerned about the workload of the nursing staff. A social worker told us they often had to update the nurses about patients' conditions and progress because the staff were not aware of the changes. Staff were unable to contribute at the doctors' ward rounds, and when asked directly staff would frequently say "I don't know the patient".

In light of the concerns raised by the staff (and by a previous CQC visit in October), the recently appointed executive nurse had undertaken a review of all nurse staffing levels across the trust and had introduced the 'Red Rules Initiative' aimed preventing nurse staffing levels falling below minimum, safe standards. There are also plans to use the 'safer nursing tool' to revise and review staffing levels in all ward areas. The trust acknowledges that the implementation of the tool requires training and a governance framework and has stated its commitment for this work to be undertaken as soon as possible. The hospital managers explained that they now had daily teleconferences led by the senior nursing team, which allowed them to review and address staffing levels regularly not only on Ward 39 but across the other wards. This process was supporting managers in optimising the allocation of staffing resource according to patient need. There were also plans for greater transparency of the nursing numbers throughout the hospital by publishing the expected and actual nursing numbers on each ward.

In addition, the trust has been actively recruiting additional nursing staff. The 'great place to work' initiative has secured an additional 135 posts across the trust. Until new staff had been properly inducted the trust had also 'block booked 'agency staff to support shortfalls and address issues regarding the continuity of care. In the interim the trust has provided additional nurse leadership on Ward 39 to support improvements in patient care and experience.

Senior management agreed that recruitment was also an issue for middle grade doctors, and medical staffing on the acute medical unit at night can be difficult if the registrar is needed elsewhere. The management have raised these

concerns to trust board level for action to be taken. The hospital was covering gaps in the medical rota with locum staff and was working to recruit permanent medical staff at the time of our inspection.

Incident reporting and risk assessments

We found that although there were systems in place to identify and investigate incidents, they were not consistently applied. We looked at incident reports for the past 12 months on Ward 39. There had been 156 incidents relating to incorrect administration of medication, of which 72 were categorised as no injuries, 54 minor, five moderate and 25 near misses.

We found 29 patients had acquired pressure ulcers, of which 10 were classed as grade 1, 17 were grade 2 and two were grade 3. There had been 224 incidents involving falls, of which 167 were categorised as no harm, 55 were minor, and two were deemed moderate harm. However, staff told us that they did not always have time to report all clinical incidents. This meant that the trust may not have been aware of the full extent of the issues within Ward 39 as reports may have been inaccurate.

In addition, although evidence-based risk assessments were available these were not always effectively used. Examples of risk assessments we looked at included falls, nutrition, bed rails, skin integrity and moving and handling. One member of staff told us, "Patient weights are done when we have the time, there will be patients whose nutritional assessment has not been completed".

We looked specifically at the records of patients who were identified as being at risk from falling. As part of this process if the patient was identified as vulnerable (at risk of falls due to a history of falls or from their diagnosis of dementia) then the initial patient assessment process required that a further, more detailed assessment of risk should be made. We found that such detailed assessments were of varying quality and in some instances they had not been completed appropriately. There was no evidence to suggest that staffing numbers were increased on for wards that had identified a high number of patients at risk of falling.

Information from the NHS safety thermometers indicates that the proportion of patients being cared for by the trust suffering new pressure ulcers including patients over 70, was consistently above the England average from November 2012 to November 2013 (with the exception of patients over 70 in November 2013). The trust has begun work on understanding and reducing the numbers of pressure ulcers acquired by patients in hospital and has agreed with commissioners to focus on four high profile areas known locally as the as the 'Safety Four'. Inpatient harm including pressure ulcers is a key feature of this work. The trust's progress in this regard is subject to close monitoring by both commissioners and regulators. Information provided by the hospital management team indicated that there had been a reduction in the numbers of pressure ulcers since our last inspection, however, we were informed by commissioners that local agreed performance targets for pressure ulcers was not on trajectory. Further targeted work is required to manage inpatient safety relating to the prevention of pressure ulcers within acute medical services.

We found one patient who had leg ulcers and a pressure sore was not being nursed on an appropriate pressure relieving mattress as indicated by the patient's high score on the waterlow risk assessment tool. This was brought to the attention of a senior nurse during this inspection who then took immediate action to secure a suitable mattress. A physiotherapist told us they felt the "culture was not about risk assessment, these assessments were variable and inconsistent particularly on Ward 39; Patients remained in bed for too lengthy periods of time". Allowing patients to remain in bed unnecessarily is considered poor practice as it increases their risk of developing complications such as pressure ulcers.

Mandatory training and safeguarding

There were systems in place to escalate adult safeguarding concerns. On Ward 39, 78.3% of staff had completed the trust's mandatory safeguarding training. There were higher numbers of staff who had completed safeguarding training in the rest of the medical wards at the hospital.

Environment and equipment

On Ward 39 we found evidence of medical equipment not being adequately checked and serviced to ensure it was safe to use. It was of serious concern that the defibrillator was not being charged and may not have been effective in the event of an emergency even though the record was signed as being checked. This meant staff did not have access to emergency equipment which was effectively checked and maintained. This may have compromised the

safety of a patient if the equipment did not function properly when used. These concerns were taken up with the matron who told us these matters would be addressed immediately.

Records

On the adult medical wards, we found medical records were well maintained. However, nursing records required improvement. One senior nurse told us, "What we need is concise documentation so you can get to the paperwork you need. It all needs to be streamlined to be more effective."

Systems, processes and practices

The adult medical wards had medical and nursing records stored in unsecure locations easily accessible to other patients and their visitors. We discussed this with the ward manager who told us they reinforced security of information during handovers with all staff, although they were aware patient confidentiality could potentially be breached by the current storage arrangements.

We asked one of the ward managers to show us information about a patient who had fallen, from the electronic records system. The staff member was unable to find and access the information we requested. One staff member commented that patient information was not always stored in the correct areas within the system. This meant that electronic records could not be located promptly when needed. Consultants we spoke with felt the system was not 'user friendly and was time consuming'.

Monitoring safety and responding to risk

The wards used a variety of ways to communicate with each other to share information and escalate concerns. However, information was not always acted upon. Staff were using handovers on the wards and a paper report providing staff with an update on each person was shared at the start of each shift. For one patient a 'body map' and a dietician referral had been requested, neither of these requests had been completed when the complex discharge nurse reviewed the case to plan the patient's discharge.

The trust had its own early warning trigger system Physiological Observation Track and Trigger System (Potts) in place. Staff were able to tell us about its use and the systems of audit in place to identify improvements and problems. However, this tool is specific to this trust and has been in use for some years. There was no evidence that the trust had formally reviewed the effectiveness and use of this tool against other research based response tools used nationally to measure its continued effectiveness in identifying risk.

Information sharing on the wards varied. Some of the wards had quality boards that displayed key performance and quality indicators that included the numbers of falls and pressure ulcers. These were known as safety crosses, other ward managers told us they were unable to review information about 'risks' because they did not have access to the information.

Anticipation and planning

The trust had a plan to deal with emergency pressures during the winter months and plans had been put in place to improve discharge arrangements. However, the trust was unable to recruit sufficient staff to support and care for patients in identified escalation areas and this had an impact on the number of medical outliers (patients who are receiving care on a ward that is not within the appropriate speciality). Staff reported that there have always been medical outliers and the numbers of these vary from week to week. They told us that they continually raise this as an issue of concern with senior managers to help support the planning and development of services, but nothing is ever done about the situation.

Are medical care services effective?

(for example, treatment is effective)

Requires improvement

Using evidence-based guidance

The service was using national and best practice guidelines to care for and treat patients. The trust participated in all but two of the clinical audits for which it was eligible.

The Royal Lancaster Infirmary does not provide primary coronary intervention (PCI) as this is provided at the Cardiac Catheter centre at Blackpool teaching Hospital NHS Foundation Trust. However, the number of patients diagnosed with a non-ST segment elevation myocardial infarction (N-STEMI - a type of heart attack that does not benefit from immediate PCI) seen by a cardiologist prior to discharge was above national average at 99.4%. That said, only 42.7% of patients with an N-STEMI are admitted to a cardiology ward.

Inadequate

Medical care (including older people's care)

The Sentinel Stroke National Audit Programme (SSNAP) is a programme of work that aims to improve the quality of stroke care by auditing stroke services against evidence-based standards highlighted that the service needed to make improvements to the care and treatment of patients who had suffered a stroke. There are two parts to the audit – Organisational and Clinical. The hospital is in the bottom quartile nationally in the organisational part and scored 'E' in the overall clinical part. This is the lowest grade awarded.

Local clinical audit

We reviewed the trust's Clinical Audit Forward plan for 2013/14 as well as its Annual Report for 2012/13. This informed us that the trust had undertaken 104 local clinical audits between 2012/13, 29 of which were by the medical directorate. There were 42 planned for the year 2013/14, which will be reported on in May. According to the forward plan, Doctors from FY2 to Consultant were involved in the audit process and these were reported locally at the Quarterly Divisional Governance meetings as well as to the trust board annually.

Are medical care services caring?

Requires improvement

The friends and family test is a national initiative to gain feedback from patients following their admission to hospital. Results are published by trust, but can also be broken down by ward allowing for comparisons within hospitals. Many trusts display their results on individual wards to encourage completion by patients and inform staff as to how their patients think they are doing. This was not the case at Royal Lancaster Infirmary. Although overall the trust was performing similar to the national average we were not given specific breakdown by ward. We were however provided with the response rate by ward, which for both Wards 37 and 39 were significantly below the national average response rate (at both 5.7% and 2.8% respectively).

Compassion, dignity and empathy

Most patients, relatives, carers and staff spoke positively about the staff and told us they were kind as they delivered care. Comments included; "The nurses are very helpful", "The staff are good and caring" and "The girls do a marvellous job". On the elderly care and stroke ward, staff were caring and compassionate.

We found that the nurses and medical staff worked exceptionally hard to meet the needs of patients and were respectful and caring when speaking with them. Although at times staff were unable to spend the time that they would like with patients due to high demands on their time.

There were instances where patients' needs were not effectively met. We observed one patient on an adult medical ward who was trying to eat their meal with an oxygen facemask in place and a patient whose medication was in their bed clothes. Both patients were being supported by a junior nurse who needed some guidance to manage these patients appropriately.

On Ward 39 a patient waited 20 minutes for a member of staff to respond to their request. In addition, a patient's relative told us they were aware their relative had been incontinent and that they waited over 10 minutes before a staff member was able to attend to their relative's needs. These incidents were clearly distressing for patients and did not ensure their dignity. Patients were afraid of 'having an accident' and were anxious about the long waits for assistance.

We received a letter from a person who chose not to make a formal complaint but told us about their concerns regarding Ward 39; "We fully appreciate that the nurses are very busy but there was such a lack of staff that patient care was seriously affected. Other patients complained about it too and one lady on my daughter's ward who had called for help several times wet her bed as no assistance came to help her to the toilet. This situation is dire and just not good enough. We feel very strongly that more staff are needed on this ward."

On Ward 23, a patient told us; "The staff pop round, turn your call bell off and say, I will be back. I feel like I wait forever."

