North Cumbria Integrated Care NHS Foundation Trust

Inspection report

Trust Headquarters, Cumberland Infirmary
Newtown Road
Carlisle
CA2 7HY
Tel: 01228608399
www.ncic.nhs.uk

Date of inspection visit: 6 to 8 June 2023 and 11 to 13 July 2023
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Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

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

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

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Overall summary

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

When a trust acquires another trust in order to improve the quality and safety of care, we do not aggregate ratings from the previously separate trust at trust level for up to two years.

Our normal practice following an acquisition would be to inspect all services run by the enlarged trust. However, our usual inspection work has been curtailed by the COVID-19 pandemic and since that time we have maintained a risk based approach.

Our findings

In our ratings tables we show all ratings for services run by the trust, including those from earlier inspections and from those hospitals we did not inspect at this time. The ratings shown are an aggregation of ratings from the original trust and those acquired by the trust which have been inspected since the acquisition as well as new ratings from this inspection.

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

The trust serves a population of approximately 320,000 in the west, north and east of Cumbria, in the districts of Allerdale, Carlisle, Copeland, Eden Valley and South lakes and Furness for some community services. It also provides services to parts of Northumberland and Dumfries & Galloway. The community is spread over a large geographical area, with 51% of residents living in rural settings. Over 65s make up a larger proportion of the population than the national average. Deprivation is similar to the England average and about 11,700 children (14.5%) live in poverty.

We carried out this unannounced inspection of North Cumbria Integrated Care NHS Foundation Trust as part of our continual checks on the safety and quality of healthcare services.

We inspected Emergency and Urgent Care and Medical care. We also inspected the well-led key question for the trust overall. We did not inspect maternity services, surgery, critical care, services for young people and children, end of life care, out-patients, or diagnostics at this inspection.

At our last inspection in 2020 we rated the trust overall as requires improvement. At that inspection we issued the trust with a section 29A warning notice in regard to the standards of care provided. At this inspection the trust rating has stayed the same. We did see improvements made as a result of our warning notice.

Our rating of services stayed the same. We rated them as requires improvement because:

- We rated safe, effective, responsive and well-led as requires improvement, and caring as good
- We rated 4 of the trust’s 17 services as requires improvement. In rating the trust, we took into account the current ratings of the 13 services not inspected this time
- The service did not always have enough staff to care for patients and keep them safe. Not all staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service did not always control infection risk well. Staff did not always assess risks to patients, act on them and keep good care records. Pain relief was not always given timely when they needed it
- The service did not always manage the safe storage of medicines and hazardous cleaning materials
- The service did not always manage safety incidents well and although there was evidence of learning following safety incidents, there was further work required to manage environmental hazards and associated risks
- Leaders did not always run services using reliable information systems. The trust’s vision and values were developed but did not have clear underpinning strategies

However:

Our findings

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers
- The service planned care to meet the needs of local people, took account of patients' individual needs and made it easy for people to give feedback

How we carried out the inspection

The team that carried out the inspection included two inspection managers, 10 inspectors, 5 specialist advisors, one assistant inspector and an inspection planner. In addition, there was an executive reviewer plus three specialist advisors experienced in executive leadership of NHS trusts. The inspection team was overseen by Sarah Dronsfield, Deputy Director of Operations.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with 7 legal requirements. This action related to 4 services.

Trust wide

- The trust must ensure that leaders are visible within the organisation and relevant information is presented openly and transparently regarding strategic decision making and challenge at senior level. This includes but is not limited, to recording of executive meetings and agendas at private and public board. **Regulation 17 (2) (d) (e) (f).**
- The trust must ensure adequate oversight and accountability for the trust's infection, prevention and control strategy. **Regulation 12 (2) (h).**
- The trust must ensure that plans are aligned with an overarching strategy which is monitored through measurable actions with appropriate timescales **Regulation 17 (2) (a) (f).**
- The trust must ensure the organisation supports all staff, including those with particular equality characteristics, to feel respected and valued and supports an environment where staff are encouraged to speak up and raise concerns without fear of blame or reprisal. **Regulation 18 (2) (a).**
- The trust must ensure it takes account of the Workforce Race Equality Standard, Workforce Disability Equality Standard and that action plans related to the standards have appropriate sponsorship and are progressed in a timely way. **Regulation 18 (2) (a).**

Our findings

- The trust must ensure patient safety concerns and quality issues are adequately reported to board and subcommittees of the board to ensure all are addressed in a timely way and all possible actions are taken to address concerns. **Regulation 17 (2) (a) (f).**
- The trust must ensure there is an accountability framework for care groups to monitor performance on action plans or mitigating risk. **Regulation 17 (2) (b).**
- The trust must adequately investigate all incidents which require and investigation. This includes but is not limited to those cases referred to the Healthcare Safety Investigation Branch (HSIB) **Regulation 17 (2) (a) (b) (e) (f).**
- The trust must ensure that structured judgment reviews are focussed upon explicit judgement of the standard of care reviewed to ensure all learning is considered from the review. **Regulation 17 (2) (f).**
- The trust must ensure that compliance with National Institute for Health and Care Excellence (NICE) guidance is assessed in a timely way and backlog in assessments are addressed. **Regulation 17 (2) (e) (f).**
- The trust must ensure that risks recorded at corporate level and in the board assurance framework are current, not duplicated and have clear actions for mitigation which can be monitored and measured. **Regulation 17 (2) (b).**
- The trust must ensure that complaints are responded to in a timely way, result in further investigation if indicated and where possible involve family in the investigation. **Regulation 16 (1) (2).**

Cumberland Infirmary, Medical Care

- The trust must ensure care and treatment is provided in a safe way for patients, including assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks. **Regulation 12 (1) (a) (b).**
- The trust must ensure storeroom doors are not left open or unlocked and accessible to patients or members of the public. **Regulation 12 (1) (2) (b).**
- The trust must ensure that persons providing care or treatment to service users have the qualifications, competence, skills, and experience to do so safely. **Regulation 12 (1) (2) (c).**
- The trust must ensure that all medicines are stored in accordance with temperature thresholds to ensure efficacy of medication is not impacted upon. **Regulation 12 (1) (2) (g).**
- The trust must ensure the timely administration and accurate recording of all medications, including oxygen, prescribed to patients under its care. **Regulation (1) (2) (c) (g).**
- The service must ensure that the assessment of risk, preventing, detecting, and controlling the spread of, infections, including those that are health care associated is managed in line with national guidance. This includes, but is not limited to, cleaning substances subject to COSHH regulations are stored securely. **Regulation 15 (1) (2)(h).**
- **The trust must ensure that systems and processes are in place to accurately review and categorise patient safety incidents logged by frontline staff. Regulation 17 (1) (2) (a) (b) (e).**
- The trust must ensure that all patient records are stored securely across the medical division to adhere to patient confidentiality and general data protection regulation (GDPR) guidelines. **Regulation 17 (1) (2) (c).**
- The trust must ensure that all staff complete mandatory training to comply with targets for completion set by the trust. **Regulation 12 (1) (2) (c).**

Cumberland Infirmary, Urgent and Emergency care

Our findings

- The trust must ensure that mandatory training including resuscitation, infection prevention and control and safeguarding meet the trust target for all staff. **Regulation 12 (1) (2) (c).**
- The trust must implement an effective system to identify and assess any potential safeguarding issues and the management of vulnerable children and young persons. **Regulation 13 (1) (2).**
- The trust must ensure that all premises and equipment used by patients are clean, secure, suitable for the purpose for which they are being used for and properly maintained. **Regulation 15 (1) (a) (e).**
- The trust must ensure that patient risk assessment are completed and updated so that staff can identify and act upon patients at risk of deterioration. **Regulation 12 (1) (2) (a) (b).**
- The trust must ensure that enough suitably, qualified, competence nursing staff are deployed. **Regulation 18 (1) (2) (a).**
- The trust must ensure that all patient records are stored securely across the medical division to adhere to patient confidentiality and general data protection regulation (GDPR) guidelines. **Regulation 17 (1) (2) (c) (d).**
- The trust must improve the quality and accuracy of record keeping ensuring clinical records are contemporaneous, detailed, signed and clearly show the care and treatment patients receive and when they have received it. **Regulation 17 (1) (2) (c) (d).**
- The trust must ensure all patients receive pain relief in a timely manner in line with RCEM guidelines. **Regulation 12 (1) (2) (a)(b).**
- The trust must ensure that controlled drugs and other medications should be stored and recorded correctly and securely. **Regulation 12 (1)(2)(g).**
- The trust must ensure that when a patient lacks mental capacity to make an informed decision, or give consent, staff must act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice **Regulation 11 (1).**
- The trust must ensure that all mental health patients had appropriate and timely risk assessments completed. **Regulation 13(1)(2)(3)(4)(d).**
- The trust must demonstrate it supports staff by challenging unacceptable behaviour and language. **(Regulation 17 (1) (2) (e).**

West Cumberland Hospital, Medical Care

- The trust must ensure care and treatment is provided in a safe way for patients, including assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks. **Regulation 12 (1) (a) (b).**
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- The trust must ensure storeroom doors are not left open or unlocked and accessible to patients or members of the public. **Regulation 12 (1) (2) (b).**

Our findings

- The trust must ensure that the medical care service is responsive in terms of access and flow, which should include specific admission criteria for each ward based within the medical care core service. **Regulation 17(1) (2) (a) (b).**
- The service must ensure that the assessment of risk, preventing, detecting, and controlling the spread of, infections, including those that are health care associated is managed in line with national guidance. This includes, but is not limited to, cleaning substances subject to COSHH regulations are stored securely. **Regulation 15 (1) (2) (h).**
- The trust must ensure that systems and processes are in place to accurately review and categorise patient safety incidents logged by frontline staff. **Regulation 17 (2) (a) (b).**
- The trust must ensure that all patient records are stored securely across the medical division to adhere to patient confidentiality and general data protection regulation (GDPR) guidelines. **Regulation 17 (1) (2) (c).**
- The trust must ensure that all staff complete mandatory training to comply with targets for completion set by the trust. **Regulation 12 (1) (2) (c).**

West Cumberland Infirmary, Urgent and Emergency care

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Action the trust SHOULD take to improve:

Trust wide

- The trust should ensure that it follows the recommended period for repeating and recording Disclosure and Barring Service checks for directors and that all qualifications are copied and recorded within directors files. **Regulation 5 (3) (d).**

Our findings

- The trust should consider developing and implementing it's mental health strategy at pace to improve the experience of patients receiving care.
- The trust should consider appointing a non-executive lead for Freedom to speak up (FTSU).
- The trust should consider support for the EDI lead role and how this role can be developed to have impact.
- The trust should consider recording timelines for disciplinary investigations against a measurable target.
- The trust should ensure that the number of staff requiring a signed off job plan meets the trust's target. **Regulation 18 (2) (a).**
- The trust should consider a trust wide action plan for improving the management of deteriorating patients.
- The trust should ensure that there is adequate oversight of the harms caused by delays to assessment and treatment in all specialties and consider the impact of health inequalities upon patients who are waiting to receive care. **Regulation 17 (2) (a) (f).**

Cumberland Infirmary, Medical Care

- The service should ensure the use of clinical sharps bins is in accordance with NHS England Guidance. **Regulation 12 (2) (e).**
- The trust should ensure that all staff adhere to fire safety protocol and cease wedging or holding open fire-resistant doors within the department. **Regulation 12 (2) (d).**
- The service should ensure that there is consistent oversight of consumable items on all wards to ensure expired items are appropriately removed from circulation. **Regulation 15 (2).**
- The trust should continue to monitor its use of blanket restrictions on wards where patients may be inadvertently deprived of their liberty. **Regulation 13 (5).**
- The trust should ensure that its alcohol withdrawal policy is reviewed and updated accordingly in a timely manner. **Regulation 17 (2) (b).**

West Cumberland Hospital, Medical Care

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- The trust should ensure that its alcohol withdrawal policy is reviewed and updated accordingly in a timely manner. **Regulation 17 (2) (b).**

Is this organisation well-led?

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Our findings

Although leaders had the skills and abilities to run the service, they did not always effectively manage all of the priorities and issues the service faced. However, there were succession plans to support staff to develop their skills and take on more senior roles.

At the time of inspection, there were 7 permanent executive and 6 non-executive directors in post, plus the chair of the board and 1 interim executive director, the chief operating officer (COO). The executive directors were all relatively new in post, joining the trust from 2020 onwards, so either just prior to or during the COVID-19 pandemic. The most recent appointments had been the executive medical director (MD) and the finance director. Prior to the appointment of the executive team the acquisition of another trust had also taken place. There had also been numerous interim appointments and changes at executive level.

The chair had only been in post for 5 months at the time of our inspection and the non-executive directors (NED) had all been appointed in 2021 and 2022. This had led to an entire board who were 'getting to grips' with an organisation which had been through significant organisational change followed by the impact of the pandemic.

However, despite this we heard that the non-executive team worked well together, and the new chair was working with the governors who previously had been disengaged through lack of communication from the board.

The executive team did not always work together effectively, and this impacted upon the ability of the board to be unitary. The executive team had identified that there was work to do to ensure that their roles aligned with the needs of the organisation in terms of developing strategy, performance, and digital maturity. There was also a need for cultural work within the organisation to set the cultural expectations and behavioural frameworks. We were not assured that the current executive team worked together in a way which would achieve sustainable cultural change within the organisation.

It was recognised by senior leaders that there was a lack of diversity at board level. There were no non-white directors and 6 women making up the board. We heard from staff at all levels, that board members were not always visible within the organisation, particularly at the West Cumberland site. Board meetings were predominantly held at the Carlisle site. There was a programme of visits across the trust, including community locations, for the NEDs and governors which had been reestablished after the pandemic. However, only 3 visits had occurred at the time of our inspection. We did see that the outcome of these visits had been discussed at quality, improvement and committee meetings (QISC) but there was no log or tracking of actions.

The executive medical director had been in post for 18 months at the time of our inspection. It had been recognised that due to low numbers of consultants in substantive posts and historical low clinical engagement, that the organisation was not clinically led. The trust intended to address this by moving to a new operating model of 8 collaboratives, an increase from 4 clinical care groups. Each collaborative will have its own triumvirate.

There were historical issues with engagement with governors. Governors were still not always encouraged to actively engage with developments, for example they had not been involved in the plans to move to 8 collaboratives. However, senior leaders and governors described moves towards greater involvement of governors and providing greater clarity for their role. A board of governors development plan had also been introduced. Governors were unaware of some of the cultural issues within the organisation. There were vacancies in governor posts with 14 out of 38 posts unfilled. Elections were due in September 2023.

The trust had also implemented a clinical policy group attended by clinical directors, senior nurses, senior managers, and executives to prioritise investment decisions and increase clinical engagement. There was also attendance by one

of the chairs of the primary care networks. The trust had implemented a new medical senior staffing committee chaired by one of the consultant body which was open to all substantive consultants and attended by the CEO and MD. These initiatives were all focussed upon clinical engagement but were strongly directed to the consultant workforce. We did not find evidence of a focus upon other clinical staff such as allied health professionals (AHPs), and nursing, for example.

There were weekly executive meetings, we were told that during these meetings strategy was discussed, developed, and challenged. However, minutes were not taken, we were not assured therefore that there was adequate recording of decision making within the executive team. For example, there was no evidence that all relevant discussions regarding the move to the larger collaborative model had been recorded. Following our inspection, the trust provided us with some actions taken from these meetings, we were not assured that these actions were monitored and adequately recorded challenge and decisions making.

A well led review carried out by an external agency for the trust had identified that agenda items discussed at private board should have appeared on the public board agenda. We saw at the time of inspection this had not been rectified.

There was a board development plan in place. There was still work to do however to map the skills of the non-executive team and areas for development across the board. Succession planning was also beginning to be developed across the senior levels of the organisation with some evidence of the development of deputy roles. However, there were recognised gaps in leadership capacity at care group level and this needed further development which was hoped to be achieved by the move to the smaller collaboratives and the recruitment to leadership posts within this structure.

A board effectiveness review had not been completed but there had been a recent review of committees reporting to the board. The people committee was a relatively newly implemented committee given the trusts substantial staffing challenges.

The pace of leadership action was often slow. For example, a staffing review was completed in 2021, but was still being implemented. Where performance concerns were raised within the organisation, senior leaders told us the organisation was slow to act. Some leaders did not take on full responsibility for the performance of the organisation, focussing only upon their own individual remit.

The director of infection prevention and control (DIPC) did not attend board meetings. They also did not line manage the IPC team. We were not assured how accountability for IPC within the trust was managed robustly. There was no non-executive director with the responsibility for IPC. The draft IPC strategy ran out in March 2023 and had not been updated. The IPC report was not published on the trust's website.

The trust had a leadership development programme which drew upon internal and external training. There was still work to do to develop pathways and on boarding into this programme.

There is a requirement for providers to ensure that directors are fit and proper to carry out their role. This included checks on their character, health, qualifications, skills, and experience. During the inspection we carried out checks to determine if the trust was compliant with the requirements of the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014).

We found the FPPR Procedure was in place and mostly the files complied with the requirements of the regulation. We reviewed 5 director (including executive) files and 1 non-executive director file in total. In some files it was not clear that all checks had been carried out within required timescales on appointment to secondments and subsequent substantive posts. Some documents, such as qualifications were missing from these files and documentation was

incomplete and remained unsigned. This did not comply with the trust's own procedures. There was an annual process in place to continuously monitor fitness to practice, however some Disclosure and Barring Service checks recorded were not within the recommended 3 year period. All executive directors' appraisals were in date and completed within the last year, although some were not signed. Appraisals for the non-executive directors were planned but they were over the 12 month review period.

The chief pharmacist had clear lines of communication to board level and all key senior leadership posts had been recruited to enabling oversight of medicines optimisation across the trust.

Vision and Strategy

The service had a vision for what it wanted to achieve and an outline strategy to turn it into action but this had not yet been further developed with all relevant stakeholders. There were limited enabling strategies in place to support the delivery of the strategy.

The trust had a vision known as 'Our NCIC way' developed in 2020 with staff. This articulated the trust's vision, values and 5 driving principles:

- Clinically led
- Positive patient experience every time
- Quality and safety at the heart
- Great place to work
- Managing our money well

The trust had a challenging legacy of change management and strategy development related to a culture of 'repeated rescue attempts'; poor clinical engagement; financial pressures from productivity and estates; vulnerable and fragile services and staffing levels. Pressures on the trust externally such as the fragile social care market and local authority arrangements had impacted upon planned bed number reductions and achievement of elective performance targets, even prior to the pandemic. Senior leaders described how they were developing plans from this low base and that the current focus had been on stabilising the organisation. The organisation had also been through an acquisition, there had been limited opportunity to harness a strategy prior to the pandemic.

The trust was in the process of organisational change which was due to go 'live' in September 2023, 3 months following our inspection visit. The trust was moving from 4 clinical care groups to 8 collaboratives, namely:

- Critical care, anaesthesia and theatres
- Diagnostics and clinical support
- Emergency care
- Community care

Our findings

- Speciality medicine
- Specialist surgical care
- Surgical care
- Women’s and children's

The ambition was to create smaller, clinically led and managed groups which reset governance and empower each care group. There were 3 immediate priorities as part of transformation:

- Culture
- Leadership
- Performance; both productivity and financial

Review of the trust’s quality strategy was on hold due to the organisational change and the patient safety incident response framework (PSIRF) implementation. The quality strategy focussed upon action plans from our last inspection related to both breaches of regulations and our recommendations. The strategy stated that action plans had also been generalised across the organisation and had not solely focused upon our inspection findings. However, we had found repeated breaches at this inspection in relation to, specifically, storage of patient records and staffing.

To monitor performance and ensure standards there was also a programme of rapid reviews across clinical services. Trends and themes were considered at the clinical policy group and progress was to be monitored weekly. This covered 6 areas:

- Performance; both productivity and financial
- Quality & Safety
- Emergency care and patient flow
- Elective recovery and standards
- An effective workforce
- Financial stability
- Organisational effectiveness

Each subject area had an executive, non- executive and clinical lead. There were also 7 enabling strategies:

- Quality improvement strategy
- People strategy
- Digital strategy
- Communication strategy

Our findings

- Financial recovery plan
- Estates plan
- Carbon reduction strategy

Five of these enablers were in development but only three, the communication, digital and people strategy had been to board. The carbon reduction strategy and estates plan did not feature in the development plans, but the trust provided evidence after our inspection that the carbon reduction plan had been approved at board.

There was also a clinical strategy that ran until 2026 and had been developed prior to the organisational restructure, but it was not clear how this linked to the organisational change other than an aspiration to be a clinically led organisation.

Overall, underpinning strategy and plans were not in place across the organisation. Strategic plans were still a long list of ideas and were not yet actionable projects with timescales and deliverables.

The trust's people strategy was co-produced was aligned with the NHS people plan. This strategy was reviewed and approved by a number of trust groups including the workforce group, the partnership forum, the executive team and workforce committee. Work had commenced on the next people strategy. However, although in third year of the current plan, it was difficult to see the impact it had. Some automation of human resource (HR) processes had been implemented, but there were still discrepancies, for example medical staff were using a bespoke system which did not align with the rest of the trust's reporting mechanisms. We did not see how the plan had tackled fundamental cultural issues or was embedded within the organisation.

The trust did not have a mental health strategy, only plans to develop one with relevant partners. There were service level agreements and meetings with the local mental health trust. However, we saw in our core service inspections that was often delays in the responsiveness of the mental health trust which impacted upon staff and patient experience within the trust. We did not see that this was being dealt with at a strategic level at pace.

A review of the medicine's optimisation strategy had taken place and an updated draft strategy had clear objectives and priorities for the period 2023 - 2028. Recruitment continued to be a significant pressure for the pharmacy team. A workforce plan was being developed in collaboration with key stakeholders in the region due to area wide pharmacy workforce challenges.

Culture

Although staff were focused on the needs of patients receiving care, they did not always feel respected, supported, and valued. Some staff told us they did not feel they could raise concerns without fear of blame or reprisal. The trust did have systems to seek and act upon feedback from staff and other relevant persons. The service did promote equality and diversity in daily work.

Senior leaders and staff told us there was work to do to improve the culture of the organisation. There had been historical concerns about incidents of bullying and harassment within the organisation. This was particularly in relation to certain staff groups such as internationally recruited nurses and junior doctors. Senior leaders recognised that this was an issue and although improving, not eliminated.

Our findings

To address the issues within the medical workforce, case managers had been allocated but it was found that staff did not wish to raise concerns formally. We also heard that senior leaders reframed some claims of bullying and harassment, denying experiences to only being perception. We did not have confidence that cultural issues were taken with the appropriate level of seriousness in the trust and were not assured that cultural issues could be fully addressed in an environment where lived experiences were undermined.

The trust had a structured behavioural framework and agreed upon values; kindness, respect, ambition, and collaboration. Each value had related behavioural indicators which set out expectations. The trust had also implemented a system of structured listening events which developed associated action plans. Whilst this process was evident throughout documents and action plans within the trust, we did not see that it was embedded or widely talked about by staff or senior leaders. Some staff told us they did not feel listened to or consulted in changes within the organisation.

Senior leaders told us that there were historical issues with recruitment which had been addressed by recruiting internationally. Issues remained in staff retention, even for newly recruited staff. The trust had recently reviewed leaver information and found only 1% of leavers had completed an exit questionnaire. Action was being taken to address this such as the new exit policy promoting managers exploring support to retain staff and changes to the flexible working policy to support staff experience and retention.

Sickness absence was reducing across the trust to 4.5%. Appraisal rates were also a focus for improving retention as they were persistently low across the organisation.

Some staff highlighted the impact that continuous change had in the organisation. There was an element of change fatigue. Not all staff understood the strategic direction and in particular, the care group structure change was not well understood by staff.

A leadership development programme was being established for different levels of leaders across the organisation. Civility and respect modules were to be incorporated in the programme from June 2022. However, there was no organisational development plan in place and senior leaders told us that the well being team did not have sufficient capacity to support the organisation.

Response rates to the national NHS staff survey were low at 42%, slightly below the national comparator average. Staff told us this was due to disillusionment with surveys due to inaction on feedback received by the organisation. For the first time a separate survey was carried out for bank staff, the response rate for the trust was 18%.

The results showed a deterioration in the key indicators of staff morale and engagement compared to the previous year and comparator trusts. The three indicators showing the most deterioration were:

- Feeling safe raising concerns about unsafe clinical practice
- Confidence that the organisation would address concerns
- Experience of discrimination on grounds of ethnic background

However, there were some areas where the trust performed better than the previous year:

- There are opportunities to develop careers in this organisation

Our findings

- Approaching managers about flexible working
- Opportunities for flexible working patterns

The trust performed better than the national comparator average in 9 indicators and worse in 15 indicators. These results had been presented as a board development session although some board members felt the findings were not reflective of the organisation. The planned response was for staff survey action plans to be developed in all care groups and some specific services to demonstrate action upon feedback. There were also plans to develop a corporate action plan which was yet to be approved. The trust told us that they had also made use of a regular staff pulse survey.