Involvement in care and decision making

Care was planned and provided in a way that took into account the wishes of the patient. Patients' views and

consent were sought and recorded. Patients told us they felt involved in decision making about their treatment. One patient said "I have been given clear information about my progress all the way along, it is useful."

We observed staff sharing and including patients in decisions about their care in a language that patients could understand.

Emotional support

Staff clearly understood the importance of meeting patients' emotional needs and tried to spend time with them to help them understand their current health condition. We spoke with one patient's relative who was supported by staff on Ward 39. The relative told us that the staff nurse was "amazing" and was very sensitive in their approach. The relative told us that due to the poor staffing levels on this ward, the staff were limited to spend time meeting the emotional needs of patents. Staff members on this ward confirmed this to us, they said they would always try to spend time with patients to meet their emotional needs, but this often resulted in them having to stay on the ward after their shift had finished to complete their paperwork.

Are medical care services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Access to services

The hospital was still experiencing capacity problems and difficulties in managing the numbers of medical outliers. However, arrangements were in place for patients to be seen regularly by a doctor so that they were given timely care and treatment.

Complaints

Complaints leaflets and health promotion information was readily available. The "We're Here to Help" leaflets about the Patient Advice and Liaison Service (PALS) were on display. The wards were keen to gather patients' feedback about the service they provided in the family and friends feedback.

Vulnerable patients and capacity

Dementia link nurses were available to provide guidance and support to staff and patients on the ward. The Butterfly Scheme was in place, which allowed people with memory impairment to have person-centred care while in hospital. We observed this scheme was in place on all the medical wards. A nurse told us that the cognitive screening tool was checked by a designated matron to ensure the information was completed accurately. One care worker told us, "Being made aware of patients who have dementia makes us think about their individual needs."

We found that most staff understood their responsibilities accessing services for patients who lack mental capacity. However, one staff member told us that they had not had any training in this area and would not know how to access the required help for patients who required support. This meant that patients who lack mental capacity may not receive the support they require to make important decisions about their care and treatment.

Leaving hospital

The discharge process at RLI has been identified by commissioners as a key priority due to delays experienced by patients awaiting discharge. The delays had had an adverse effect on the patient's length of stay in hospital and effective patient flow. This was of particular concern on the medical wards.

There was a collaborative approach to discharge planning and information provided by the trust indicated a CQUIN (Commissioning for Quality and Innovation) target for providing patients with medicines information on discharge from hospital. Progress was being monitored, showing improved patient experience. In addition, the waiting times for TTOs (medicines to take out) were being monitored and showing improvement in the times taken to provide medicines for patients on discharge.

The hospital had recently set up an 'early supported discharge team' that provided a stroke service to continue patients' care and treatment after discharge. The team consisted of a physiotherapists, occupational therapist, speech and language therapist and support workers. The team worked in partnership with patients who had suffered a stroke and their families or carers to ensure safe discharge and appropriate support at home. Patients were positive about their experiences with the team.

Inadequate

Medical care (including older people's care)

Environment

The ward environment was not always appropriate for patients' needs. A physiotherapist we spoke with who provided treatment to patients on Ward 39 told us, "It is very challenging to get the correct equipment around the patient to support them with their rehabilitation due to a physical lack of space."

The stroke service had a therapy treatment room; this was a dedicated room on Ward 23 that contained adjustable height plinths and therapeutic equipment so that individuals or groups of patients could benefit from physiotherapy activities such as balance and gait training.

Are medical care services well-led?

Inadequate

Vision, strategy and risks

We received mixed views from staff on the medical wards about the trust's overall vision for improving patient safety and quality of care. One staff member told us they felt things in the trust were starting to "change for the better". Four staff members we spoke with told us that they did not know about the trust's strategy 'Better Care Together'. This strategy was in development for the future provision of health services both within the hospital and community. The trust had set up meetings for staff to engage in helping to shape how services needed to develop. However, some staff did not know that these meetings had been arranged and one staff member told us, "I knew about the meetings but could not attend because of the pressure of working on the ward."

This meant that staff did not always have the opportunity to be involved in these important meetings to help influence change based upon their experiences of directly working with patients.

Governance arrangements

The governance structure within the trust expected divisional governance board meetings to be held. Here the divisional risk register, incidents, safety alerts, infections, audits and mortality reviews are undertaken. We were not given any evidence (in terms of minutes) from the medical directorate to assure ourselves that these were being undertaken appropriately.

We looked at the divisional risk register and noted insufficient nursing staffing had been on the register since 2011.

The trust had an electronic system in place for incident reporting and incidents were escalated to senior managers quickly in order to investigate them and mitigate any future risk. There were some positive examples of reporting securing positive change. One ward manager showed us that improvements had been made following a root cause analysis investigation into a grade three pressure ulcer that a patient had acquired on their ward.

Leadership and culture

Most staff told us that their line managers were supportive and that senior management were visible. Senior staff were able to tell us who the relatively new members of the trust executive team were. On all of the wards, the matron and/or ward sister were visible and accessible to their staff. We found the ward sisters and staff to be very approachable, and they made us feel welcome on the wards. Staff confirmed their managers were supportive when they were not too busy.

Nursing staff were also positive about the new executive nurse who, since her appointment, had been visible in the hospital. Two staff nurses felt hopeful that 'things were on the up'. However there was a feeling from the majority of nurses we spoke with who felt the senior leadership team were not responding quickly enough to the difficulties they faced on the medical wards. One staff member told us, "It would help if a senior member of staff worked on this ward, they then might understand the pressure and difficulties."

Patient experiences, staff involvement and engagement

Some staff told us that positive changes were happening in the trust and that the new management arrangements made them feel more positive, but that staff morale was still generally low. Two staff nurses on Ward 39 told us that they felt anxious about the standard of care that patients were receiving as it did not meet their own professional standards and that they were anxious when they were off duty in case they had failed to meet a patient's needs. Both nurses remained behind after their shifts had finished to complete records as they wished to spend time with patients who were worried or needed additional support at the end of life.

Inadequate

Medical care (including older people's care)

Staff working on the medical wards were disappointed that they did not always get an opportunity to engage in team meetings. We were told that there had not been a team meeting on Ward 39 for two months. One staff member told us, "It would help if there was a newsletter or communication book on Ward 39."

Despite the improvements made by the trust, staff working on the medical wards at RLI felt that there was still much to be done before a high standard of care and treatment was consistently provided for patients in their care.

Learning, improvement, innovation and sustainability

There was limited use of performance data and quality dashboards in the medical wards. There were limited systems for staff to meaningfully measure the safety and quality of the care delivered to patients. The executive lead nurse has plans to introduce a range of quality initiatives by June 2014 so that there are performance monitoring systems to provide staff with effective methods for surveying patient harm and analysing results so ward teams are able to measure and monitor.

Staff told us team meetings were planned and part of the meeting was to share learning from incidents that had occurred to prevent them happening again but due to the high level of patients' needs staff were unable to be released from the ward to attend and meetings were quite often cancelled.

Good

Surgery

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

Information about the service

The surgical services provided approximately 110 inpatient beds in the surgical and orthopaedic wards and 30 beds on the day surgery unit.

A range of surgical services were provided, which included: general surgery, vascular, trauma and orthopaedics, ear nose and throat (ENT) and ophthalmology. There were eight theatres consisting of four general theatres, one obstetric (maternity) theatre, one gynaecology theatre and two day surgery theatres.

As part of our inspection we visited the general theatres, female day surgery unit, Ward 33 (vascular), Ward 34 (colorectal) and Ward 35/36 (trauma and orthopaedics).

We spoke with 14 patients and two relatives of patients. We observed care and treatment and looked at patient records. We also spoke with a range of staff at different grades including support staff, nurses, doctors, consultants and the senior management team.

Summary of findings

There were effective systems and processes in the surgical wards and theatres to provide safe care and treatment for patients. The majority of patients we spoke with across the surgical services expressed satisfaction with the care received and felt that staff were knowledgeable and caring. Integrated care pathways were in use on the surgical wards and patients were making informed choices about the treatment they were receiving.

The surgical wards and theatres were clean and well maintained. There was compliance with the World Health Organisation (WHO) Safer Surgery Checklist. Staff worked effectively as a team within the specialties and across the surgical services.

However, we found that surgical service was affected by vacancy rates and that staff were working excess hours to maintain staffing levels on some surgical wards.

We also found that medical staff were not regularly undertaking ward rounds on some wards, which made it difficult for staff to plan and arrange discharge arrangements effectively.

Good

Surgery

Are surgery services safe?

Good

Cleanliness and hygiene

The wards and theatres were clean throughout. Wards had been de-cluttered to minimise the risk of trips and falls. We found equipment on wards was clean and in good working order. There was an ample supply of hand washing facilities and alcohol gels to support good hand hygiene. Staff observed 'bare below the elbow guidance', personal protective equipment (PPE) such as gloves and aprons were provided. However not all nursing staff followed good practice in this regard as we saw a nurse walking between patient bed bays and dealing with patients wearing the same gloves and apron. Gloves and aprons should have been changed between patients to minimise the risks of cross infection.

Staffing

We found the staffing establishments on surgical wards were reduced due to vacancies, maternity leave and sickness. Ward managers reported the vacancy review process had been slow but matrons told us the new recruitment system was speeding up the process of securing new staff. Matrons managing the surgical unit were aware that the new executive lead nurse was establishing the "red rules for safety". This would ensure all staff would be working within agreed criteria to maintain patient safety and minimum staffing levels. Although the trust had recently recruited an additional 135 whole time equivalent nurses there were still vacancies within the surgical division that managers were keen to fill.

On Ward 34 there were concerns in relation to staffing levels. The ward manager confirmed that that there was five nurse vacancies, with two more nurses who had submitted their resignation notice. Vacancies were being covered by bank staff and ward staff covering extra shifts. The ward manager was included in the daily clinical numbers of staff available and was providing direct patient care therefore found it difficult to act in a supervisory role. On Ward 33 by looking at staff rotas we found that staff were being asked to work additional hours to cover staff shortages as a result of 4 nurse vacancies. This resulted in one nurse working days, nights and long day shift patterns in one calendar week.

Environment and equipment

Equipment check lists on the wards were completed. Resuscitation trollies were checked daily and defibrillator discharge checks completed. Staff could be confident that emergency equipment was well maintained and well serviced**.** In theatres we found that equipment and surgical instrumentation was safely managed.

Incident reporting and learning

Senior nurses told us they felt incident reporting across the surgical division was slowly improving; however there was acknowledgement that the culture in the trust and the confidence of staff to report incidents effectively, had "still some way to go". It was envisaged that this would improve following the appointment of permanent matrons across the surgical division, as one of the key priorities for matrons was to ensure support for staff in incident and near miss reporting. Feedback once incidents had been reported was also cited as an issue as historically incidents would be escalated but feedback from managers about action taken was inconsistent and in some instances not received at all. It is important that staff receive feedback following incident reporting so that lessons may be learnt and practice revised to prevent a reoccurrence.