The trust had a volunteer's programme which supported training to access support volunteers to gain paid roles within the trust.

Gender pay gap

The trust's gender pay gap report and action plan was published in 2022. The mean hourly rate of pay represented a gender pay gap of 8.6% and the median, a gap of 2.54%. The greatest gender pay gap was within the medical and dental workforce. Action planned to address the gap was outlined in the EDI plan and included recent changes to the flexible working policy in conjunction with staff groups.

Freedom to speak up guardian

The trust had 1 substantive and 2 assistant Freedom to Speak up Guardians (FTSUG). The lead guardian was a fulltime role and had been in post for 2.5 years. Two assistant FTSUG were part time and also worked in a clinical role in the trust. There were also 50 champions recruited from staff across the organisation. The champions also supported on EDI issues and had dual role training. The FTSUG worked closely with the new EDI lead role within the trust and provided them with support.

The trust had followed guidance from the national guardian's office when determining how freedom to speak up had been operationalised within the organisation. The FTSUG reported to the national guardian office in line with guidance, as well as producing an annual report to present at the trust's board meeting. The chief executive line managed and supported the lead FTSUG and met with them regularly.

The FTSUG attended the clinical policy group and executive meeting quarterly to deliver the FTSUG report. There were newly established links between FTSUG and the workforce committee, but this was in its infancy.

There were 39 new cases raised to the FTSUG between 1st January 2023 and 30th March 2023, 6 of these were anonymous. The FTSUG received concerns from a range of professional groups and services. There were known issues of bullying and harassment within the organisation, and this was reflected in the cases raised to the FTSUG with bullying, harassment and inappropriate behaviour being the highest proportion of cases.

Staff reported that cases still took too long to be resolved. Regular changes in management arrangements impacted upon progression of cases and there were issues with psychological safety from staff who feared raising issues with managers. Feedback highlighted a need for more comprehensive management and leadership training to support managers in their role.

Our findings

The FTSUG had focussed upon increased visibility within the organisation, attending the different hospital sites. The lead FTSUG also chaired the regional guardian meeting and attended the national meeting. The role was well established and well known and utilised by all staff groups. The FTSUG also supported the staff networks including chair the LGBQT+ network, as well as attending quality groups, staff forums and staff side representative meetings. However, there was no mandatory training for staff around the FTSUG role.

Guardian of safe working

The trust had a guardian of safe working in post. They met with the trainee doctors every two months in junior doctor forum. The medical director, director of medical education, associate medical director for medicine, Local Negotiating Committee (LNC) Chair and British Medical Association (BMA) representative were also invited to the forum.

The guardian of safe working did not have a manager as per the requirements of the guardian role, but they worked closely with the medical director.

The trust board received a report quarterly outlining issues raised by the junior doctors. We heard the board were receptive to issues raised and action had been taken as a result.

Equality and diversity

The trust's equality, diversity and inclusion (EDI) lead had only been in post a short time and was a relatively junior member of staff in terms of grade. It was not clear how this role would have impact when dealing with and potentially challenging higher levels of management within the organisation. The EDI lead was line managed by the organisational development team but received support from the FTSUG.

Staff networks for LGBQT+, disability, diversity and veterans were active within the organisation. The networks were relatively new and had limited impact to date. The disability network had lobbied for improved turnaround times for equipment required for reasonable adjustments to support staff who were off work or returning to work. Staff who chaired networks that we spoke with were passionate about the impact they could have and ideas which were being generated within the networks. The networks had a forum to come together in EDI steering group.

Senior leaders were to commence reverse mentoring, where they receive mentorship from lower grade staff from ethnic minority groups within the wider organisation to explore their experiences of working for the trust and addressing potential bias.

The Workforce Disability Equality Standard (WDES) was introduced in 2019 and is mandated for all NHS trusts in England with the aim of furthering equality and inclusion for disabled staff in the NHS. There are 10 metrics calculated from data collected directly from trusts and the NHS staff survey. According to the latest WDES data, the trust was performing better for one indicator compared to last year, the likelihood of shortlisting for non-disabled candidates to vacancies. For most indicators there was no data available to compare changes from last year's data set and one indicator had stayed the same. Two indicators had deteriorated from last year's results; the percentage of disabled staff in bands 1 – 9, very senior manager (VSM) (including executive board members), medical/dental and other staff, compared with the percentage of non-disabled staff in these categories; and the percentage difference between the organisation's board voting membership and its organisation's overall workforce.

The Workforce Race Equality Standard (WRES) became mandatory for all NHS trusts in 2015/16 and trusts are required to show progress against 9 workforce indicators. In 2022 the trust performed better than in 2012 for 6 out of 9 indicators

including the percentage of staff from an ethnic minority background experiencing bullying, harassment or abuse from other staff and those experiencing discrimination from a manager, team leader or colleagues. There was however a slight increase in the percentage of staff from ethnic minorities experiencing bullying, harassment or abuse from the public and the percentage of staff from ethnic minority backgrounds believing that the trust provided equal opportunities for career progression or promotion.

The latest WRES / WDES action plan covered a wide range of initiatives which were rated and updated quarterly. Whilst the action plan indicated some executive team involvement in the plan, executive sponsorship of the plan was not obvious and where actions were not on track these were often awaiting executive team input or approval. There were multiple actions which also crossed over into the EDI action plan developed with staff networks and the strategic EDI group. Some actions were not updated each quarter and were at risk of not be delivered.

International recruitment

The trust had recruited a number of internationally recruited nurses, predominantly from India. It had been recognised that, despite recruiting and supporting these staff, retention due to their experiences within the trust had been an issue. To respond to this the trust had developed an action plan as well as tackling individual instances of racial discrimination.

A stay and thrive scheme was being implemented. This included supporting family members of staff who may have a health care qualification to pass examinations and secure employment and to support staff with specialism experience move into roles commensurate with their skills and knowledge. A survey of internationally recruited staff carried out by the trust showed that 86% of staff indicated they wished to remain at the trust.

The trust also recognised that there had been discrepancies in how new starters in the trust had been on boarded and this was now done without separation of overseas or more locally recruited staff.

Disciplinary processes

From board papers, there were 17 disciplinary cases in the period June 2022 to December 2022. There were no set targets for completion of investigation, but these cases (including investigation) took from 1 to 17 weeks (taking 4.8 weeks on average) to conclude. Adherence to process was monitored and no breaches were identified. 5 of the cases had been concluded and none had resulted in dismissal. Themes were information governance breaches and conduct and offences committed outside of work. These themes were fed into the communications teams as reminders for staff around values and behaviours.

Governance

Governance processes did not operate effectively across the organisation to ensure risk and performance issues were identified, escalated appropriately, managed, and addressed promptly.

Governance processes did not operate effectively across the organisation to ensure risk and performance issues were identified, escalated appropriately, managed, and addressed promptly.

The trust's governance structure included 7 committees reporting to the board: quality, improvement and safety; estates and procurement; remuneration; audit and risk; finance investment and performance; and people committee. Each committee was chaired by a non-executive director and led by an executive.

Our findings

There was also an executive and new clinical policy group which reported into the board. There were 7 committees or groups reporting to the executive group:

- Care group boards
- Elective care group
- Operational management group
- Urgent and emergency care group
- Delivering quality and safety group
- Charitable funds
- Strategy and Financial planning group.

The clinical policy group was chaired by the executive medical director and focussed upon clinical decision making. The executive group was referenced as a strategic trouble shooting meeting. This meeting was not recorded and there was a risk that key strategic decision making was not clearly documented.

The quality, improvement and safety committee received reports from the delivering quality and safety group, infection prevention and control, safeguarding, medicines management and mortality surveillance groups. Senior leaders told us papers were often shared at short notice and gave inadequate time to review them all prior to meetings.

Reports to board and committees were being developed, but they lacked measurables and standardisation. There were no regular performance reports or dashboards and committees relied on reports mostly of narrative. There was a risk that key issues were absent from reporting mechanisms to board.

It was unclear from the governance structure and meeting minutes how certain working groups adequately reported into the quality and safety committee. There were no standard agenda items for risks such as falls or pressure ulcers, for example. Items were only discussed when they had been raised as an issue elsewhere leading to a reactive approach. The slips trips and falls group and tissue viability group reported into the patient safety group which was a single item agenda on the committee. They provided a quarterly report to the delivering quality and safety group which reported into the quality, improvement and safety committee.

The quality improvement and safety committee was refreshed in April 2023. The agenda for the quality improvement and safety committee had a very large remit, however the meeting had been reduced to every other month to allow for actions to be completed between meetings. We were not assured this gave adequate capacity to review all issues with adequate scrutiny.

Governance teams at care group level had been managed and recruited to within the groups with no standardisation. There was variability in the composition of teams, skills, and the grades of staff within them leading to an inconsistent approach to governance at care group. There was also variability of governance meeting arrangements at care group level and the trust could not be assured that all issues were appropriately shared or escalated at care group level.

Care groups had recently implemented performance and accountability meetings which had a standard agenda; however, the agenda items were very broad and the processes were not embedded.

Job Plans

Signed off job planning was below target of 90% at 73%, a further number of plans were in progress and if signed off then this number would be 87%. There were also historical discrepancies with job plans which currently stood at 55 incomplete, 25 were going through review and would be resolved. Of the remaining 30, 1 third were new starters still in progress. 20 job plans had unresolved discrepancies. The trust therefore did not always have oversight of the deployment and efficiency of workforce across specialities.

Learning from deaths

The trust had a policy and procedure in relation to learning from deaths and a monthly mortality surveillance group.' A quarterly assurance report was presented to the quality improvement and safety committee for oversight and assurance.

All deaths were reviewed by the medical examiner and any triggering a structured judgement review (SJR) had this carried out by a clinician not involved in the care of the patient. Findings, learning and good practice fed into the trust wide mortality surveillance group.

We reviewed 6 SJRs and found that they lacked explicit judgements around the standards of care given. The records provided were incomplete, for example they had no time of death or date of completion of the review or the author. The documentation did not contain reasons for carrying out an SJR and only asked for yes / no choices rather than encouraging explanation and judgement. There was no evidence of interactions with families, the coroner or other health care professionals who may be involved in the care of the deceased. The reviews did not cover discussions regarding do not attempt cardio pulmonary resuscitation (DNACPR) in sufficient detail. We were not assured therefore, there was adequate scrutiny of the events leading up to and after death reviews, which would leading to shared learning within the organisation.

SJRs were carried out following the death of a patient with a learning disability (LD) or autism, the investigation was supported by the trust's learning disability nurse. A referral to the National Learning from lives and deaths of people with a learning disability and autistic people (LeDeR) was also submitted by the trust's lead nurse for LD, Autism and Complex needs, who was also a member of the regional LeDeR action from learning group and the mortality surveillance group. The trust had an improvement plan in line with the NHSI LD Standards and it was expected that the trust would be fully compliant with the standards by 2023/24.

Incidents and incident reporting

The trust did not follow NHS England guidance on the investigation of cases referred to the health and safety investigation branch (HSIB). Rather than conducting their own review of the incident following the early learning from an initial 72-hour report they waited for the return of the HSIB report. The trust was unable to triangulate the HSIB findings with an internal investigation outcomes. This was a risk as actions and learning was delayed waiting for the publication of the HSIB report.

The trust had a backlog of approximately 65 action plans from incidents dating back to 2020 which was being addressed. Following our inspection the trust confirmed that the backlog had been reduced and the longest overdue was 2021.

The trust had started to implement shared learning from incidents. For example, recent incidents have led to the training on recognising delirium, improving nutrition and hydration, improving nasogastric tube care and a task group on the identification and management of food allergies.

Our findings

The trust has in place a project board to oversee the implementation of PSIRF and were progressing in accordance with national timeframes. However, given the lack of assurance that all SIs were adequately escalated and investigated there was a risk that significant learning from incidents would be missed when moving to the new system which gave the trust greater autonomy in investigation processes.

Clinical audit and guidance compliance

There was an internal audit programme supported by an external agency to give organisational assurance which reported into the audit and risk committee. There was a clinical audit plan in place, but there was minimal evidence of the action taken as a result of audits. Results were not corroborated, and data could not be scrutinised to a level that would allow for impact upon patient care.

There was a backlog of assessments against NICE guidance. The organisation did not have full assurance that they were compliant with evidence-based guidance.

Medicines

Medicines leaders were part of the trusts governance systems at care group level to ensure that medicines priorities were communicated effectively. Medicines governance processes were in place with clear reporting lines between committees, key medicines committees were quorate and well represented. Medicines service level agreements were monitored through appropriate committees this included reviews of the outpatient pharmacy service and homecare.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively. We were not assured the board had sufficient oversight and focus on the operational risks or had effective systems to ensure learning from incidents were shared with actions implemented. The trust did not always identify or escalate relevant risks and issues or identify actions to reduce their impact. The trust had plans to cope with unexpected events.

Risk

The board assurance framework (BAF) was linked to the trust strategic objectives and contained 11 risks reflected in the corporate risk register (CRR). However, the BAF constituted a long list of actions which were not tracked. Actions were not measurable and the BAF did not reflect risk appetite within the organisation. These issues with the BAF had also been identified within a well led review commissioned by an external organisation but had yet to be addressed.

The level of assurance provided by the BAF was low, 8 out of 11 risks on the BAF having limited assurance and only 3 having reasonable assurance. The BAF was reviewed quarterly and updated annually and had been recently reviewed in June 2023; with 3 new risks from the CRR being added. However, older risks had not been updated or cleansed as part of this process. It was not clear how the BAF was being used to inform strategy development.

The CRR recorded risks with an initial score of 15 or above. There were in excess of 65 risks in the document and we were not assured that these risks were being appropriately managed due to their high number and lengthy narratives. It did not appear that risks were appropriately downgraded when mitigations had been put in place. This meant there were old out of date risks on the register, for example those that had been mitigated over 3 years ago to much lower risk scores. Some risks had ongoing actions and it was not clear why timescales were so protracted over several years. Some

risks had gaps of over two years between review dates and we were not assured they had been adequately overseen in this time period. Risks were also not clearly articulated and defined. Controls were long lists of narrative, with no clear actions or timescales for completion. Given that this document was difficult to track and review we were not assured that it was given adequate scrutiny and oversight.

The trust had a risk management policy and strategy which outlined the trust's approach to risk appetite. Within care groups, risk registers were co-ordinated by the leadership team. Each speciality held their own risk register with risks being owned and mitigated at the lowest level. Risk registers were discussed at governance meetings. Any risk with a score of 15 or above was reviewed at the monthly risk management committee. As all risk registers were being escalated and not downgraded at lower levels the volume of risks at risk management committee was too large to give them all adequate scrutiny.

There was no accountability framework for care groups to monitor performance on action plans or mitigating risk. Senior leaders told us they were not confident that managers throughout the trust had adequate risk management training which impacted upon the consistency with which risk was recorded.

Estates risks were not considered separately despite the estate's challenges within the organisation. However, the trust had set up a new estates and procurement committee to support this. Estates risks were reviewed in the emergency preparedness, resilience and response (EPRR) group. Fire safety documentation was in date and fire plans were signed off in accordance with the fire safety policy.

Incident reporting and oversight of incidents

We reviewed 6 serious incidents (SI) and tracked the investigation and learning from these. Investigations were completed within reasonable timescales with the average taking approximately 3 months from the time of the incident.

Documentation for serious incidents was held within an electronic system and information was stored in separate parts of the system. The initial information supplied did not contain evidence of the trust's compliance with Duty of Candour (DoC) (a legal requirement for trusts to say sorry when things have gone wrong); although this was supplied following the inspection and records showed communication with families had happened and that the DoC requirement had been fulfilled.

SI action plans did not contain evidence of timescales for completion and did not link to the early learning identified with 72-hour reports. We were not assured the tracking of progress on action plans was robust There was limited evidence of shared learning from SIs, and we found that senior leaders were not always aware of themes and trends from SI reporting. Prior to our inspection we were made aware of incidents which had to be retrospectively reported as SIs due to being missed by the usual trust processes.

Falls, pressure ulcers and Healthcare acquired infections (HCAI)

We were not assured that the trust had full oversight of the incidence of falls and level of harm within the organisation. Prior to our inspection, CQC raised with the trust that the numbers of falls being reported appeared to be low. The trust had carried out a deep dive into the reporting of falls and pressure ulcers. They had found some falls with harm which should have been reported as serious incidents and had identified that the process for reporting a fall as an SI was not robust. The trust could not account for the low numbers of falls with harm and there did not appear to be a link to strong working practices to reduce falls.

Our findings

The trust had a reduced number of falls with harm, but they were unable to confirm to us whether this was due to a backlog of incidents being uploaded to the electronic system. There had been an increase in reporting falls overall since the deep dive. As part of the work on falls the trust had held a falls symposium and shared good practice and key staff had been identified as fall leads. Following a fall with harm, the team involved in the patient's care carried out a fact-finding assessment. The outcome of this was presented to the slips, trips and falls group and learning and actions were added to the trust wide improvement plan.

In line with commissioner guidance, the trust were only reporting grade 4 and unstageable pressure ulcers (PU) as potential SIs. Given that processes were not always robust for the reporting of SIs within the organisation we could not be assured that all PUs that required SI investigation were given the appropriate level of scrutiny.

For all category 3 / 4 / unstageable PUs and deep tissue injury within the in-patient wards/departments, damage was reviewed by the tissue viability team (TVT) who supported the clinical area to commence an investigation alongside a safeguarding review tool. On completion of the investigation, the main findings/lessons learned were presented by the department staff at the monthly tissue viability steering group meeting. This meeting was attended by the head of nursing for patient safety and clinical quality, matrons, safeguarding leads, TVT and governance facilitator.

The number of hospital acquired HCAIs for clostridium difficile had reduced within the current year compared to last year, by 4 cases. The number of community acquired cases remained static. Performance for clostridium difficile was below trajectory. There had been 3 MRSA bloodstream infections, all of which were community onset.

There had been 26 hospital onset MSSA bacteraemia cases, an increase on the previous year's performance and above national average. E Coli infections were falling but still above national average. The infection prevention nurses completed post infection reviews which were discussed at the fortnightly IPC team meeting. Outcomes including actions to be addressed were sent back to the clinical area and actions were tracked in care group governance meetings.

We did not see robust action plans to address trends in IPC incidences, for examples estates issues were identified in several incidences, but there was no co-ordinated action plan to address these issues across the organisation. There was a draft IPC plan due for sign off but this only addressed new build areas in terms of estates. There was also limited evidence that learning was shared across the organisation as a result of post infection reviews.

There was a water safety policy which was in date and reviewed by the water safety group. The water safety group reported into the IPC committee and was responsible for ensuring the policy was adhered to.

Deteriorating patient

There had been a trust wide National Early Warning Score (NEWS2) audit which showed poor compliance to the NEWS2 policy and escalation at both hospital sites. Recording and compliance with NEWS2 and sepsis tool use was monitored monthly by each clinical area. The audit results were reviewed at the deteriorating patient and sepsis group on a quarterly basis. Improvement actions were managed within the departments and care groups. There was no trust wide action plan although this had been recommended internally.

The trust had a commissioning for quality and innovation (CQUIN) to achieve 60% of all unplanned critical care unit admissions from non-critical care wards of patients aged 18+, having a NEWS2 score, time of escalation, and time of clinical response recorded. This was being met with the trust achieving 66% for the quarterly average.

Our findings

Compliance with Paediatric early warning score (PEWS) was not reviewed in the deteriorating patient meeting. The trust did not record response times for the critical care outreach team (CCOT).

Safeguarding

The safeguarding report went to the safeguarding group quarterly. This meeting was chaired by the chief nurse and attended by associate directors of each care group. This group reports into the quality, improvement and safety group and an annual report was sent to the board. The trust's safeguarding policy was in date. However, the trusts female genital mutilation (FGM) guidance was out of date by 12 months, the trust told us this was due for review.

The trust had no substantive looked after children specialist nurse however, there were interim arrangements in place. The head of service provided support and mitigation in the absence of the interim support. The safeguarding team provided 5 days a week support to the trust and had recently used communications to raise awareness of their team. The team had seen an increase in the numbers of referrals in the last 12 months. There was still work to do to engage medical staff with the team.

The safeguarding team had examples of working outside of their immediate roles to support safeguarding within the trust, for example working with asylum seekers and implementing prompts to identify potential victims of abuse within the emergency departments. They also audited mental capacity assessments (MCA) and deprivation of liberty safeguards (DoLs), incidents and training compliance across the trust. They also reviewed cases where there may have been missed opportunities for learning.

Operational performance

Operational performance, particularly for elective care and cancer waits was improving. The interim chief operating officer had a strong emphasis on empowering teams to address performance issues themselves rather than relying on external support and that was beginning to have impact. The trust was utilising mutual aid across the north east and Yorkshire and Humber regions.

The trust had been receiving national support for its cancer performance, but this had been removed. Cancer patients waiting more than 62 days had reduced from a peak of 420 in May 2022 to 93 by the end of 2022.

The trust met targets to eliminate both 104-week waiters and 78-week waiters. The 2023/24 plan set a priority to eliminate 65-week waiters by March 2024 and the trust was on plan to deliver this In June 2023, the Trust had 107, 65 week wait open pathways. There was a trajectory in place and the trust was ahead of plan. However, there was an increasing trend in volume which was having to be managed. Theatre utilisation was still an area of concern and work with senior doctors was being initiated to address this.

Following the Covid-19 pandemic, the trust's diagnostic waiting list reached a maximum size of 14,315 with 53.6 % of patients waiting over 6 weeks for their diagnostic test. The waiting list has been reduced to 9,419 in June 2023 with 17.5% of patients waiting more than 6 weeks for their diagnostic test.

The Trust had secured capital funding for the development of a community diagnostic centre which was due to be operational from January 2025. In addition to this, the trust has secured support in principle to a short-term business case to support and build a new endoscopy unit at the Cumberland Infirmary. These developments were hoped to improve the sustainability of diagnostic capacity for patients.

Our findings

There was an agreed process for clinical harm reviews, but the policy did not have a review date. The harm reviews covered all patients with a 52-week breach or 104 day cancer wait. There were backlogs in clinical harm reviews, but these were monitored and a plan was in place to review all cancer cases to reduce the backlog to zero for non-open pathways. 52 week clinical harm reviews remained a pressure to the trust although performance was improving. Data from May 2023 showed that of 871 reviews were required, 443 were complete with 0 major harms identified and 25 moderate harms. There were some specialities with larger backlogs of harms reviews such as gynaecology, urology and dermatology which posed an unknown level of risk within these services.

The trust had not begun any work to look at high risk groups of patients who were waiting or to consider health inequalities. They had employed a public health consultant to begin this work.

Acute services faced significant flow pressures, predominantly due to the numbers of patients who no longer met the criteria to reside but could not be discharged pending the provision of social care. As a result, emergency departments had periods of congestion with challenges around ambulance handover time as well as the length of time patients remain in the department following a decision to admit.

The trust had been working with their own community teams and the primary care networks (PCNs) to improve both admission avoidance and community support on discharge. The trust had also strengthened their internal escalation and oversight of flow as well as working with clinical staff to explore bottle necks and unnecessary internal delays.

The trust had business continuity plans contained within the emergency preparedness, resilience and response policy which was up to date and fit for purpose. There was also a major incident framework in place which was up to date.

Medicines management

The medicines safety officer was embedded in the trust governance groups. Incidents were reviewed daily and passed to care groups for collaborative actions and shared learning. The medicines safety officer was engaged on a regional and national level. The pharmacy risk register was reviewed through pharmacy governance group with risks monitored and escalated to wider trust risk management group as required. The chief pharmacist knew who to escalate risks to and was able to challenge trust wide risks when required.

Finance

In 2023/24, the Trust's plan showed a planned deficit of £51 million which assumed that all of the top-up income is recurrent, and all of the Elective Recovery Framework (ERF) income was recurrent. The planned deficit in 2023/34 was predicated upon achieving cost improvement savings and delivering on 113% activity under the ERF.

The Trust was forecasting to deliver on the 2022/23 financial plan. The finance committee's annual effectiveness report to the board had been delayed. We were not assured the finance committee understood its role regarding estates and procurement to avoid any duplication or omission of responsibilities with the new estates and procurement committee. The audit and risk committee had been invited to review the annual governance statement before its publication, but this had not been recorded as noted or discussed by the committee. In future, the Audit & Risk Committee had been asked to be part of the review process.

Information Management

Our findings

Staff could find the data they needed, but not always in easily accessible formats that helped them understand performance, make decisions and improvements. The information systems were not all integrated and security was a risk.

Prior to the current director for strategy taking on Information Technology (IT) as part of their portfolio 6 months previously, the trust did not have sufficient focus upon IT at board level. The director was supported by an associate digital manager, but this post did not historically have any link into senior management. There was also support from an experienced external director which was funded for 1 day per week.

NHS digital had recently completed a digital maturity index in which the trust score 1.9/5, with a regional ICS average being 2.9. There was a vacancy for the chief clinical information officer (CCIO) which was being covered by the MD and was out to recruitment. Prior to this recruitment the CCIO was only allocated 1 planned activity (PA) the equivalent of half a working day to discharge this role. It was recognised that this was insufficient. There was no chief nurse information officer (CNIO) but this was being planned as part of the trust's investment into an electronic patient record (EPR).