There had been three surgical 'never events' (a never event is classed as an event that should never have happened) in the trust (two of them in this hospital) from December 2012 and November 2013. Staff had learned from these events and had reviewed and revised theatre procedures to prevent a reoccurrence. The changes include a revised and detailed World Health Organisation (WHO) check list for safer ophthalmic surgery. The checklist had been implemented following an event in ophthalmic surgery that left the patient's condition under corrected. Plans were in place to monitor the checklist monthly, though as the new checklist had only recently been implemented there had only been one audit undertaken at the time of our inspection. The audit did not find any areas of concern or result in any recommendations.

We also saw evidence of cross trust sharing of these learning actions with theatres at Furness General Hospital.

WHO Surgical Safety Checklist

We noted patient identity checks were completed on arrival to theatre and there was compliance with the World Health Organisation (WHO) safety checklist. Audits of the checklist were carried out each month and confirmed that theatres had achieved 100% compliance.

Good

Surgery

Mandatory training and safeguarding

As a result of long standing staffing pressures, ward managers found it difficult to free staff from the ward to attend mandatory training. There was no practice educator to support the training of staff on the wards. Senior managers confirmed a practice educator would be in post by 01 March 2014 at RLI. In general theatres staff attended mandatory face to face training on monthly audit days when emergency theatre sessions were undertaken and this face to face learning was supplemented by computer based training.

We were told by senior staff the numbers of safeguarding incidents reported had seen a 60% increase. Managers attributed the increase in referrals to the raised awareness of staff following training (mandatory safeguarding training levels were at 89.7%) It is important that this trend is closely monitored by managers so they can assure themselves that this is the case and that there are not any other underlying factors contributing to increased referrals.

Risk assessment

We found that patients care was assessed and planned using evidence based guidance and tools. Surgical wards had adopted 'The Productive Ward' project that focuses on improving ward processes and environments to help nurses and therapists spend more time on patient care thereby improving safety and efficiency. However, failure to consistently complete the required safety crosses meant the projects effectiveness could not always be accurately measured. Some ward managers were unable to confirm the numbers of incidents such as falls and pressure ulcers on their wards.

We found inaccuracies and a lack of clarity in the definition of pressure ulcers and that Doppler scans were not routinely undertaken to confirm contributing factors due to peripheral arterial disease. This means that risks to patient safety were increased and remedial action is required to support staff in better understanding risk factors associated with patients with peripheral vascular disease.

Are surgery services effective?

(for example, treatment is effective)

Good

Using evidence-based guidance

The service was using national and best practice guidelines to care for and treat patients. The trust participated in all but two of the 38 audits it was eligible to take part including the fractured neck of femur audit and national bowel cancer audit.

There were no risks or recommendations identified in relation to the fractured neck of femur audit, The number of cases assessed as achieving compliance with all nine standards of care measured within the National Hip Fracture Database was also statistically acceptable and the orthopaedic wards had recently implemented the enhance recovery programme.

The trust was found to be performing worse than expected for two of the five National Bowel Cancer Audit indicators. The first of these was regarding the number of patients seen by a specialist nurse. In relation to patients seeing a specialist nurse the trust scored significantly worse than the national rate of 82%. In addition the level of data completeness was only 1% for the 87 cases having major surgery. The national level is 71%. This lack of data means that the service may not be able to assess its effectiveness in this area.

Information on patient-reported outcome measures (PROMs) was gathered from patients who had had groin hernia surgery, vascular vein surgery, or a hip or knee replacement. No risks were identified in relation to outcomes for these groups.

In addition, the surgical services are performing within expectations for the number of emergency readmissions for both emergency and elective surgery and there are no outstanding mortality indicators for this hospital.

Multidisciplinary working and support

We saw that multi-disciplinary staff worked well in the majority of areas we inspected. There was effective communication between the teams within the surgical specialties. Trainee doctors and nurses we spoke with told us they were supported well.

Good

Surgery

Patients were complimentary about the level of physiotherapy following orthopaedic procedures. One patient said "They are really good, firm but really make sure they help you". Allied Health Professionals worked well with ward based staff to support patient's recovery and timely, safe discharge following surgery.

Are surgery services caring?

Good

Compassion, dignity and empathy

The majority of patients we spoke with across the surgical services expressed that they were satisfied with the care received. Comments included: "Very happy", "Staff really are good, they are trying their best" and "Staff on this ward are really good, there is no difference between days and nights, they look after you". Another patient told us "The staff are really conscientious, they are short staffed and under pressure but they are very caring".

In the recovery area of the theatre department we saw staff dealing with patients in a caring manner. Curtains were pulled around trolleys when staff were checking wounds prior to returning patients to their wards. Relatives are allowed to come into the recovery area to help reassure and calm an anxious patient. Staff ensured patients were comfortable and appropriately covered before returning to the wards so that the patient's dignity and comfort was maintained.

Involvement in care and decision making

Staff respected patients' right to make choices about their care and patients spoke positively about being involved in their care.

The patients we spoke with confirmed that staff had sought consent verbally and in writing prior to performing surgical procedures. Patients felt staff explained procedures to them well and they felt they were aware of their treatment options in terms of benefits and risks.

Trust and communication

Staff communicated with patients in an open and honest way. Patients questions were answered in a way that patients could understand and staff worked hard to allay patient's fears and anxieties.

Staff were working on ways to provide effective pain relief for people with dementia who may be unable to let staff know they are in pain or uncomfortable.

Emotional support

We observed good interaction between patients and staff both on the day surgery unit and in theatres. Staff spent time talking with patients and gave support to patients on an individual basis.

Are surgery services responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

The surgical service at RLI was performing within expectations in relation to the number of cancelled operations. The service was also performing within expectations in relation to the time patients received diagnostic tests and the time they waited to have their operations. This indicated that the surgical service at this hospital was responding to people's needs in a timely way.

Within theatres there had been progress with "cross trust working" with the theatres at FGH. A productive theatre project was in place which monitored theatre utilisation and efficiency, aiming to reduce cancelled operations due to lack of theatre availability.

Vulnerable patients and capacity

We found that most staff understood their responsibilities accessing services for patients who lack mental capacity. Where patients lacked capacity to make decisions staff sought appropriate support so that a decision about care and treatment could be made in the best interests of the patient.

We received comments during a staff focus group that the chaplain service was under resourced and that the spiritual needs of patients in the surgical wards was often not acknowledged. This is important as patients may well need some spiritual support to help them cope with their surgery, particularly if the surgery leads to life changes.

Access to services

Access to the surgical wards was sometimes hampered by increased demand for beds from patients being admitted

Good

Surgery

via the A&E department. When this occurred, patients were placed in other areas. However, the doctors worked hard to ensure that patients were seen by specialist medical staff on a regular basis so patients were treated appropriately.

Leaving hospital

Patients we spoke with told us they were happy with arrangements made for their discharge.

On the Day Surgery unit we spoke with patients who were going to be discharged home. We confirmed they had been given medicines and appointments to return to out-patient clinics. Contact numbers for the unit had been given for use in any emergency or if the patients had any concerns or queries. Staff worked closely with their care partners to ensure that patients had appropriate support at home following their surgery.

The trust is performing within expectations in regards to delayed discharges.

Learning from experiences, concerns and complaints

Availability of complaints information leaflets and information about the hospital Patient Advice and Liaison Service (PALS) was not consistently available across the wards and departments.

When we spoke with patients on the ward, most were not aware of any information or guidance as to making a complaint or comment about the care they were receiving.

Are surgery services well-led?

Good

Vision, strategy and risks

Staff were unclear about the future direction of the trust and there was limited progress in developing a 'trust wide' 'approach to service provision.

Governance arrangements

Monthly governance meetings were held within the surgical division. A surgery and critical care risk register had been complied to identify areas of risk within the wards and departments. Each risk area had a nominated lead and regular updates on actions taken were recorded.

However there was lack of accuracy in the management and performance information provided by the electronic system. Consequently staff are unable to measure performance effectively and target remedial action where it is necessary.

Leadership and culture

Front line staff on the surgical wards were positive about their confidence in their immediate line manager. Staff were comfortable about raising their concerns and felt that their managers listened to them. They were less confident about the responses from senior managers in relation to feedback and actions taken when incidents were reported. However, staff were positive about the newly appointed executive lead nurse who had visited the wards and was seen as visible and accessible. Staff felt well supported locally.

Senior staff voiced some concern that they had feedback from staff in respect of the overall culture within the trust, that they believed was "to find someone to blame", and that the increased visibility of matrons on wards meant staff were being "watched" rather than supported. At a meeting for Allied Health Professionals staff alleged elements of a blame culture within the trust.

Senior nursing staff explained that the trust was encouraging staff to make comments and raise their concerns anonymously if they wished. The Royal College of Nursing "Speak out Safely" campaign was being supported by having comment boxes within the surgical services. However despite the new approach it is evident that not all staff had confidence in the senior team and remain concerned about the culture and senior leadership within the trust.

Student nurses felt well supported. They said qualified staff on the wards always ensured they had the right level of responsibilities and took the time to teach them despite being very busy.

Good

Intensive/critical care

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

Information about the service

The Critical Care Unit at Lancaster Royal Infirmary is known at the Intensive Therapy Unit (ITU). It consists of 6 beds providing care for critically ill patients.

The service does not provide a clinical outreach team.

Summary of findings

Patients received care and treatment according to national guidelines and admissions were prompt and appropriate on both the Coronary Care Unit and Intensive Care Unit. Staff worked well as a team and there was good communication and support between medical and nursing staff. Patients and those close to them felt involved in their care and treatment.

Staff were aware of current infection prevention and control guidelines. There were clearly defined roles and responsibilities for cleaning the environment and decontaminating equipment. Critical care services were clean, safe and well maintained.

Patient safety information was used effectively to prevent harm and 'safety crosses' (a system for measuring harm free care) were visible and accurately maintained.

Good

Intensive/critical care

Are intensive/critical services safe?

Good

Cleanliness and Hygiene

Intensive care was provided in a purpose built unit that was clean and well equipped and well organised. There were an appropriate numbers of hand wash basins and hand gels. Staff followed the hygiene standards and 'bare below the elbow' guidance. Staff were observed wearing personal protective equipment, such as gloves and aprons, whilst delivering care.

There were isolation rooms to manage any infection control risks within the unit.

This meant that steps were taken to ensure patients were appropriately protected from cross infection risks and staff could nurse people whose condition meant they were susceptible to infection in a safe environment.

The unit contributed to the Intensive Care National Audit and Research Centre (ICNARC) database. This demonstrated that the number of unit acquired infections such as methicillin resistant staphylococcus aureas (MRSA) and clostridium difficile where within expected for a unit of this size.

Staffing

We found the intensive care and high dependency unit (ICU/HDU) was adequately staffed by appropriately skilled nurses to provide appropriate care to critically ill patients. In the Intensive Care Unit Staff ratios were always at least one nurse to each patient.

There were daily consultant led ward rounds and multi-disciplinary working was well established.

There was 24 hour medical cover with a registrar on call for additional support.

On ICU staff sickness levels were reviewed and staffing levels were maintained through the use of bank (or agency) staff to ensure patient safety was not compromised. However there was limited time for ward managers to carry out administrative work as they often were caring for patients as part of the ward team. Senior nursing staff on the unit often stayed late to complete 'paperwork' as there was no capacity during the shift due to their involvement in clinical work.

We found risk assessments for patients both in ICU/HDU and the coronary care unit reflected their individual needs and promoted safe and effective care.

Outreach team

We were told that although there used to be a formal outreach team available during working hours, this was now often unavailable due to staffing pressures and the need for them to work on the unit. There is no formal provision for outreach services out of hours.

Systems, processes and practices

There were detailed care bundles in place within ICU/HDU. These are best practice guidance for care of the critically ill patient to improve care by having standardised methods of care whilst in intensive care settings. On the unit these included central catheter care, which provides fluid administration and ventilator care, which is a machine which mechanically breathes for the patient.

Medicines

Medicines, including controlled drugs, were securely stored. Staff also carried out daily checks on controlled drugs, medication stocks and emergency equipment.

Incident reporting

We found staff in the ICU/HDU had a good understanding of the incident reporting system.

There had been incidents when patients had developed medical device related pressure ulcers. Staff had learnt from these incidents and there was good practice guidance available to prevent such incidents reoccurring. We found the staff had worked with the local critical care network to ensure the risk of patients developing pressure ulcers from medical devices and being nursed in bed for long periods was minimised. The numbers of medical device related pressure ulcers had reduced as a result.

Mandatory training

Training information showed that the majority staff had completed their mandatory training. The staff we spoke with told us the quality and standard of training was good.

Good

Intensive/critical care

Are intensive/critical services effective?
(for example, treatment is effective)

Good

Using evidence-based guidance
The care bundles in use in the service ensured patients were receiving care and treatment that reflected current, evidence based practice that promoted patient safety and good quality care.

Performance, monitoring and improvement of outcomes
The Intensive Care National Audit and Research Centre data demonstrated that mortality outcomes for the unit where in line with national and comparable equivalent units.

Staff, equipment and facilities
We found risk assessments for patients in ICU/HDU reflected their individual needs and promoted safe and effective care.

Multidisciplinary working and support
In ICU nurses were well trained and highly skilled in the care of the critically ill patient. Nursing staff were well supported by the medical team and there was also good support from allied health professionals such as physiotherapists.

Are intensive/critical services caring?

Good

Compassion, dignity and empathy
Patients on both units were given good highly personalised care. We found the atmosphere on the units was calm and patients were comfortable and well supported.

Communication with patients was sensitive and questions about their care were answered in a compassionate way. One patient told us, “The staff have been fantastic, from the cleaners to the ward manger, they’re lovely”.

A relative of a patient who had been in intensive care for a long time told us, “Nothing is too much trouble for the staff.” Another relative told us, “The staff are very professional and hardworking and they genuinely cared about the patients.”

In ICU/HDU one relative told us: “The team are fantastic any issues and they are on it straight away.” The relative reported they felt the staff were trained well and “extremely competent” in their jobs.

Involvement in care and decision making
In ITU/HDU a relative reported that the nursing and medical team kept the patient and his family informed of developments and explained all aspects of the care provided. Patients were asked their view about treatment changes. We saw one patient being asked to consider having an arterial line; staff fully explained the benefits of the proposed treatment before the patients consent was secured.

Trust and communication
Patients and relatives had confidence and trust in the support that they were being offered by staff. Staff were clearly able to communicate information to patients and their relatives in a manner that they understood.

Emotional support
The ITU provided support for the relatives of patients and relatives spoke positively about the support they had received. They told us staff kept them informed at all stages of their relative’s care. One patient’s relative in ICU/HDU said staff dealt with their relative in a very sensitive manner; The relative told us “Staff explain what is happening at every stage and have spent time listening and discussing treatment and care thoroughly”.

Patients said staff always took time to sit and listen and not appear to be rushed, although they knew they were busy.

Are intensive/critical services responsive to people’s needs?
(for example, to feedback?)

Requires improvement

Access to services
Due to lack of capacity elsewhere in the hospital there were occasions when patients who no longer required the ITU

were not able to be discharged to the wards. The ICNARC data confirms that delayed discharges for more than four hours were an issue at this site. In addition, 15% of patients from April to July 2013 were discharged out of hours (20:00 to 06:59). This percentage has slowly increased over the past 5 years in which ICNARC data has been collected in comparison to the national figures which has stayed fairly static.

Due to capacity issues within the unit there were occasions when patients had to be transferred to the theatre recovery area to allow another critically ill patient to be admitted. There was consideration of risks and benefits of transfer before this was allowed to happen and staff would not transfer a patient who required Level 3 support.

Vulnerable patients and capacity

We found that most staff understood their responsibilities accessing services for patients who lack mental capacity. Where patients lacked capacity to make decisions staff sought appropriate support so that a decision about care and treatment could be made in the best interests of the patient.

Facilities for relatives

Overnight accommodation, food and drink were available if required so that relatives could remain close to patients who required intensive care.

Are intensive/critical services well-led?

Good

Vision, strategy and risks

We looked at performance and quality data. This showed that information relating to patient safety and risks and concerns were accurately documented, reviewed and updated at least monthly within the departments and at divisional level. Incidents, capacity issues and patient feedback were monitored well locally and demonstrated that learning from incidents was shared and evaluated to improve patient safety and reduce the risk of reoccurrence.

Governance arrangements

There was an effective clinical governance system in place that allowed risks to be escalated. There were action plans in place to address the identified risks that were securing improvement. In each area we inspected, there were staff meetings to discuss issues and to share information.

Leadership and culture

There were clearly defined and visible leadership roles in the critical care services we inspected. Staff were aware of the reporting structures in place. Managers were highly visible in each area, and all staff recognised them. The ward staff were well led by ward managers The critical care services were led by consultants and junior medical staff reported to consultants in each specialty.

The staff we spoke with were happy with the access to training within the trust. The training was competency based and staff told us the training provided within the trust was of a good standard. . The staff we spoke with told us they attended staff meetings and that their immediate line managers were accessible and approachable. However, there was a mixed response from staff in relation to engagement by senior or executive management. Some staff told us they had met members of the executive team and others told us they felt disconnected from the executive team.

Learning, improvement, innovation and sustainability

Staff had the appropriate skills and training to make effective clinical decisions and treat patients in a prompt and timely manner.

Requires improvement

Maternity and family planning

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

Information about the service

Royal Lancaster Infirmary (RLI) is one of three hospital sites where maternity and gynaecological care is provided within University Hospitals of Morecambe Bay Trust (UHMBT). Geographically there are 46 miles between RLI and Furness General Hospital (FGH) and 21 miles between RLI and Westmorland General Hospital (WGH). The larger proportion of women receiving maternity care is provided by teams of midwives within the community setting.

Across UHMB trust the Women & Children's Services Division is led by a clinical director supported by a general manager, a head of midwifery supported by an interim governance lead and three matrons for midwifery and one for gynaecology. There is a matron on each of the hospital sites. Each ward has a manager / ward sister who is accountable to the site matron.

In 2011/2012 there were 2050 births at RLI which was an average of six births per day. There are 40 hours consultant obstetrician cover per week on the labour ward and eight consultant obstetricians currently in post. The maternity ward has 24 beds for antenatal and postnatal care and there is a Day Assessment Unit (DAU) and a labour ward.

The gynaecological ward at RLI has ten overnight beds and the flexibility to accommodate more if required. Our visit to RLI focused mainly on the maternity services.

During our inspection we visited the antenatal outpatient clinic, antenatal and postnatal ward, labour ward and gynaecology ward. We spoke with a total of 12 patients, three relatives as well as 10 staff which included nurses, midwives, ward sisters / managers, matrons, doctors, consultants, senior managers and support staff. We observed care and treatment and looked at care records. We also reviewed the trust's performance data.

Requires improvement

Maternity and family planning

Summary of findings

Maternity & gynaecological services were safe overall although some improvements were required. The service needs to continue to monitor the safety and quality of the provision using a whole range of information relating to performance, incident reporting, workforce planning and lessons learnt.

Improvements are required for maternity services to better meet the needs of women using the service.

Services were caring. All women, patients and relatives that we spoke with told us the quality of the care they received was of a high standard and that their needs were more than adequately met.

The current lack of a future strategy for maternity services combined with the work done to meet regulatory requirements gives the impression that the service is reactive.

Are maternity and family planning services safe?

Good

Cleanliness and Hygiene

Patients on both the maternity service and the gynaecology areas were cared for in an environment that was very clean. Staff were provided with appropriate personal protective equipment and there were good supplies of hand washing facilities and alcohol hand gels. Staff observed the 'bare below the elbow guidance' and were seen to wash their hands frequently between patients.

We noted that staff observed safe practice guidance to control and prevent infection.

Staffing

The midwife to live birth ratio at the hospital was 1:29 which, although is slightly above the best practice guideline of 1:28 is sufficient to ensure safe conditions of care. However this was achieved by supplementing the midwifery staffing levels with agency midwives. There had been a reduction in the use of agency midwives since our inspection in October 2013 as the service had successfully recruited additional permanent midwifery staff.

There was 40 hours of dedicated labour ward consultant cover. National guidelines (Safer Childbirth 2007) recommend that for units with under 2500 births per year, consultant cover on the labour unit should be assessed according to local need rather than setting a specific recommendation. The arrangements for anaesthetic cover met the national standards for the number of deliveries.

Senior managers confirmed that there were minimum safe staffing levels in place in all clinical areas. Workforce data that was sent to Monitor (NHS regulator) as part of an action plan for UHMT to improve in relation to maternity services on a monthly basis confirmed this. However, we noted that this data was not included in the maternity performance dashboard at a local level. This meant that all data relating to staffing may not be used to inform staffing requirements effectively.

Equipment

Equipment was clean, well maintained and safely stored.

Requires improvement

Maternity and family planning

Incident reporting and learning

All incidents were reported and reviewed by a multidisciplinary team (MDT) on a daily basis. Senior managers report that there has been an increase in reporting rates over the last two years following previous maternity incidents and inspections. Information provided by the trust supported the increase in incident reporting.

The process in place ensured that a response was provided to the person who reported the incident and to explain what actions were to be taken. This response was provided within 48 hours and the content of the mandatory study days was adapted to focus on the additional learning required. Where widespread lessons needed to be learnt had been identified, these were published in a regular newsletter for staff. We found an example relating to 'growth charts' had been reported on in early 2013 and an education package was produced to inform staff. However the same concern was still noted more recently and had now been included in mandatory training.

Mandatory training and safeguarding

Some of the staff we spoke with described a three day mandatory training session that they attend annually. We were also told that there were regular learning sets in addition to the three mandatory days and MDT updates.

There were systems in place to escalate adult safeguarding and child protection concerns. Staff were familiar with the system and were confident in raising them.

Safe capacity of unit

There are two obstetric theatres within the labour ward for women requiring surgical intervention. On the day of the visit we saw that the labour ward reached safe capacity levels and had to instigate the divert facility to other maternity services within the trust. We were told that the data about implementing the divert facility or the trend of the transfer of women during labour had just started to be recorded. This meant information that may identify trends and inform strategy was not yet available.