The trust had an approved business case for the EPR and was planning to go out for procurement. The EPR would then provide interoperability with the regional wide care record across secondary, community and primary care. The trust currently had a combination of paper and electronic records and where they had electronic records these were not consistent across specialities, for example different systems were used in maternity and emergency departments. We saw during our core service inspection that this impacted upon being able to adequately track patient's care records.

The trust were implementing an electronic prescribing system for medicines administration (ePMA) but this was not rolled out to both hospital sites and did not include paediatrics or out-patients which are high risk and high volume respectively for medicines prescribing. The trust was behind target on the scanning of paper medical records due to issues with coding of records from the two trusts prior to acquisition.

The trust had a digital strategy to strengthen the digital infrastructure and improvements to data. However, the trust was still working with legacy systems in some areas which provided some issues with data completeness. The trust did not have an integrated performance management system and the Information Performance Report (IPR) did not contain quality and safety metrics only performance targets in relation to productivity and waiting times. Business intelligence was impacted by the lack of data with poor forecasting. Information provided by the trust for quality and safety oversight only contained information for the electronic reporting systems for incidents and risk. This was not correlated or triangulated with any other performance data.

The pharmacy department had a variety of key performance indicators (KPI) for the medicines service, although KPI data showed several areas were below the target, plans were in place in the strategy and in the developing workforce plan to address this.

The trust had different systems for staff management. Whilst the trust had implemented dashboards for managers which showed team sickness, mandatory training in some areas, doctors for example were not on e roster and used a bespoke system. There were issues with this system suffering outages and poor functionality.

Cyber security was not strong, as the trust was running on an older operating version and was not yet on the more secure NHS mail system. Although an approved project plan was in place to update operating systems.

Our findings

The senior information risk owner (SSIRO) worked with the Caldicott guardian and head of information governance to ensure information governance was reviewed. There had been incidents reportable to the guardian's office and there had been an internal information governance breach which had been dealt with through HR processes.

Engagement

Leaders were beginning to actively engage with patients, the public and local organisations to plan and manage services. Engagement with staff and the public was not yet robust. They collaborated with partner organisations to help improve services for patients, in response to pressures.

The trust did not have a patient and public engagement policy, but a plan had been developed which mapped the current position and outlined actions. However, the plan only ran until 2022 and we did not see further evidence of work ongoing or analysis of what had been achieved into 2023. Actions such as developing dashboards for use in care groups and gathering proactive data had not been achieved.

The patient experience team carried out local surveys but there was limited evidence of this being routinely shared through the organisation. We did not see evidence that patient experience was fed robustly into the subcommittees of the board. The team carried out bespoke surveys at the request of local teams and conducted discharge and post discharge surveys.

Patient and public involvement (PPI) was immature within the trust. The trust had recruited a patient safety partner in line with the move to PSIRF. There was a patient panel which attended the patient experience forum, patient information advisory group and visits to clinical areas. They were also becoming involved in digital innovations.

The patient experience team were updating all services to include questions on equality, diversity and inclusion following the publishing of the NHS Equality Delivery System 2022. Once the new collaboratives were in place, they would be allocated a member of the patient experience team to ensure they all had feedback surveys in place and to assist in compliance and monitoring themes. There were some initiatives based upon patient feedback such as the reduction of noise at night and the quality of food.

Results of the CQC 2021 inpatient survey showed, in terms of indicative national comparisons, 44 indicators scored about the same as the national average and 3 score better or somewhat better than the national average. There were only 6 results which were worse in 2021 compared with 2020 with 33 showing no statistically significant change and 2 showing improvement.

The trust had implemented the accessible information standard (AIS). The trust's website contained accessibility information including where there were known accessibility issues and a contact address to raise concerns. The trust had been rated the top out of 214 trusts for its website accessibility by an external organisation. For patients who required reasonable adjustments there was guidance in place to record this within their medical record. There was a patient information advisory group which produced procedures for the production of information for patients, including the importance of accessibility.

The trust did not always communicate in the most accessible format for staff. For example, staff received communications only by email, even when their working practices meant they often did not have time to access their emails prior to starting clinical shifts. The CEO delivered a key message communication each week which was attended by a representative from each clinical team. We were not assured however this was fed back to staff.

Our findings

The trust was building a network of people promise champions who would support employee engagement and experience. Following on from the work in local teams around the national staff survey, the trust wanted to establish more listening opportunities and increase responses to feedback.

There was a nursing, midwifery and AHP board meeting where professional issues were discussed, and this was chaired by the chief nurse. The trust also ran a programme of patient safety learning forums. These sessions were recorded and available for staff view if they were unable to attend the meeting.

There had been historical issues between the trust and local communities and local authorities (LA) following the trust acquisition and the potential impact upon services across the area. The LA had just recently split to form two different authorities. The trust was however, developing its partnership role within the integrated care system (ICS). Most of the work had been in relation to how the system could support the trust in improving flow through the trust's services. This had led to closer working with the local authority to discuss particularly complex discharge cases. There were daily huddles on both main hospital sites with partners from the local authorities and there were weekly multidisciplinary team meetings with partners across the integrated care communities to discuss complex cases for service users both in acute and community care settings.

The trust was beginning to look at options for sharing workforce and support to social care and bank heath care assistants were already able to book shifts in 2 local care homes. The trust also provided community services which was aligned with the local primary care networks (PCNs) and community health teams.

Recent initiatives had included working with the PCNs on health pathways, there were 296 live pathways which guided clinical staff on the management of specific conditions and signposted them for referrals across the system including community and acute. Community teams had also several projects which supported patients to stay at home and were suitable for the rural locations covered by the trust.

The chief pharmacist and leads for clinical areas were involved in local and national networks to support their development of the service. The pharmacy service was able to seek feedback for key services such as homecare and the dispensary however this had not been fully utilised to ensure service met patient's needs.

Learning and continuous improvement

Systems and processes for continually learning and improving services were beginning to be embedded. Learning from complaints and incidents was variable across the trust. There was some evidence of innovation, particularly in the trust's community teams.

The trust used 15 step methodology approach to quality improvement (QI) but it was still very much in its infancy. At the time of our inspection only 350 staff had received training in the quality improvement methodology. Senior leaders described pockets of innovation, but these were not at scale or measured for impact or timescales.

The trust had aspirations to further utilise IT to support services delivered in a rural location. A pharmacy robot that was procured to support medicines supply to the trust's community locations became active from April 2023. The robot had also streamlined dispensing at the West Cumberland Hospital and plans were in place to increase its use across the trust.

The trust had an underpinning quality strategy, dated January 2021, which aligned to the wider system strategy. The aim was to address 10 areas of improvement identified by the trust from a variety of patient safety intelligence sources:

Our findings

• Prevention of Acute Kidney Injury

• Improve pathways for patients lacking capacity to consent

• Effective discharge summary

• Improve patient involvement in their care

• Effective modern ward rounds

• Improve results and follow-up

• Falls

• Nutrition and hydration

• Personal care and oral hygiene

• Infection prevention and control

These priorities were reported to QIS on a quarterly basis and formed part of the quality account. However, the report did not contain measurable targets, outcomes or timescales. Some descriptors, of actions taken were, vague and difficult to scrutinise, for example, for discharge summaries the report to board for quarters 2 and 3 stated; 'The completed audit showed that the standard of summaries was high, but areas requiring improvement have been highlighted. Anecdotal evidence suggests real progress has been made, although it is difficult to quantify.'

Some updates were very brief despite the reporting period covering 6 months from June to December 2022 and there was no update for IPC. The quarter 4 report did contain IPC updates but only for clostridium difficile numbers.

In some cases, there was limited evidence that actions had resulted in improvements or that improvements made had been sustained. For all 10 areas actions were long lists of actions with no measurable outcomes or timescales.

The trust had a green sustainability plan, there was a board member responsible for net zero targets and the plan. There was also a network of staff champions to support this work.

Performance on complaints was variable across care groups, with an average performance of 70% of all responses being sent within 30 days for the core services we inspected. Due to extreme operational pressures between December 2022 and January 2023 the target had been increased to 40 days, but we did not see evidence of how this was monitored in the trust at the time. In some ward areas no complaints responses were meeting the 30 day target. We were not assured that scrutiny to adherence to complaints response times was applied across the trust. Acknowledging complaints performance was better in the core services we inspected with only 1 out of 225 complaints missing the target of acknowledgement within 3 days.

We reviewed 6 complaints and in all cases the responses were poorly written, contained medical jargon and often did not address the points raised by the complainant. Two of the complaints we reviewed had been significantly delayed in

Our findings

the response being received by the complainant and there was evidence to show that complainants were unhappy with responses, but nothing had been followed up by the trust. However, 87% of informal complaint cases handled by the patient advice and liaison service (PALS) were recorded as the service user being satisfied with the response they had received.

The trust had implemented digital solutions such as virtual ward rounds in care homes, remote virtual assessment and monitoring of wounds and pressure ulcers and electronic patient held maternity records.

Community staff were also upskilling to support admission avoidance for patients with leg ulcers, those requiring intravenous fluids and those requiring minor surgeries.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ➔➔ Nov 2023	Requires Improvement ➔➔ Nov 2023	Good ➔➔ Nov 2023	Requires Improvement ➔➔ Nov 2023	Requires Improvement ➔➔ Nov 2023	Requires Improvement ➔➔ Nov 2023

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

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute locations	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Overall trust	Requires Improvement ➔➔ Nov 2023	Requires Improvement ➔➔ Nov 2023	Good ➔➔ Nov 2023	Requires Improvement ➔➔ Nov 2023	Requires Improvement ➔➔ Nov 2023	Requires Improvement ➔➔ Nov 2023

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Cumberland Infirmary	Requires Improvement ➔➔ Nov 2023	Requires Improvement ➔➔ Nov 2023	Good ➔➔ Nov 2023	Requires Improvement ➔➔ Nov 2023	Requires Improvement ➔ Nov 2023	Requires Improvement ➔➔ Nov 2023
Penrith Community Hospital	Requires improvement Sep 2023	Not rated	Not rated	Not rated	Good Sep 2023	Good Sep 2023
West Cumberland Hospital	Requires Improvement ➔➔ Nov 2023	Requires Improvement ➔➔ Nov 2023	Good ➔➔ Nov 2023	Requires Improvement ➔➔ Nov 2023	Good ➔➔ Nov 2023	Requires Improvement ➔➔ Nov 2023
Overall trust	Requires Improvement ➔➔ Nov 2023	Requires Improvement ➔➔ Nov 2023	Good ➔➔ Nov 2023	Requires Improvement ➔➔ Nov 2023	Requires Improvement ➔➔ Nov 2023	Requires Improvement ➔➔ Nov 2023

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for Cumberland Infirmary

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement →← Nov 2023	Requires Improvement ↓ Nov 2023	Good →← Nov 2023	Requires Improvement ↓ Nov 2023	Requires Improvement →← Nov 2023	Requires Improvement →← Nov 2023
Services for children & young people	Good Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018
Critical care	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
End of life care	Good Mar 2017	Requires improvement Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Outpatients and diagnostic imaging	Good Mar 2017	Not rated	Good Mar 2017	Requires improvement Mar 2017	Good Mar 2017	Good Mar 2017
Surgery	Requires improvement Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018
Urgent and emergency services	Requires Improvement ↑ Nov 2023	Requires Improvement →← Nov 2023	Good →← Nov 2023	Requires Improvement →← Nov 2023	Requires Improvement →← Nov 2023	Requires Improvement →← Nov 2023
Maternity	Requires improvement Sep 2023	Good Nov 2018	Good Nov 2018	Good Nov 2018	Good Sep 2023	Good Sep 2023
Overall	Requires Improvement →← Nov 2023	Requires Improvement →← Nov 2023	Good →← Nov 2023	Requires Improvement →← Nov 2023	Requires Improvement ↓ Nov 2023	Requires Improvement →← Nov 2023

Rating for Penrith Community Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity	Requires improvement Sep 2023	Not rated	Not rated	Not rated	Good Sep 2023	Good Sep 2023
Overall	Requires improvement Sep 2023	Not rated	Not rated	Not rated	Good Sep 2023	Good Sep 2023

Rating for West Cumberland Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement ➔➔ Nov 2023	Requires Improvement ➔ Nov 2023	Good ➔➔ Nov 2023	Requires Improvement ➔ Nov 2023	Requires Improvement ➔➔ Nov 2023	Requires Improvement ➔➔ Nov 2023
Services for children & young people	Good Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018
Critical care	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
End of life care	Good Mar 2017	Requires improvement Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Outpatients and diagnostic imaging	Good Mar 2017	Not rated	Good Mar 2017	Requires improvement Mar 2017	Good Mar 2017	Good Mar 2017
Surgery	Requires improvement Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018
Urgent and emergency services	Requires Improvement ➔ Nov 2023	Requires Improvement ➔➔ Nov 2023	Good ➔➔ Nov 2023	Requires Improvement ➔➔ Nov 2023	Good ➔ Nov 2023	Requires Improvement ➔➔ Nov 2023
Maternity	Requires improvement Sep 2023	Good Nov 2018	Good Nov 2018	Good Nov 2018	Good Sep 2023	Good Sep 2023
Overall	Requires Improvement ➔➔ Nov 2023	Requires Improvement ➔➔ Nov 2023	Good ➔➔ Nov 2023	Requires Improvement ➔➔ Nov 2023	Good ➔➔ Nov 2023	Requires Improvement ➔➔ Nov 2023

Rating for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement Sep 2019	Requires improvement Jul 2017	Good Jul 2017	Requires improvement Sep 2019	Requires improvement Sep 2019	Requires improvement Sep 2019
Wards for older people with mental health problems	Good Sep 2019	Requires improvement Sep 2019	Good Sep 2019	Requires improvement Sep 2019	Good Sep 2019	Requires improvement Sep 2019
Wards for people with a learning disability or autism	Requires improvement Feb 2017	Requires improvement Sep 2019	Good Sep 2019	Requires improvement Sep 2019	Requires improvement Sep 2019	Requires improvement Feb 2017
Long stay or rehabilitation mental health wards for working age adults	Requires improvement Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
Mental health crisis services and health-based places of safety	Requires improvement Sep 2019	Requires improvement Sep 2019	Good Sep 2019	Requires improvement Sep 2019	Inadequate Sep 2019	Requires improvement Sep 2019
Community-based mental health services of adults of working age	Good Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018
Community-based mental health services for older people	Requires improvement Jan 2018	Requires improvement Jan 2018	Good Jan 2018	Requires improvement Jan 2018	Requires improvement Jan 2018	Requires improvement Jan 2018
Community mental health services for people with a learning disability or autism	Good Mar 2016	Good Mar 2016	Good Mar 2016	Not rated	Good Mar 2016	Good Mar 2016
Specialist community mental health services for children and young people	Requires improvement Jan 2018	Requires improvement Jan 2018	Good Jan 2018	Inadequate Jan 2018	Requires improvement Jan 2018	Requires improvement Jan 2018

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Requires improvement Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
Community health inpatient services	Requires improvement Jan 2018	Requires improvement Jan 2018	Good Jan 2018	Good Jan 2018	Requires improvement Jan 2018	Requires improvement Jan 2018
Community health services for children and young people	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017
Community end of life care	Good Mar 2016	Requires improvement Mar 2016	Good Mar 2016	Good Mar 2016	Requires improvement Mar 2016	Requires improvement Mar 2016
Community dental services	Good Jan 2018	Good Jan 2018	Outstanding Jan 2018	Requires improvement Jan 2018	Requires improvement Jan 2018	Requires improvement Jan 2018

Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

West Cumberland Hospital

Homewood
Hensingham
Whitehaven
CA28 8JG
Tel: 01946639181
www.ncic.nhs.uk

Description of this hospital

North Cumbria Integrated Care NHS Foundation Trust (NCIC) was created in October 2019 following an acquisition of North Cumbria University Hospitals NHS Trust (NCUH) by Cumbria Partnership Foundation Trust (CPFT).

The trust provides a range of acute hospital services based at the West Cumberland Hospital (WCH) in Whitehaven.

The trust serves a population of approximately 320,000 in the west, north and east of Cumbria, in the districts of Allerdale, Carlisle, Copeland, Eden Valley and South lakes and Furness for some community services. It also provides services to parts of Northumberland and Dumfries & Galloway. The community is spread over a large geographical area, with 51% of residents living in rural settings. Over 65s make up a larger proportion of the population than the national average. Deprivation is similar to the England average and about 11,700 children (14.5%) live in poverty.

Urgent and emergency services

Requires Improvement 

Is the service safe?

Requires Improvement 

Our rating of safe improved. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff, however not all staff had completed it.

Nursing staff received and kept up to date with their mandatory training. Data showed that nursing staff had exceeded the trust target.

Not all medical staff had not kept up to date with their mandatory training. Data received from the trust showed shortfalls in all 14 modules. Overall compliance rates were 64% which was below the trust target.

Compliance rates for mandatory training for paediatrics staff were 96% which exceeded the trust target.

The mandatory training was comprehensive and met the needs of patients and staff. The trust delivered mandatory and statutory training aligned to the core skills training framework. Mandatory training subjects included Information governance, equality & diversity, fire safety, Infection, prevention and control level 1 & 2, conflict resolution, health and safety, safeguarding adults' level 1 to 3, safeguarding children level 1 to 3, moving and handling level 1 and 2, resuscitation level 1, basic life support, immediate life support, adults and paediatric and prevent awareness.

Compliance for the highest life support training had not been achieved. Data provided by the trust showed only 65% nursing, 63% of medical and 75% paediatric staff had completed advanced life support adults training. Furthermore only 60% nursing and 73% medical staff had completed advanced life support paediatric training except for paediatric staff that had achieved 100% compliance.

Only 44% of nursing staff had completed Immediate life support adults training. Immediate life support paediatric training rates were nursing 50% and paediatric 71%. During the inspection we interviewed the clinical educator who told us there were training days scheduled for staff to achieve compliance.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism, and dementia.

The trust provided data that showed that nursing and paediatric staff had completed training specific to supporting patients with mental health needs, learning disabilities, autism, dementia, and end of life.

The trust had a recognition and management of sepsis policy and sepsis screening tools were used in both adults and paediatrics, however data showed that out of 157 staff only 5 had completed sepsis training.

Staff had not completed training in de-escalation, conflict resolution or restraint.

Managers were able to monitor mandatory training and could alert staff when they needed to update their training.

Safeguarding

Staff did not always have the training on how to recognise and report abuse. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

Nursing staff received training specific for their role on how to recognise and report abuse. Data showed that nursing staff had achieved the trust target for safeguarding children level 3, however level 2 compliance was only 78%. Nursing staff had exceeded the trust target for safeguarding adult training levels 1-3.

Medical staff received training specific for their role on how to recognise and report abuse. Medical staffing compliance for safeguarding adults' level 1 and 2 were slightly below the trust target. Only 63% had completed safeguarding adults' level 3.

Only 61 % of medical staff had completed level three safeguarding children training. This was a concern and meant that not all medical staff may not recognise possible safeguarding concerns.

Paediatric staff had full compliance with safeguarding training adults and children.

Staff that we spoke with could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The service used a nationally recognised electronic child protection information sharing system. Any information received into the department was checked at the point of arrival and shared by way of a flagging system on the electronic record and by documenting on the triage paperwork.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff followed safe procedures for children visiting the ward. Entry into the Paediatric emergency department were accessible by a swipe system which was staffed and monitored 24/7

Cleanliness, infection control and hygiene

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

The emergency department areas were clean and had suitable furnishings which were well-maintained.

The emergency department generally performed well for cleanliness and cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). We saw staff did not always wash her hands before and after patient contact.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Urgent and emergency services

Environment and equipment

The design, maintenance and use of facilities, premises did not always keep people safe. Staff were trained to use them. Staff managed clinical waste well.

Patients call bells were in reach and we saw that staff responded quickly when called.

The design of the environment followed national guidance.

Staff carried out daily safety checks of specialist equipment. We observed that mostly all oxygen ports within the ED and Paediatrics had green dot sticker but no dates available to say when tested. Some did have a date on to say when service was due however the dates had expired.

We found that the vital signs monitor used in triage had not been pat tested We raised this with the nurse in charge and this equipment was removed immediately.

During the inspection, the emergency alarm had been activated in majors' area during the delivery of patient care, however at the time nobody responded as there was a fault with the alarm and it could be not heard and caused a delay in response. We escalated this immediately and the department responded promptly.

The service had suitable facilities to meet the needs of patients' families. There were dedicated relative and bereavement rooms located within the department.

We were shown a dementia friendly cubicle, however we noted that there was nothing additional in this room that we observed that would have made it dementia friendly.

We found the adults mental health room that were used to accommodate patients with mental health conditions was not fit for purpose. There were ligature points, heavy unsuitable furniture, no strip alarms, and no external windows. The room did not conform to Psychiatric Liaison Accreditation Network (PLAN) standards.

There was evidence of back-up generators receiving regular essential service and testing across both sites.

The service had enough suitable equipment to help them to safely care for patients.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff did not always complete risk assessments for each patient swiftly. They did not always remove or minimise risks and update the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. There was a clear streaming and triage process in place with all patients receiving an initial clinical assessment by a healthcare practitioner within 15 minutes of arrival. We saw examples of streaming being undertaken and the use of a nationally recognised streaming tool being used to support the process. Performance data demonstrated that greater than 70% of patients were triaged within 15 minutes of arrival.

Staff did not always complete risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. During our inspection, we saw that important risk assessments, such as venous

thromboembolism (VTE), bed rails, falls risk, SSKIN (a resource pack to aid in the assessment and care planning for people at risk of pressure ulcers) and mental health were not completed in line with trust policy. This included missing checks, incomplete checks, and unlabelled documentation. We reviewed over 20 sets of patient records and found that 15 did not have the relevant checks.

We reviewed the most recent audit data for National Early Warning Score (NEWS2) which highlighted that from January 2023 to June 2023 the audit data was not consistent with only 3 months of the 6 months available. Of the data available the range was 79% to 97%. Compliance was monitored through the deteriorating patient and sepsis group on a quarterly basis and improvement plans are monitored at department level.

We reviewed the most recent compliance audit data for Paediatric Early Warning Score (PEWS) which showed that they had consistently achieved 100% with the exception of March where they significantly dropped to below 90% in all areas. The data also identified that staff did not always record when an action had been triggered by the PEWS score. The department had already identified this as an area of improvement and was discussed at the daily safety huddles.

Staff knew about and dealt with any specific risk issues.

The department had 24-hour access to mental health liaison and specialist mental health support. staff were concerned about a patient's mental health.

Staff did not always complete, or arrange, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide at triage.

We saw evidence that staff shared key information to keep patients safe when handing over their care to others.

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

Nurse staffing

The service did not always have enough nursing staff and health care support staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers reviewed staffing levels and skill mix daily. Bank and agency staff were given a full induction.

The service did not always have enough nursing and support staff to keep patients safe.

Staff told us that there were always two registered paediatric nurses on shift this was in line with the Royal College of Paediatrics and Child Health (RCPCH) standard. We reviewed previous rosters, and this confirm that staffing was in line with national standards.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

The department manager could adjust staffing levels daily according to the needs of patients. Staffing was monitored throughout the day and managers attended meetings twice daily in relation to staffing and capacity. If additional support was required in the department, this was escalated during these meetings and where possible, additional resources were supplied.

The number of nurses and healthcare assistants did not always match the planned numbers. Senior staff told us their usual staffing was down by 1 or 2 members of staff. We saw there were gaps in the roster.

Nursing vacancy rates were around 8%.

The service had low vacancy rates, low turnover rates and low sickness rates for medical staff.

The service had low and/or reducing rates of bank and agency nurses.

Managers limited their use of bank and agency staff and requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service before any shifts being allocated.

Medical staffing

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

The service had enough medical staff and skill mix of staff to keep patients safe. The emergency department had 14.9 whole time equivalent (WTE) ED consultants that worked cross site. This had improved since the last inspection but was slightly lower than the recommended numbers set by The Royal College of Emergency Medicine Consultant Workforce Recommendations (2018), of one whole time equivalent consultant to every 4000 new attendances. The current shortfall in ED Consultant numbers was mitigated using locum ED consultants employed to work weekend shifts.

We reviewed 4 weeks data of medical staff rotas and saw the medical staff matched the planned number. Consultant cover achieved the standards of being on site for 16 hours and then provided an on-call rota for the remainder of the time by an ST4 (specialist emergency department doctor) or above.

The department had dual trained emergency consultant however, we saw that this consultant covered both adults and children.

The service had low vacancy rates, low turnover rates and low sickness rates for medical staff.

The service had reducing rates for the use of bank and locum staff.

Managers could access locums when they needed additional medical staff and made sure they had a full induction to the service before any shifts were allocated.

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

There was always a consultant on call during evenings and weekends in line with RCEM guidance.

We saw evidence of this in the thematic review of missed fractures in the emergency department.