Monitoring safety and responding to risk

There was a maternity performance dashboard in place that identified key activity in maternity services and clinical data. This provided an overview on the safety and performance of the service enabling the monitoring of risks. However we were advised by senior managers that some specific information such as postpartum haemorrhage and workforce data was not possible to capture due to the IT systems within the trust. This meant that the identifying and monitoring of potential risk was not completed in all areas of risks.

Are maternity and family planning services effective?

(for example, treatment is effective)

Good

Performance, monitoring and improvement of outcomes.

The standardised maternity indicators for elective and emergency caesarean section, puerperal sepsis and other puerperal infections, maternal and neonatal readmissions were all within expected limits. The trust's perinatal mortality rate was significantly lower than expected.

The trust had implemented a written maternity risk management strategy that indicated during antenatal care women who were identified as a high risk were cared for by an obstetrician jointly with a community based midwife and their General Practitioner (GP). For the lower risk pregnancies there were a large proportion of midwives with specialisms to provide midwife led antenatal care. This meant that women received care within a good skill mix that promoted their safety and wellbeing.

Are maternity and family planning services caring?

Good

Compassion, dignity and empathy

Care and treatment was delivered in a caring and compassionate way. Women were well supported by the staff and were positive about their experiences of the service.

The trust performed similar to other units in CQC Maternity Survey 2013 in areas such as labour and birth, staff and care in hospital.

Requires improvement

Maternity and family planning

Involvement in care and decision making

Staff were open and honest with women using the service and explained care options clearly. Benefits and risks were explained and women felt involved in decision making.

One woman we spoke with told us that although the plan to have a normal delivery was changed due to complications and she had to have a caesarean section, she and her husband were kept informed at all times.

Another woman we spoke with told us that arrangements had been made for her to go home earlier than planned and that, ''Staff had gone out of their way to arrange it''.

Trust and communication

We were told by one woman that she had a complicated labour which at times had been distressing however she said, ''I felt very safe and completely trusted the midwife to be honest with me''. Another person we spoke with told us that they had ''felt safe'' when having to go to theatre in an emergency.

Are maternity and family planning services responsive to people's needs? (for example, to feedback?)

Requires improvement

Access to services

There were times that the unit was very stretched in terms of capacity and on the day of our visit we found that the main maternity ward was fully occupied with women waiting to be discharged.

If the unit was deemed full it would put in place a 'divert' strategy which meant women in labour who were deemed to be high risk (and therefore could not deliver in the community) would be diverted to Furness General Hospital.

In attempt to address capacity issues, the hospital had established a separate Antenatal Day Assessment Unit is separate to the Antenatal Clinic, staffed by midwives and Maternity Support Workers from Monday to Friday 07.45am – 20.45pm. The unit is specifically focused on supporting and assessing women who were receiving antenatal care. This service has reduced the need to use a bed on the labour ward for women who are not in labour. We were told that the use of the DAU had reduced the admissions to the labour ward by 40%. The trust did have data to support this reduction.

Information about the services

There was no information provided on the trust website regarding the maternity services for expectant mothers. A telephone number was provided for the 'Women's unit' but it was not clear whether this included the labour ward.

Environment and equipment

We saw that since our last visit all areas of the ward had been freshly decorated and that there were renewed and improved showering facilities available for women being cared for on the ward. The labour ward was organised in a way to be sensitive to patient's needs. There was a designated room which was outside of the main labour ward where women and families with poor birth prognosis were given care and support. The room had been made homely with the décor and furnishings. The room gave extra privacy and meant that people could be given time in a private environment to deal with any emotional anxieties.

Learning from experiences, concerns and complaints

The maternity services provided by the trust have been the subject of scrutiny since 2010. Initial concerns arose after several maternal and neonatal deaths. These have been the subject of an on-going police investigation. In response to these concerns and identified service failings both CQC and Monitor have used their powers of enforcement to secure service improvements. Monitor was assessing progress against the action plan submitted by the trust to secure service improvement. Performance information was submitted to the regulator monthly.

Are maternity and family planning services well-led?

Requires improvement

Vision, strategy and risks

Information collated in the maternity performance dashboard was discussed regularly at the divisional team governance meeting to inform risk management. We looked at the data for risks identified across the division of women's services dated September, October and

Requires improvement

Maternity and family planning

November 2013 all three reports consistently identified medical outliers on gynaecology as being in the top three risks. However we did not see any action plan or strategy in place to address this ongoing risk.

We asked for data in relation to the number of women being diverted to other maternity units within the trust to enable provision of safe care and we were told this data was not captured. However,the trust confirmed that this data is captured through the safeguarding reporting system. We were aware that on the day of our visit and the day before the labour ward had used the trusts divert facility. We were told that this is becoming more frequent to ensure safety capacity levels are maintained. However this had a direct impact on two women who had their planned caesarean sections postponed.

We were told by the divisional team that they had worked hard over the last two years as the service had been reacting to the regulatory requirements of both CQC and Monitor. When we asked the team about the vision for the service we were told there was a mixed perception and staff felt that it would likely be dependent on the outcome of ''Better Care Together' 'a current review of local health services.

They said that would need to be combined with the trust's ability to maintain staff and skills along with negotiation with the commissioners .They told us they were, ''Still on a continuing improvement cycle and getting on with business as usual''.

There was no written strategy in place for maternity care in this hospital.

Governance arrangements

The maternity performance dashboard as a tool was not complete in the current format used and had elements of data missing that may help manage risks and the effectiveness of the service for example workforce data and postpartum haemorrhage data. These are significant omissions that should be included in the performance dashboard to support the safe and effective management of the service. We were told that **a** governance lead for maternity was appointed two years ago as an interim post**.**

Leadership and culture

Senior management told us that they had focused on an 'improvement journey'. They said over the last two years their work had been driven by meeting actions set from and responding to, regulatory requirements in response to service failings. They felt that they had now achieved and completed the required actions from the regulators and described their new focus as 'business as usual'. This response indicated that there was a reactive rather than a proactive culture within the service.

Requires improvement

Services for children & young people

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

Information about the service

The children's services The Royal Lancaster hospital includes a 21 bedded unit comprising day care beds, inpatient beds and the assessment unit; a children's outpatient department and the neonatal intensive care unit (NICU).

We talked with 14 parents (or relatives) and their children and 13 staff including nurses, junior doctors, consultants, senior managers and support staff. We observed care and treatment and looked at care records. We received comments from our listening events and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Summary of findings

Paediatric services were caring and child centred, the wards were well appointed with a good supply of toys and play equipment. Evidence based guidance was used in relation to assessing the clinical needs of children admitted to the ward, Medical and nursing staff treated patients with respect and dignity. Time was taken to listen to children and their parents. We found that staff worked well with other health professionals to best meet children's individual needs. Parents were kept informed and included in decision making regarding the care and treatment of their child.

Work was required to ensure that cross infection risks were managed effectively as good practice guidelines were not always followed. We found that hand-hygiene by staff on the children's ward was poor. Very few staff adhered to proper hand cleansing routines.

Requires improvement

Services for children & young people

Are children's care services safe?

Requires improvement

Cleanliness and hygiene

We observed that hand hygiene on the children's ward was poor. We saw that very few staff adhered to proper hand cleansing routines. Doctors did not wash their hands or use hand sanitation liquids when they entered the wards or before attending to patients. Neither did they clean their hands between patients. We also observed a doctor taking bloods without washing their hands prior to or after the procedure.

We discussed infection control and hand hygiene with the ward manager. The wards quality assurance safety indicators for hand hygiene had scored 'red' in September, November and December 2013 (October 2013 was not included on the dashboard). The action plan on display stated that in response to the findings of the audit the service would be 'working to ensure all staff have completed a hand hygiene assessment and two additional hand hygiene champions' would be put in place. Our observations showed that the plan had been ineffective. There was no indication that this had been recognised as an ongoing problem and required escalation for additional review at trust level.

Staffing

We found that the current nursing establishment was based on a recognised staffing assessment tool. The tool involved categorising and scoring the dependency level of each child. The aggregated number would determine the required number of qualified staff. We were informed that this system provided evidence when additional staff were required. If accepting another admission was considered to be unsafe and there were no internal alternatives, the ward would be closed and children diverted to FGH some 46 miles away. This had occurred twice in the past few months. Doctors and nurses felt this was an effective way of maintaining the safety of children on the ward.

The risk register confirmed that the service was experiencing shortages in middle grade doctors. The department had seven staff consultant paediatricians, two of which were locum paediatric consultants; this meant five consultants were responsible for carrying out leadership roles, mentoring trainee and junior doctors as well as clinical development. This shortage of middle grade doctors meant that consultants often had to arrange their own cover and resulted in the middle grade doctors and consultants working very long hours, including nights and returning part way through the following day

Medical cover at night was supposed to be a middle grade doctor who remained on site with a consultant on call. However in reality the consultants worked the on-site cover because there were insufficient middle grade doctors.

The Trust was exploring ways of securing additional medical staff to address the shortfall and was continuing its attempts to appoint additional consultants and middle grade paediatricians.

Staffing in the Neonatal care unit' was two qualified paediatric nurses and two health care assistants on duty at every shift for 10 cots. This was in line with national guidance.

Safety huddles

The trust used a system for updating the nurses on duty about safety issues on the ward called a 'safety huddle'. This occurred three times each day. At these times nurses were expected to discuss the safety issues on the ward including the clinical and nursing needs of patients, safeguarding considerations and staffing. We also saw from the checklist that this was also an opportunity for the manager to review staff conduct such as adherence to the dress code.

We attended a 'safety huddle'. The 'huddle' was attended by a nurse from inpatients, day care and the assessment unit. Staff discussed each patient and scored their dependency levels that was then added together and indicated the number of qualified staff required for the shift. The aggregated number at the 'huddle' we attended suggested that there should have been an additional qualified nurse. The nurses and the ward manager discussed this finding and also considered additional information. They assessed that children's needs would be safely met with the current number of qualified staff.

Other risks discussed at the 'huddle' included children and young people with similar names and those waiting for CAMHS assessments.

Management of the deteriorating patient

A paediatric early warning tool was used to aid the recognition of sick and deteriorating children. This made

sure children were seen as quickly as needed. We also saw that the Children's Physiological Observation Track and Trigger (Cpotts) system had been completed for each child. The Cpotts is currently one of the best-practice vital sign assessment tools for use with children and young people.

Incident reporting and learning

Incidents were electronically reported and the ward manager confirmed that all incidents and concerns were logged onto a centralised computer system. We saw that the system recorded detailed information about the type of concern. There were a number of headings that included complaints; concerns; safeguarding; and incidents. Each heading was split into subheadings so that precise information could be recorded. We reviewed recent concerns that had been recorded. We saw that when these were fully investigated the record was closed down. We also noted that reports were highlighted 'red' if an investigation was ongoing. It was unclear whether the data from this system was reviewed and analysed so that trends could be identified and appropriate action taken.

Environment and equipment

The ward was split into two distinct areas – one for inpatients and the other for day cases and the assessment unit. There were two high dependency side rooms within the ward of which room one was used more frequently because of its vicinity to the nurse's station.

We found that there was only one emergency resuscitation trolley on the ward, this was situated in room one, this meant that the trolley was a distance from the day surgery and assessment unit beds. Also access to the trolley was restricted when the room was in use. We discussed the observation about the distance of the emergency resuscitation trolley from the day ward and the assessment unit with the senior management team who agreed to take remedial action.