Records

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

Patient notes were not always comprehensive; however, all staff could access them easily. We were not assured of the quality of records produced and used by the department. The department used a combination of electronic and paper documents to record care and treatment of patients.

When patients transferred to a new team, there were no delays in staff accessing their records.

We saw that records were always stored securely.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines in line with trust policy and procedures.

Staff did not always follow systems and processes to prescribe and administer medicines safely. We reviewed four patients in the departments, in three of the patients we looked at we found evidence that patients had received their medicines on time and as prescribed.

However, for one patient who was receiving treatment for sepsis we found antibiotics were not given in line with NICE guidelines. Further sepsis audit data provided to us by the trust post inspection further corroborated our findings and showed that for the time period April 2022 – March 2023 only 66 patients out of the audited 73 received intravenous antibiotics within the 1hour criteria time advised by NICE.

We found equipment to be used in an emergency were not always checked daily, for example in the emergency department we found 38 days where no record of checks had been made between 23 April 2023 – 7 June 2023.

Controlled drugs were stored securely, and stock checks were taking place. Audits on controlled drugs by the pharmacy were taking place however the frequency of this was not in line with trust policy with the last audit taking place in September 2022. We also found the audit did not relate to the Omnicell (automated dispensing medicine storage) cabinet. No audit data however was provided for the resus department.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. There was currently no clinical pharmacy service in the emergency department however all staff we spoke with confirmed that should support be required it could be obtained by contacting the pharmacy department.

Staff completed medicines records accurately and kept them up to date. Electronic prescribing (EPMA) was not in place in the urgent care department, with medicines being prescribed on to paper charts. The EPMA team we spoke with confirmed that the urgent care department would be the last place it would be implemented. This meant once patients were transferred out of the department to a ward speciality their prescribed medicines would need to be transferred on to the EPMA system by medical staff. Whilst we saw no evidence in the delay of care in the department, we did see evidence on one of the wards following a subsequent transfer from the emergency department where there was a delay in prescribing patients medicines resulting in them not being administered as prescribed.

Urgent and emergency services

Staff stored and managed all medicines and prescribing documents safely.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. We found no evidence of this whilst on inspection.

Incidents

Serious incidents which occurred within the trust were not always reported in line with national guidance. However, when things went wrong, staff apologised and gave patients honest information and suitable support. Local managers investigated incidents and shared lessons learned with the whole team and the wider service.

Data showed that between March 2022 and February 2023 the department reported 4 serious incidents in urgent and emergency care.

Staff knew what incidents to report and how to report them.

Staff now knew how to raise concerns and report incidents and near misses in line with trust policy.

Staff did not always report serious incidents clearly and in line with trust policy. We saw evidence of this in the thematic review of missed fractures in the emergency department.

All staff were aware of the duty of candour, and they understood the importance of being open and honest when delivering care and gave patients and families a full explanation when things went wrong

Staff received feedback from investigation of incidents, both internal and external to the service.

Lessons were learnt following the investigation of incidents and learning was shared with staff via emails, shift handovers and safety huddles. There were examples on display where a range of staff shared learning about serious incidents. Several staff told us they had received direct verbal feedback. Staff told us that simulation training was delivered in response to incidents. The trust conducted a thematic review of missed fractures within the Emergency Department, recommendations for changes to practice were implemented.

Staff met to discuss the feedback and look at improvements to patient care. Staff now received feedback from investigation of incidents and had the opportunity to discuss the feedback and look at improvements to patient care. From reviewing clinical governance minutes and reports we saw evidence of incidents being monitored and discussed.

There was evidence that changes had been made as a result of feedback. Following a serious incident relating to a patient transfer from West Cumberland Hospital to Cumberland Infirmary, the service developed the High-Risk Transfer policy to support decision making around patient transfer which has implemented into practise. Whilst on inspection we reviewed a high-risk patient transfer which was appropriate and timely.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We saw evidence in investigation reports were kept informed and updated.

Urgent and emergency services

The clinical team debriefed and supported staff after any serious incident.

Is the service effective?

Requires Improvement 

Our rating of effective stayed the same. We rated it as requires improvement

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff did not always protect the rights of patients subject to the Mental Health Act 1983.

Staff had access to and followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

The emergency care and medicines group participated in national benchmarking clinical audits and followed National Institute for Health and Care Excellence NICE) guidelines. Baseline assessment tools were implemented following participation in NICE guidelines 108: Decision making and mental capacity. We saw evidence of further training and protocols had been developed since participation.

We reviewed data that showed that the emergency department worked towards the ten recommendations that is set out by the Royal College of Medicine (RCEM) report how to achieve safe, sustainable care in our emergency departments.

Staff did follow and protected the rights of patients subject to the Mental Health Act and did apply and follow the code of practice.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural, and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients were given the option of hot and cold food whilst they were in the department. Staff were able to request snack packs for patients outside of mealtimes.

During inspection we observed that patients all had water jugs and cups

Patients were given a choice of food and drink to meet their cultural and religious preferences. Any specialist diets were colour coded and prepared separately and brought to the unit from the kitchen on a separate trolley. Dietary information was available that gave a breakdown of ingredients and nutritional information.

Drinks and snacks were available in the waiting room vending machines.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. However, staff did not always fully and accurately complete patients' fluid charts where needed.

Urgent and emergency services

Pain relief

Staff did not always assess and monitor patients regularly to see if they were in pain and did not give pain relief in a timely way.

Staff did not always assess patients' pain using a recognised tool and did not always give pain relief in line with individual needs and best practice.

Patients did not always receive pain relief soon after it was identified and when they needed it or requested it.

Staff prescribed but did not always administer and record pain relief accurately. We found occasions when pain relief was not given as prescribed. No rationale documented as to why prescribed doses have not been administered.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. The emergency care department took part in several national clinical audit reports in 2023 that had been completed and ratified.

Data from the Royal College of Emergency Medicine (RCEM) pain in children 2020/2021 showed that performance had significantly improved since the last audit in 2017/18 across all of the three standards, and the trust was now performing above the national standard in most areas.

Data from the RCEM infection prevention and control national report 2020/21 identified two areas of improvement. Patients who are identified as vulnerable (for example immunosuppressed) are only isolated in a side room 37% of the time. Secondly patients identified as being potentially infectious, it typically took 45 minutes from arrival in the department to being placed in isolation. This was related to prolonged triage times and limited bed capacity to isolate patients.

Data reviewed from British Thoracic Society (BTS) Outpatient management of pulmonary embolism 2021 showed that the results were in line with national results and the recommendations from the national audit would apply.

At the time of the inspection the service told us that the 2022/23 cycle of the Seven Day Standards Audit was not available.

Outcomes for patients were positive, consistent, and met expectations, such as national standards. The emergency department did provide action plans following their clinical audit programme to outline how they would action and sustaining improvement and outcomes.

Managers and staff used the results to improve patient's outcomes.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The department had a planned comprehensive audit programme.

Managers used information from the audits to improve care and treatment. Managers told us that audits were used to identify areas of learning and improvements. Results from audit were linked to the department's education and training programme.

Managers shared and made sure staff understood information from the audits. Information from audits were disseminated across the emergency department.

The service had a lower-than-expected risk of re-attendance than the England average. The trust percentage of patients that reattended the A&E department within seven days of a previous attendance was generally similar to, or lower than, the England and regional averages from March 2021 to February 2023

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. Staff had the appropriate skills and knowledge to meet the needs of the patients. All nursing staff in the ED had either completed or working towards completion of the Manchester Triage Training (MTS). Data provided by the trust showed that paediatric triage compliance was 100% and adults 94%.

All adult and paediatric nursing staff completed the Royal College of Nursing Emergency Competency framework which included face to face training sessions, simulations and included paediatric sessions.

Staff attended annual study days for adults and paediatrics which were aligned to the Royal College of Nursing (RCN) competencies. We saw evidence of scheduled training dates and courses for the next 6 months.

Newly recruited staff members completed preceptorship training framework over a 23-month period.

The department had access to specialist link nurses for dementia, safeguarding, and sepsis.

Managers gave all new staff a full induction tailored to their role before they started work. The department had a comprehensive induction which included competencies and equipment checklist. The clinical educators provided support and supervision to newly recruited staff. Staff that we spoke with were positive around the induction process and felt supported by the ED team.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. The trust did not provide data for nursing staff appraisals rates.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Appraisals rates for medical staff were 72%.

The clinical educators supported the learning and development needs of staff. The department each had a clinical educator who role was to support learning and development.

Managers made sure staff attended team meetings notes were disseminated when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Multidisciplinary working

Doctors, nurses, and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held daily multidisciplinary meetings to discuss patients and improve their care.

Staff referred patients to the Psychiatric Liaison Team (PLT) for mental health assessments service when they showed signs of mental ill health, depression, self-harm, or suicidal thoughts.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week. The emergency department was open 24 hours a day, seven days a week. Consultant cover was provided in line with RCEM Workforce Recommendations 2018.

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. The department had developed patient information leaflets as an online resource and there were posters with quick response (QR) codes around the department so that patients could look at any leaflets that might be useful.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patient's consent. Staff did not always demonstrate the correct skills to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They did not always use agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. However, we observed that this was not always applied in practice.

Staff did gain consent from patients for their care and treatment in line with legislation and guidance.

When patients could not give consent, staff told us that they would make decisions in their best interest, taking into account patients' wishes, culture and traditions.

Urgent and emergency services

Staff made sure patients with capacity to make decisions consented to treatment based on all the information available.

Staff did not always record consent in the patients' records.

83 % of nursing, medical, and paediatric staff had received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

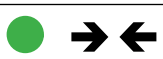
Staff that we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them.

Staff knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Policies could be accessed via the intranet and paper copies were available within the department.

Staff did not always implement Deprivation of Liberty Safeguards in line with approved documentation.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Privacy curtains were drawn when required protecting the patient's dignity.

We observed staff taking the time to positively interact and engage with patients and those close to them in a respectful and considerate way.

Patients and relatives told us staff treated them well and with kindness. During the inspection, we spoke with several patients and relatives. They told us that staff were helpful, kind, and considerate to their needs.

Staff did follow policy to keep patient care and treatment confidential.

Staff mostly understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Each member of staff was kind, showed empathy and was understanding to their needs.

Staff recognised, understood, and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs. There were posters in the department with details of religious and spiritual support that what was available for patient and how to access.

Emotional support

Staff provided emotional support to patients, families, and carers to minimise their distress. They understood patients' personal, cultural, and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed staff providing support to both patients and relatives.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. The department had a relative's room which could be used.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff had completed end of life and bereavement training as part of their induction process to help them when dealing with difficult situations. There was further additional staff training available.

Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them. Staff demonstrated that they were aware of emotional and social factors and what impact it could have. Staff could refer and signpost patients to other services and external agencies.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families, and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. We observed staff across all areas of the department explaining to patients their plan of care and answering any questions that patients asked. We spoke with several families. They told us that staff had explained what was happening and kept them updated.

Staff talked to patients in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The trust sends all patients who have attended the emergency department a SMS text message with a link to a patient experience tool which contains the friends and family questions.

Staff supported patients to make advanced decisions about their care.

Staff supported patients to make informed decisions about their care.

The feedback from the Emergency department survey test was positive. The feedback from the emergency department friends and family survey June data showed a positive response rate of 74%.

Urgent and emergency services

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. The ED service had a GP (General Practitioners) streaming pathway for ambulatory patients that presented with a primary care complaint. Appointments were provided between 9am- to 5pm. Cumbria Health on Call (CHOC) provided out of hours support appointments Monday to Friday 6:30pm to 8am and 24 hours at weekends. This is in line with recommendation 1 set out in RCEM report "How to achieve safe, sustainable care in our Emergency Departments".

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The emergency department had single bed bays for patients.

Facilities and premises were appropriate for the services being delivered.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia. Psychiatric Liaison Team (PLT) were available 24/7 for support and assessment. The department had link specialist nurses available for support.

The emergency department had systems to help care for patients in need of additional support or specialist intervention.

The service relieved pressure on other departments when they could treat patients in a day.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. The emergency department used 'This is me' and passports to support patients who had particular needs as a result of a learning disability. These booklets, owned by the patients, detailed personal preferences, likes/dislikes, anxiety triggers and interventions, all of which were helpful in supporting patients during difficult periods.

The service had information leaflets available in languages spoken by the patients and local community. Information for patients was available in a range of formats, including easy read information and large print.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Access to translation and interpretation services were available. Sign language interpreters could also be provided for patients with hearing or speech-impairment who required a qualified communicator, 24 hours a day.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Access and flow

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

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets.