The resuscitation trolley and equipment was checked each day to ensure it was complete and items were ready to use.

We checked the dates on maintenance stickers on equipment such as the vital sign observation monitors, small electrical items and weigh scales. The dates confirmed that these items had been checked and maintained as required.

Safeguarding

There was a clear safeguarding policy was in place. This policy confirmed good links with the local authority and met with the Royal College of Nursing best practice. There were named safeguarding liaison nurses who had excellent links with the local authority and had a good knowledge of safeguarding procedures. Staff we talked with understood their responsibilities in relation to protecting children from abuse and responding to concerns of this nature. The electronic training record confirmed that all nursing staff had completed either level two or level three safeguarding and child protection training.

The ward manager stated that over the past year a greater emphasis had been put on child protection. Safeguarding champions and supervisors were in place and the trusts safeguarding policy included a trigger checklist to be completed for every child so that nurses had to pause and 'think' about child protection. Records we looked at confirmed that this was being implemented in the unit.

Mandatory training

The ward manager told us that they had completed paediatric life support training and information on the electronic training record showed that In February, 60% of staff at had undertaken advanced paediatric life support training and 100% had undertaken paediatric immediate life support training.

Are children's care services effective?
(for example, treatment is effective)

Requires improvement

Using evidence-based guidance

Paediatric care pathways for common childhood illnesses such as viral infections were in use and were based on up to date NICE guidance.

Performance, monitoring and improvement of outcomes

We reviewed the records for four children and young people. The children had been admitted through different pathways: - directly onto the ward following a phone call; via the emergency department; and for elective surgery. We saw that the assessment process, observations and subsequent care plans were in keeping with the reason for admission. We noted that a pain score assessment had not been completed, however there was clear evidence that analgesia had been given regularly to those who needed pain relief. Other specialist care and risk assessments had

been completed. Care plans had been developed and these were evaluated at the end of each shift. Blood tests and other medical investigations were completed. Results of tests and investigations were recorded and doctors explained what the result of the tests meant and the actions to be taken when results were outside the normal parameters.

Use of clinical audits

It was evident that the trust's response to clinical audits needed to improve. We found that audits were completed by the ward manager and the results indicated that the ward was consistently underperforming and scored 'red' or 'amber' in a significant number of quality and clinical effectiveness indicators. No comprehensive analysis or action plan was in place to initiate and monitor improvement.

One of the most significant of these related to pain control. According to the audit pain assessments were not being completed on admission and the effectiveness of analgesia was not being monitored. Children and parents were not informed about the analgesia and available pain control. The audit we reviewed was for September, October and December 2013. (November 2013 was not available.) The plan of action presented alongside the dashboard stated 'From December results, we will be working to ensure all staff document a pain score on admission and new nursing documents developed.'

We reviewed four sets of nursing and medical records and no pain assessments had been completed for these children. In addition the basic pain assessment section on the initial assessment form had been covered over with the safeguarding check list sticker. This meant that the assessment form was not fit for purpose because prompts for gathering essential information were not visible. This also meant that actions identified form the audit that required improvement were not being monitored or sustained.

We talked with children, young people and their parents about pain control. Despite the shortcomings with the assessment, those we spoke with thought pain control was well managed. The parent of a baby told us: "A cannula had to be put in but they gave pain relief before they started putting it in." Another parent commented, "Nurses are very nice they come round every hour and ask about pain."

A young person told us that they experienced "a good deal of pain but staff always ask and respond." This patient also confirmed that staff asked for a pain score following medication being given.

Members of the senior management team also outlined a number of different monitoring and auditing initiatives being undertaken in the children's department. Some were 'Bay wide' and so did not relate specifically to the safety and effectiveness of the children's ward at the RLI.

Neonatal Intensive Care Unit (NICU)

The trusts performance data indicated that the trust had a higher than expected readmission rate for neonates (between June 2012 and June 2013 there were 152 readmissions when the expected rate was 138.7. This number covered readmissions for Furness General Hospital and the Royal Lancaster Infirmary). We discussed this matter with the clinical director. It was explained that the figure could be due to the use of the assessment unit to triage children and so these counted as admissions, whereas this would not be the case if they had been triaged and sent home through the emergency department. However we were not provided any information to support this assertion.

Multidisciplinary working and support

There was effective multidisciplinary working. Children with long term and complex medical needs were often treated at the larger children's hospitals, including Preston Hospital; Alder hey Children's Hospital in Liverpool and Manchester Royal Children's Hospital. Children were also transferred back to the ward following treatment at one of these hospitals.

Are children's care services caring?

Good

Compassion, dignity and empathy

We saw that nurses were effective in meeting the needs of the children on the ward. We saw that medication was administered on time, clinical observations were completed, care plans were followed and the information was updated as required. We saw positive interaction

between patients and staff and medical and nursing staff treated patients with respect and dignity. We saw that staff took time to talk with patients and parents and responded to requests quickly.

Children and young people told us they were treated with respect. We were told: "Staff keep you informed, I was seen straight away, they've been brilliant in here. They're always coming in and looking after me. If you ask they explain stuff." Parents were positive about the treatment and care provided and commented: "Everyone was great, we were able to stay over and everything was explained."

We talked with consultant paediatricians, the clinical director, the matron, the ward manager and the play worker. All were eager to provide a safe, effective and caring service. Each was passionate about their role.

Involvement in care and decision making

Information in medical and nursing records confirmed that children and young people were involved in planning their care. We saw that when necessary consent forms were signed by the young person and their parent. Patients were also given a copy of their consent forms.

Trust and communication

We read through four sets of medical and nursing records on the ward and three sets in outpatients. We saw that reports were written in a considerate and respectful manner. Reports included an overview of the emotional condition of the child and a description of anxieties which may have been raised. Staff also recorded the conversations and action taken to try and reassure patients and their relatives.

Correspondence and records in the patients' medical and nursing files showed that there was effective communication and staff followed instructions about investigations, treatment and discharge planning. Staff communicated with patients and their parents /carers in an open and honest way. Parents had confidence in the staff team and staff worked hard to establish a rapport with the children and young people being cared for.

Are children's care services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Access

There was a folder on the ward with information about the children who were known to the ward and able to access the ward directly. The information included district nurse numbers and important information about the child's diagnosis and presenting clinical needs.

We discussed the care of children with life-limiting conditions or a long term illness with the ward manager and a paediatric consultant. We were told that parents were able to come to the ward without going through the emergency department. This meant that parents could be confident that reassurance and medical support could be provided quickly. This helped to relieve the anxiety of children and their parents.

Meeting people's needs

The Children's Ward

The children's ward was divided into two distinct areas separated by a nurse's station and a number of equipment and clinic rooms. There were two single-sex bays on the inpatient side. There were also side rooms used for babies or when children or young people needed privacy or isolation. The treatment room was fitted with a visual-light display that would help to distract children during uncomfortable procedures or examinations.

The ward was in the process of developing a 'teen' room. There was a small but well stocked parent's room where food and drinks could be stored. Toilet, bathroom and shower facilities were also available. There was also a quiet comfortable lounge called Oli's Room. This room was used for different purposes including mental health assessments, and talking to parents about their child's health concerns.

Folding beds were available so that parents could stay overnight with their children.

There was a large bright playroom with access to an outside play area. Plans were in place to improve this outside area because at the time of the visit it was not in use. The ward had a play specialist who worked from 8am to 4pm Monday to Friday and who was effective at providing diversional and meaningful play activities for the

younger children. Part of the play activities included exploring the process of going to theatre. This helped allay the children's anxieties and supported parents. They would also support the outpatient's clinic if required.

We were also informed that a teacher worked with children and young people on the ward for one and a half days each week.

Neonatal Intensive Care Unit (NICU)

We found that the NICU was well-designed and met the needs of the babies who received care and treatment. There was sufficient space between cots and equipment was readily available and accessible.

Ward staff were willing to provide support and guidance to parents who rang the ward. Staff asked specific questions about the condition of a child before giving advice and parents were encouraged to return to the ward if they had ongoing concerns about their child.

The ward used a 'jobs book' for doctors, this meant that there was a means of communicating lists of routine jobs that needed to be carried out without the doctor having to go to individual files. We saw that once the 'job' had been completed the doctors updated individual records.

Support for children with life limiting illnesses

We discussed the management and support provided to children with a life-limiting illness with the ward manager and member of the consultant team. We were informed that this was clinically led and discussion would be ongoing. The management of care and treatment was reviewed with the parent and child as required. The current policy at the RLI was based on the ACT Care Pathway for children with life-limiting and life-threatening conditions. We were provided with a copy of the 'ACT pathway family companion' used to help patients and parents understand the care and support available and the choices that could be made.

The ward manager told us that the trusts policies and guidelines were on the intranet but provided us with a copy of the trusts "Guidance for discussions about child and family wishes when life is limited." We reviewed this document and saw that it was in the form of a care planning booklet. This would be completed by the child, parent and staff in a collaborative way. The areas covered reflected the ACT care pathway and would provide a good record about the choices made by children and parents.

The consultant was confident that palliative and end of life care was well planned and met the needs of children and parents. We were told there was excellent collaboration with Alder hey Children's Hospital, and the palliative care team from Alder hey hospital were often part of the multi-disciplinary team involved in supporting and planning care and treatment for children with a life-limiting illness.

Vulnerable patients and capacity

Consultants and nurses talked with the child or young person in the presence of their parent, we could not determine if the young person had agreed to this. Young people were asked about their sexual experiences in front of their parents and the questions were not always asked in a sensitive way. This meant that young people may not be forthcoming with personal information that may be relevant to their diagnosis if parents were always present.

It was not possible to check whether the trusts written consent and capacity guidelines were compliant with the Fraser guidelines concerning consent and children under 16 years old. We saw that in keeping with good practice, it was assumed that the young person was able to understand the care and treatment unless it was previously found or became clear that there might be a limit to their capacity.

We were told that there had been a significant increase in the number of children admitted to the ward with mental health needs. We saw that referrals were made to the Child and Adolescent Mental Health Services (CAMHS). The CAMHS team from Lancaster visited the ward three times a week. This meant that children could be on the ward for a significant period of time before being assessed. The trust had identified the increase in admissions of children with mental health care needs as a high risk concern. We saw from the governance newsletter for January 2014 that the deficit in the CAMHS service was reported as a departmental risk. On the day of the visit to the children's ward a significant number of young people had been admitted because of mental health needs.

Members of the CAMHS team visited children on the ward; staff took time to meet with the CAMHS team member and supported patients and their parents to have private consultations.

Requires improvement

Services for children & young people

We discussed the use of interpreters and leaflets available in different languages. We were informed that a telephone interpreter service was available.

Leaving hospital

Discharge planning was included as part of the admission plan. The discharge plan was comprehensive and included confirmation that advice had been given about aftercare and recovery and also that referrals had been made to outpatient clinics and other community based specialisms as required.

We saw that the trust had developed leaflets about the common childhood illnesses such as bronchiolitis although it was noted that information was not readily available. Parents also commented that although conditions were explained written information was not always provided.

Learning from experiences, concerns and complaints

The paediatric governance newsletter included a section called 'lessons learned.' This information was mainly a description of gaps in processes such as the availability of guidelines and lack of a comprehensive audit programme. There was also a brief report about staff not fully following the medication protocol; in response staff were reminded to follow the medication policy. No other information about concerns, complaints or incidents concerning the clinical or medical wellbeing of the patients was mentioned in this document. We reviewed information in the 'Children and Young People leaders- experience assurance' report, dated January 2014. There was no information about current complaints and it was written that the group had relatively recently received the complaint report from November 2012.

The trust had involved patients and ex-patients in the 15 Step Challenge for children and young people in acute inpatient services. This process helped staff and patients to work together to identify improvements that could enhance the patients experience.

Are children's care services well-led?

Requires improvement

Vision, strategy and risks

There were examples of good leadership at ward level. Ward staff confirmed they felt well supported by the senior nurses who visited the ward frequently. The ward manager felt nurses were listened to by the trust board and this had resulted in nurses having more control over the service and improved staffing on the ward.

Leadership and culture

There was a positive culture on the ward, in the NICU and the children's outpatient department. All the staff we talked with were positive about their colleagues and immediate line managers.

Medical Staff felt that the trust did not always respond effectively to issues of concern and consultants were concerned that as a result of the shortage of middle grade doctors, they did not have the opportunities to develop the paediatric service and respond to research and development projects in the way they would like. They felt the trust had not been assertive enough in addressing this matter.

There was a sense that the trust board did not value or understand the paediatric ward at the RLI that was supported by the children's ward (ward 32) not being included on the trusts website for the RLI.

Patient experiences, staff involvement and engagement

The trust had commissioned the "iWantGreatCare' independent quality assurance company to collect information about the patient experience and provide outcomes data. The senior management team identified that the initiative would capture the experience of the patient pathway for children and teenagers.

However, this work is relatively new and we were not able to ascertain the impact of the initiative at this inspection.

Learning, improvement, innovation and sustainability

The wards quality dashboard provided evidence that the trust did not provide effective leadership when ongoing

concerns were identified. Risks were identified and there were no clear action plans to mitigate the risks or reduce them. Improvements made in response to audit were not always evaluated and sustained.

Good

End of life care

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

Information about the service

End of Life/ Palliative care services were provided throughout the trust across the three sites, Royal Lancaster Hospital (RLI), Furness General Hospital (FGH) and Westmorland General Hospital (WGH).

There is a network of nurses across the three sites within the trust that have training in palliative care. The trust has a bereavement team that can provide care and support to relatives following the death of those close to them. There are also well organised links with charitable and voluntary organisations providing hospice care, counselling and bereavement support.

During our inspection we spoke with 10 patients, three relatives, four nursing staff, two receptionists, three consultants, two senior doctors, the dementia nursing lead, three department managers, one palliative care educator and the bereavement support staff.

We observed care and treatment and looked at care records for patients cared for in medical and orthopaedic wards in the hospital. We received comments from our listening events and from people who contacted us to tell us about their experiences. We also reviewed the performance data provided to us by the trust as well as the information provided in our own intelligent monitoring tool.

Summary of findings

The trust has a dedicated palliative care team who provided good support to patients at the end of life. Care and treatment was given in a sensitive and compassionate way. Staff worked hard to meet and plan for patient's individual needs and wishes. Staff were very motivated and committed to meeting patients' different needs at the end of life and were actively developing their own systems and projects to help achieve this.

Patients were very positive about the service from the specialist team.

The Multi-disciplinary team worked well together to ensure that patients care and treatment were was planned and coordinated. People were positive about the care they received and the support they were given. There were effective working relationships with local hospices to coordinate people's end of life care where the hospice was their preferred place of care

Patients receiving palliative and end of life care in a hospital setting had limited access to specialist support at weekends and at night.

We found variation in the standard of records in relation to DNARCPR documentation as they were not always completed appropriately

Good

End of life care

Are end of life care services safe?

Requires improvement

Safety and performance

We found that where appropriate the doctors discussed with patients regarding their Do not attempt Cardio-pulmonary Resuscitation (DNACPR) form. There was a clear policy in place on DNACPR forms approved in January 2014. This policy and procedural guidance was in line with current good practice and legislation.

We found variation in the standard of records in relation to DNARCPR documentation that included a lack of comprehensive information about multidisciplinary team and patient and relative involvement in decision making. There were occasions when the decision had not been endorsed by the most senior clinician. This is important because the overall clinical responsibility for decisions about CPR, including DNACPR decisions, rests with the most senior clinician in charge of the patient's care.

Equipment

The hospital had its own syringe drivers for people needing continuous pain relief. A syringe driver is an alternative method of administering medication and may be used in any situation when the patient is unable to take oral medication. A range of syringe drivers were being used in different areas of care across the trust. Having different types and makes of equipment within the hospital can cause confusion. It may present a hazard when patients' and staff move from one area of care to another as staff may not be familiar with each different type of equipment.

The palliative care team and staff we spoke with were aware of the importance of consistency with equipment to ensure there was no interruption or delay in treatment. As a result a business case for the replacement of syringe drivers across the trust had been submitted to the trust board. This would enable the trust to standardise this type of equipment in use and reduce potential hazards and delays in relation to patient's pain management and administration of medicines.

Training for staff

Electronic educational packages were in place for staff and learning modules on palliative care and oncology were readily available. This was considered mandatory training for junior doctors and Band 5 nurses involved in caring for oncology patients. The e learning system recorded when training had been completed so senior staff could monitor training uptake.

Not all eligible staff had completed the training as yet. Staff who had completed the training had found it useful in developing their practice in caring and treating patients requiring palliative care.

The palliative care and end of life team had developed clinical and educational strategies to improve the experience, quality and effectiveness of the service provided to patients. The strategy covers the period March 2013 until March 2016 and its implementation is being monitored by the palliative care team through formal reviews.

The strategy is very new and not yet implemented; therefore we could not evaluate the impact of the strategy at the time of our inspection.

Are end of life care services effective?
(for example, treatment is effective)

Good

Using evidence-based guidance

The trust had set targets for achieving the Gold Standards Framework (GSF) This is national, accredited training initiative aimed at enabling frontline staff to provide a gold standard of care for people nearing the end of life .The trust had made progress in this area although staff informed us that the trust had not yet met 100% of the targets set, This trust envisages that when all elements of the GSF had been implemented staff will be better skilled to meet the needs of patients requiring palliative and end of life care. This will also help staff on general wards to care for and support people at the end of life.

Following an independent review by The National Institute for Health and Clinical Excellence (NICE) was rewriting guidance for patients at the end of life The trust had published guidance for staff regarding the review .The palliative care consultant and senior managers were aware of these change and confirmed that the trust was no longer using the Liverpool Care Pathway (LCP) to support care and treatment decisions.

Good

End of life care

Some nursing staff we spoke with still referred to the pathway and felt that following the withdrawal of this guidance there was less structure now to the planning of individual care for people at the end of their lives. Staff confirmed that they had been given information and training on the Gold Standard Framework (GSF) In addition, the palliative care team had issued information to staff in 'Guidance to Health Care Professionals Caring for Patients in the Last Days of Life'. This summarised the key elements of caring for the patient who was dying. This was to support staff until the revised recommendations from NICE were available for implementation.

Multidisciplinary working and support

The Multi-disciplinary team worked well together to ensure that patients care and treatment were was planned and coordinated. People were positive about the care they received and the support they were given. There were effective working relationships with local hospices to coordinate people's end of life care where the hospice was their preferred place to die.

Elderly care consultants and dementia care leads were also positive about the GSF and felt that the GSF approach had improved the care of older people as well as improvements in the way the multi-disciplinary team worked together.

Are end of life care services caring?

Good

Compassion, dignity and empathy

There were some very good examples of person centred, compassionate care. Patients and those close to them were positive about their interaction with the palliative care team. Patients felt that care and communication was good and that their individual needs were met in a sensitive and respectful way.

Patients and those close to them were less positive about the care given on the medical wards. They felt that staff were rushed and did not always have the time to spend with them.

Patients felt staff were, "kept busy" and that more staff were needed. Despite that, staff came quickly when they were called and were "respectful and kind" when they were delivering care.

Involvement in care and decision making

Patients and those close to them were actively involved in care planning and decision making. Patients were actively encouraged by the Palliative Care team to ask questions, to discuss their treatment and share their concerns. Care records were well maintained with patients preferences clearly documented. One patient told us "I have always received excellent care and attention and have been kept well informed of my condition and progress. Staff have always reassured me that I can ring them any time should I feel the need to discuss any concerns or doubts I might have about my condition. Reports by the relevant hospital departments are also sent to my GP to enable him to monitor my condition".

Trust and communication

Staff understood the importance of effective and sensitive communication for patients who were receiving palliative or end of life care. Staff worked hard to establish a good rapport with patients and those close to them so care and treatment could be managed in an environment of trust and transparency. Time was spent explaining care and treatment including benefits and possible side effects and complications. Staff were open, honest and transparent with patients and those close to them. Difficult messages were given in a compassionate and sensitive way.

Staff were taught and assisted with communication skills through the 'Sage and Thyme' programme This is a foundation level communication skills workshop developed by a multidisciplinary team at the University Hospital of South Manchester NHS Foundation trust in response to the publication of NICE guidance for Supportive and Palliative Care for Adults with Cancer (2004). The specialist palliative care staff had all attended advanced communications training. They were coordinating the training and monitoring its progress as was rolled out to their colleagues across the trust.

Information and guidance was also available for people to be able to contact other support services such as local hospices, Morecambe bay cancer information guide, the Marie Curie service and the Hospices at Home service.

Emotional support

Staff encouraged an atmosphere of open and honest communication between staff and patients. One patient told us that "I feel I can ask anything when I go for treatment".

Good

End of life care

Patients who were anxious or emotional about their treatment and prognosis were supported well by staff who went to great lengths to reassure patients and offer emotional support.

Prior to our inspection of the hospital we held a meeting with local voluntary and support organisations who had contact with the trust services or supported people who did. Positive comments were made about the bereavement service. People felt that the team were working well and offering good support to people who were bereaved.

Are end of life care services responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

Patients had access to generic support from occupational therapy, physiotherapy, and speech and language therapy. There was access to a specialist lymphoedema service, complimentary therapies and breathlessness management at the hospital; however, there was no dedicated team to make sure people had timely access to these services.

The trust has reviewed its performance against National Institute for Health and Clinical Excellence (NICE) guidance on opioid prescribing in palliative care. As a result of this the need was identified to provide more information for people using this medicine. A patient information booklet had been developed and was in use as well as standard procedures for staff to follow.

There was a dedicated bereavement team working across the Trust with an office in each site to provide a point of contact for people recently bereaved. The bereavement specialist nurse was able to see families in privacy and to direct them to other support services. Bereavement support was offered immediately to help people with cope with the difficulties of being bereaved.

Vulnerable patients and capacity

The palliative care team provided support and information to the patient, their families and the care team working on the ward. However as the service was not available over a 24 period and at weekends there were times when patients could not easily access specialist support when required.

Telephone support lines were available from 5pm until 8am the following morning and at weekends. Preston hospital takes the helpline calls to help support patients out of hours.

The inpatient wards were introducing a dragon fly symbol that would alert staff to patients who as a result of their illness needed more time and support.

Leaving hospital

The trust was aiming to develop a seamless process for discharging patients that would enable a patient to be discharged home safely and quickly with all necessary support. It is emotionally and psychologically important for patients at the end of life to return to their chosen place of care, and rapid and well supported discharge is a key feature of good end of life care. The trust acknowledged that there was more work to do to address the difficulties in arranging timely and well supported discharges from hospital for patients with palliative and end of life care needs.

The percentage of summaries provided to GPs within forty-eight hours of discharge from hospital remains low. The trust has made some progress and has implemented an electronic solution to secure further improvements never the less current performance remains a concern as General Practitioners are informed in a timely way of changes in a patient's condition and this means that a patients care and treatment could be compromised as a result.

Learning from experiences, concerns and complaints

Staff working in the services were very keen to take up training and development opportunities to provide a good service to patients. They were learning from patient experiences and using them to support service development.

Are end of life care services well-led?

Good

Vision, strategy and risks

The specialist palliative care consultant and the specialist palliative care nursing team demonstrated great enthusiasm and commitment to developing good palliative care for their patients.

Good

End of life care

They had developed clinical and educational strategies to help them be clear about their objectives and focus and to continuously develop their knowledge and skills.

An aim of the palliative care clinical strategy is to establish a fully integrated palliative and end of life care service that offers patients both specialist and non-specialist care over a 24 hour period for seven days a week by 2017. Staff providing palliative and end of life care on the medical wards were keen to improve the care they provided and appreciated the support they received from the specialist palliative care nurses and bereavement team. They acknowledged that the specialist teams were visible and present on the wards; however, support was limited to 'office hours'. This meant that there were times when patients and staff may have benefitted from specialist advice and such advice was unavailable.

Leadership and culture

Local leadership at service level was good. There was a shared commitment within the palliative care and oncology teams to provide the best for patients. There was a culture of collaboration and improvement. Staff were keen to develop and expand the service so that patients received the best care possible. Staff were positive about their colleagues and direct line mangers. Staff supported each other and worked extra shifts to try to provide cover on the wards to provide continuity of care and support to patients and their colleagues. They were less confident in senior managers and felt that responses and actions to concerns lacked pace.

Patient experiences, staff involvement and engagement

Patient experiences of this service were largely positive. Staff worked well together to facilitate and secure service improvement. Patient's individual needs and wishes were respected and planned for. If care was necessary within the hospital environment, the palliative care team provided support and information to the patient, their families and the care team working on the ward.

Requires improvement

Outpatients

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

Information about the service

The trust runs a range of outpatient clinics across its 3 sites, there had been a steady increase in required appointments over the last three years. In 2012-13 there were 481,862 outpatients seen at the trusts hospital sites, up from 448,314 in 2011-12 and 416,912 in 2010-11. (Source: HES data 2010/11, 2011/12 and 20112/13.)

We inspected four of the outpatient clinics and we spoke with 11 patients, four relatives and 19 staff both nursing medical and support staff across the 3 hospital sites.

We received comments from our listening events and from people who contacted us about their experiences. We also reviewed the trust's performance data.

Summary of findings

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 professional and caring staff team

Staff working in the department respected patient's privacy and treated patients with dignity and respect.

However, we found that waiting times for appointments were long in some departments and there will still difficulties in securing case notes and test results for patients' appointments.

Requires improvement

Outpatients

Are outpatients services safe?

Requires improvement

Cleanliness and hygiene

Clinics and departments were clean throughout and gloves, aprons and other items of protective clothing were readily available in the clinics. There was a good supply of accessible hand wash basins and alcohol gel dispensers. Staff used the facilities in accordance with good practice guidance for the prevention and control of infection.

Availability of patient records

We found that all the outpatients departments across the trust continued to experience some operational difficulties as patient records were not always available for outpatient clinics and diagnostic results were not always returned in a timely way so that they were available for the patient's next clinic appointment. In some clinics a number of patients had temporary notes as their case notes were not available. There are still issues regarding the provision of case notes for short notice clinics and the medical records team not being informed of a patient's appointment. The trust's current percentage for case note availability in the outpatients department is 90% and is monitored on a monthly basis. The trust has initiated a Paper Lite project to have electronic information available for patients and to improve the efficiency and effectiveness of outpatient services. This would benefit patients and reduce the reliance on paper records

Safeguarding

We saw that safeguarding policies and procedures were in place. Staff we talked with in the outpatient's clinics had completed safeguarding training and understood their responsibilities in relation to protecting people from abuse and responding to concerns.

Monitoring safety and responding to risk

Performance in the Breast Screening Unit was closely monitored to ensure good practice in relation to reducing the numbers of repeat x-rays and mammography required as a result of poor imaging. There are quarterly reports highlighting any trends and performance issues. The reports inform remedial and, management actions to address performance and risks.

While we were inspecting the Breast Screening Service at this hospital we were informed of concerns in relation to the breast screening of patients who had gone on to develop symptomatic breast cancer at the site of their original assessment. We have raised these concerns directly with the trust who has commissioned an independent review of these cases and has agreed to share the outcome of the review with us.

The management of patient safety and active follow up was monitored at board level for this service due to the historical concerns relating to a serious untoward incident in 2010 .Further investigation highlighted that over 1400 patients had been affected by the poor implementation of an electronic booking system that had not been actively or appropriately managed by the board prior to 2011.

Are outpatients services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Not assessed

Are outpatients services caring?

Good

Compassion, dignity and empathy

The patients we spoke to said that staff had been polite and caring towards them. Staff spoke with patients respectfully and were open and friendly in their approach. Vulnerable patients were managed sensitively and attended to as quickly as possible. Difficult messages were given to patients and those close to them sensitively and privately. Patients were given time to understand the messages and ask questions.

Involvement in care and decision making

Patients we spoke with told us they were well aware of their condition and that the doctors and nurses had explained this clearly to them. Patients told us they felt well informed about their care and treatment and could make informed choices.

Diagnostic tests were explained and patients consent sought as appropriate.

Requires improvement

Outpatients

Staff were competent in seeking and obtaining patient consent for treatment, clearly explaining benefits and risks in a way that patients understood.

Emotional support

Patients gave varying accounts regarding the level of emotional support from staff that differed from clinic to clinic. Some patients were very positive about the support they received from staff. Others felt that staff were not very supportive and did not really spend time offering emotional support to patients.

Are outpatients services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Meeting people's needs

Due to the ongoing operational difficulties within this service and although performance has improved , there is still much to do in scheduling, organising and managing the outpatients departments before the service can be assured that it is meeting patients' needs in a timely way.

Vulnerable patients and capacity

Vulnerable patients were managed sensitively in outpatient departments. Staff were responsive in meeting patient's individual needs. Patients who suffer from dementia were managed in a thoughtful way and staff tried to make sure that they were seen quickly.

Staff were aware of their responsibilities in relation to people who lacked mental capacity and they sought advice, guidance and support for patients from appropriate professionals to support best interest decision making.

There is limited information available in the departments for patients who have a learning disability We could not find information available in easy read formats; similarly we could not find written information in formats suitable for patients who had a visual impairment.

Patient information leaflets were available in different languages and an interpreter could be booked in advance of their appointment. We asked staff about what was available for people when English was not their first language so they could understand their treatment and care.

The trust used 'language line' that could be used for interpretation or support. Staff told us that they had used this service and had not encountered any significant problems nor had not received any complaints from patients about the service. We did not see this service in use during our inspection.

Patient transport

Transport arrangements were sometimes difficult for patients attending the out patients department. Transfer arrangements led to some people arriving very early for appointments and were then subject to long waits; patients also experienced long waits for transport to take them home afterwards.

Patients felt that the difficulties with transport arrangements for outpatient attendance led to a poor experience that required better organisation and support.

Access to services

From our performance information the trust is meeting expectations in relation to referral to treatment times.

Reception staff told us that their biggest problem was the waiting times in outpatients. Staff said that they told patients if the clinics were running late. Staff told us if people wanted to complain about their appointment they were directed to the team leader. The team leader would discuss the issues with them and look into their complaint and try and resolve things "face to face" first. Patients were subject to lengthy waits and transport difficulties that made the outpatient experience often less than satisfactory.

Learning from experiences, concerns and complaints

Following a serious untoward incident regarding the lack of follow up on a patient in outpatients, there was an investigation into the trusts outpatients department by an independent consultant. The investigation report was completed in January 2011 and made a number of recommendations for action on the part of the trust. Since that time the trust has worked to improve its management of the outpatient department and strengthen the governance arrangements for managing the department and the escalation of risk.

Systems and management arrangements have improved, however staff and patients are still experiencing difficulties in scheduling and arranging appointments for example, in

early 2013, there were two pain clinics with no patient attendance as the system had failed to generate letters to patients informing them of their appointment and so patients did not attend.

Environment

Patients were seen in private consultation rooms where conversations could not be overheard. Patients had private areas to undress and wait, if this was necessary.

Staff told us that if they had to give patients 'bad news' this was done in the privacy of the clinic rooms and that staff were prepared before the patient came into the consultation room so that appropriate support was available for the patient.

Are outpatients services well-led?

Good

Governance arrangements

The outpatients department was part of the trust's core clinical support division The Outpatients Department is part of the Core Clinical Services Division. This is headed by a Clinical Director and supported by a Divisional General Manager and Head of Therapies.The executive nurse chaired the outpatient improvement group, that was linked to the patient experience committee to get feedback from patients about the out patients department. The trust was currently developing a Patient Experience and Public Involvement Strategy. The objectives were being monitored, along with current patient experience initiatives, on a quarterly basis by the Clinical Governance and Quality Committee. Initiatives had included a 'customer care champion day' and the "I Want Great Care" service. This was currently being piloted within the trust and therefore we were unable to see any evaluation of these initiatives.

There were systems to report and manage risks. Staff were encouraged to participate in the change programme for the department and there was departmental monitoring at board level in relation to patient safety. This was a recommendation of the investigation into the outpatients department reported in January 2011.

Staff told us that if they had concerns they raised them with their immediate managers. We spoke with eight staff in the breast screening unit who were aware of how to escalate concerns and about whistleblowing on poor practice. However, two members of staff were disappointed at the level of response made by the trust in relation to the earlier mentioned Breast Screening Service.

Leadership and culture

Staff in Outpatients did exhibit strong teamwork and a desire to make systems work.

We spoke with staff who told us that they met representatives of the outpatient's improvement group regularly and that they were aware of who was leading the service.

We were told by staff that not all specialities did things the same way that caused inconsistencies in the delivery of services.

Some staff said that when they had presented alternative views to trust management they had not been listened to and the systems in place did not support them. This view had been expressed to us before and during our inspection of the trust.

Patient experiences, staff involvement and engagement

Staff working in the outpatients department told us that they felt there was good team working in the department. Staff showed commitment to making the electronic systems work and minimise disruption to patients, although often they said they had no control over the systems they used.