In March 2022 to December 2022 the trust averaged 8,800 attendees per month however in January and February 2023 this dropped below 8,000. There has been an increase in March 2023 to 8,731, which replicated the trend the previous year.

West Cumberland Hospital consistently saw the percentage of ambulance handovers taking more than 60 minutes generally under 5% except for December 2022 which saw a spike to 15%. This spike was also seen across the whole Northwest Ambulance Service, likely as a result of winter pressures across the NHS.

The trust's median time from arrival to initial assessment was consistently shorter than the England average from March 2021 to June 2022. Between June 2022 and October 2022, the trust did not submit data. Once they did start to resubmit, performance was longer than the England average however has improved in the last two months, seeing a return to national average.

Trust data showed that 70% of patients were seen within 4 hours in May 2023.

Managers and staff worked to make sure patients did not stay longer than they needed to.

The number of patients leaving the service before being seen for treatments was low. The percentage of the trust's patients that left the ED before being seen for treatment was consistently lower than the England and regional averages for the last two years.

Data showed in February 2023 the trust percentage was 2.8% compared to the England average of 4.8% and regional average of 5.3%.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs, however they experienced significant challenges relating to access to other services for discharge.

The trust's percentage of patients waiting more than four hours from the decision to admit to admission increased (deteriorated) considerably from 36.0% in June 2022 to 60.8% in December 2022. This was much greater than the increase in the England and regional averages over the same period (from 35.0% to 44.1%). Since December this has improved but remains higher than both the England and the Northeast average.

There was a considerable increase in the number of the trust's patients waiting more than 12 hours from the decision to admit to admission from 199 in June 2022, to 728 in November 2022. This figure has declined since then but as of March 2023 is at 439. Overall, the last 12 months have seen an upward trend.

Staff supported patients when they were referred or transferred between services.

Urgent and emergency services

Managers monitored patient transfers and followed national standards.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives, and carers knew how to complain or raise concerns details of how to make a complaint were displayed in patient areas.

Staff told us that they understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. Complaints were investigated by the care group and assigned an investigating officer.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. We saw evidence that learning from incidents were disseminated across the team.

Staff could give examples of how they used patient feedback to improve daily practice. Staff that we spoke with could provide examples of complaints and what changes had occurred.

Is the service well-led?

Good 

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The department leaders had the relevant skills, knowledge, experience, and integrity to run the service.

The emergency department was part of the Emergency Care and Medicines care group. The care group had an associate director of nursing, associate medical director and an associate director of operations. Beneath this, was the service triumvirate team which comprising of a clinical director, matrons, and managers.

The care group met weekly and monthly to review operational oversight of risk, challenges, performance, and learning.

However, we found examples on inspection where processes were not undertaken in line with trust and national guidance which had been highlighted as concerns at the last inspection. We identified ongoing issues with restraint training, the use of restrictive practices and environmental issues. We were not assured that leaders had addressed all the key concerns highlighted at the last inspection or had sufficient oversight of their progress to date.

Staff told us that at service level the triumvirate team were visible, supportive, and approachable, however the senior leadership were not widely recognised across both sites.

Staff told us the clinical director and consultants were very supportive to the ED medical and nursing team.

Staff were supported to develop their knowledge and skills and take on more senior roles.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

There was a clear vision in place which was on display within the emergency department to provide safe, high, quality care for every patient every time. The vision encompassed 4 values which included kindness, respect, ambition, and collaboration.

The service had a number of strategies that supported the trust vision.

The trust did not have mental health strategy; however, they had a service level agreement with another mental health trust.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear, however staff felt that not all managers and leaders were open and responsive.

Staff continued to display resilience following the impact of the COVID-19 pandemic and wider system pressures. Despite the challenging circumstances, staff were positive about working within the emergency department and praised the teamwork and educational ethos.

Frontline nursing and medical staff described a positive working relationship with each other, and they were proud to work for the organisation.

Staff told us that the local leadership team were visible and supportive.

Staff felt listened to by the senior leadership team and had regular meetings to facilitate discussion and raise any issues.

We reviewed the data from the national staff survey 2022 result which were disappointing. Results highlighted emergency care and medicine staff were at risk of burnout and required wellbeing support. Action plans have been developed.

The occupational health and wellbeing service provided an opportunity to reflect safely with colleagues, within their own team, on the challenges and experiences they had been facing.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Senior leaders and senior staff had clear roles and responsibilities for managing risk and incidents outlined in the emergency care and medicines group governance framework.

The emergency department appointed a consultant as the governance lead which included mortality. We reviewed the minutes from the emergency department clinical governance monthly meetings from March, April, and May 2023 which detailed a clear agenda and ownership of action points.

Information boards within staffing areas clearly displayed specific learning and development requirements, as well as outcomes from departmental audits which served as visual aids for staff members.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The emergency department had a risk register. We spoke to departmental leaders and staff, and they told us about their risks on the register and the strategies they were taking to address the concerns, however some of the risks they told us were not on the risk register.

The trust had a major incident framework which detailed how to appropriately respond to internal and external declared critical or major incidents which was in date and version controlled.

The trust had an electronic central alert system (CAS) policy and procedure to communicate and disseminate important patient safety and device alerts information.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

During our inspection we found safeguarding information was recorded on both paper and electronic patient records. We found inconsistent recording of information which did not always correlate. This meant data was not always accurate in providing an overview of service activity and performance to ensure informed and effective decisions could be made to improve the service.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.

Urgent and emergency services

The emergency care and medicines group clinical governance disseminate a newsletter to all staff to publish key messages, patient experience and learning and quality improvement.

The emergency care and medicines group engage with staff by arranging away days, lunch and learn events for example following incidents around specific areas such as safeguarding.

The emergency department also received thank you cards and messages which staff were informed about when it was a personal compliment.

The trust continued to work hard to improve the patient experience when accessing the service. This was based upon listening to patients and gathering feedback to align service delivery with the needs of the local population and to ensure the highest possible standards of care were being delivered.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

The department was committed to quality improvement by addressing incidents and complaints to improve patient safety.

The emergency department clinical educators had taken steps to promote a learning culture which adhered to both RCEM and NICE guidelines.

We spoke with the quality lead for the department who told us that staff were encouraged to lead on quality improvements projects and develop initiatives and further learning.

The trust had a quality improvement strategy delivery plan which focused on 10 quality improvement initiatives for 22/23.

Medical care (including older people's care)

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory Training

Although the service provided mandatory training in key skills to all staff, not all staff members ensured they kept their training records up to date.

Not all nursing staff kept up to date with their mandatory training. Data provided by the trust highlighted showed the most significant shortfalls within basic life support training (lowest compliance rates between 50% and 81%), immediate life support training (lowest compliance rates between 43% to 72%) and moving and handling level 2 training (lowest compliance rates between 68% and 77%)

Most medical staff kept up to date with their mandatory training. However, there were some shortfalls with the completion of fire safety awareness training, infection prevention and control training, annual basic life support training and immediate life support training within the medical division.

However, managers were able to monitor mandatory training and could alert staff when they needed to update their training.

The mandatory training was comprehensive and met the needs of patients and staff.

The trust provided us with evidence following our inspection which showed staff completed training specific to supporting patients with mental health needs, learning disabilities, autism and dementia.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing staff received training specific for their role on how to recognise and report abuse. However, at the time of the inspection there were some shortfalls noted across some of the wards with some compliance rates varying between 50% and 100% for levels 1 safeguarding adults training across a range of wards. Completion rates for safeguarding adults level 2 training varied between 57% and 100% and safeguarding children level 2 training between 13% and 100%.

Medical staff received training specific for their role on how to recognise and report abuse and at the time of the inspection, compliance rates for safeguarding training were generally in-line with trust targets. However, there were some shortfalls with PREVENT awareness training and level 2 safeguarding children training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Medical care (including older people's care)

Despite some shortfalls in training compliance rates, staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. However, on the wards we visited as part of the inspection, we did not always see safeguarding information and guidance on display for both patients and staff.

Cleanliness, infection control and hygiene

Although staff used equipment and control measures to protect patients, themselves and others from infection and kept equipment and the premises visibly clean, the service did not always follow infection preventions and control guidance in regards to suitable storage of materials to enable thorough cleaning of the premises.

Ward areas we visited were clean and had suitable furnishings which were clean and well-maintained.

The service performed well for cleanliness and cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

The trust provided us with up-to-date versions of the policy for decontamination of reusable medical devices which was scheduled for review in June 2027.

Trust-wide IPC standards were consistently high with most wards achieving over 90% compliance with COVID-19 and clostridium difficile (CDiff.) audits. Where IPC action plans had been developed as a result of issues highlighted within audits, we saw evidence of progress made against these objectives to improve standards of IPC. Although general standards of cleanliness and IPC adherence were positive, data supplied by the trust highlighted inconsistencies with the submission rates for IPC audits over the entire medical division, with only four wards within the entire trust having a submission rate of 90% and above for May 2023.

All wards had access to hand gel on entrance with relevant guidance on promoting high levels of hand hygiene. We also saw multiple examples of signs displayed outside ward side rooms reminding staff about standard precautions of hand hygiene, effective cleaning and use of PPE for infection, prevention and control for patients who were infectious.

Staff mostly followed infection control principles including the use of personal protective equipment (PPE). However, during the inspection we saw storage of some consumable items in large boxes which was not in-line with infection control guidance, as they had been placed on the floor within stock cupboards instead of designated shelving.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff managed clinical waste well, however hazardous substances and sharps products were not always stored safely.

During the inspection we observed storage doors left open on most wards we inspected. Doors had digi-locks in place; however, we found that most doors were either left propped open or unlocked. Storage rooms contained consumables for the wards including, sharps, venflons and intravenous fluids (IV). We also found sluice rooms and storage rooms that stored substances such as alcohol solutions and cleaning products were left unlocked. Hazardous cleaning fluids were stored on work surfaces in the sluice rooms in large containers ready for use.

On multiple wards we saw several bottles of chemical cleaning solution stored on trollies in corridor areas. This was used for the cleaning of equipment, however, should be stored in locked storage cupboards, in-line with control of substances hazardous to health (COSSH) guidelines. This was a safety risk as patients and visitors had free access to the unlocked storerooms where these potentially hazardous items were stored. Some patients on the wards were vulnerable with the potential for episodes of confusion and delirium.

On one ward we visited there had been a recent incident reported where a patient had gained access to one of the storerooms and had been able to access clinical sharps. On this same ward we found maintenance equipment (a mallet and drill) which had been left unattended on a workbench in one of the unlocked storage cupboards which patients could easily access.

We escalated our concerns to senior leaders on the day of inspection. However, we were not fully assured of safe and effective practice surrounding the storage of hazardous chemicals and sharps products prior to our inspection.

Whilst on-site we highlighted concerns regarding the location of one particular medical ward on-site, specifically in regards to the distance it was located away from the main hospital building should a patient require an urgent support from the resuscitation crash team.

Staff based on the same ward also told us that there had been some difficulties with the volume of the emergency buzzer system, impacting upon staff ability to respond to emergencies.

We escalated our concerns during the inspection with the senior leadership team for medicines, who told us that environmental audits were undertaken routinely and agreed that our concerns would be reviewed and actioned accordingly. We were also provided with assurances regarding the ability of the resuscitation crash team accessing all wards in a timely manner and that the issues with the emergency call bell had been due to the wrong button being pressed and staff training had been provided in response to this.

On the wards we visited, most patients could reach call bells and staff were able to attend in a timely manner. However, there were multiple patients on one of the higher acuity wards who were unable to reach their call bells and did not know what the call bell was used for.

However, all departments within the hospital were clearly signposted and easy to find and entrances onto all of the medical wards were covered by an intercom service.

Although there were some concerns with the inappropriate storage of items in clean utility cupboards, all of the ward areas visited were tidy and clutter free.

There were dedicated relatives' rooms located either within or within close proximity of the wards we visited, all of which were suitably furnished and visibly clean, most of which provided access to a water cooler.

The service had enough suitable equipment to help them to safely care for patients and staff carried out daily safety checks of specialist equipment such as hoists.

We saw multiple resuscitation trolleys across a range of wards. All of which were suitably cleaned and maintained. Safety check logs for the resuscitation trolleys were requested from the trust post-inspection due to there being no historical checks held in paper form. Data provided after the inspection highlighted regular checks had taken place across a range of the wards we visited.

Clinical waste was managed in a way that kept people safe. Arrangements were in place for the segregation, storage and disposal of waste.

Most of the consumable items that we checked during our inspection were within their expiry date. However, we did find some syringes that had recently expired. These items were immediately removed by staff and disposed of accordingly.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient; however not all risks were removed or minimised. Staff identified and quickly acted upon patients at risk of deterioration.

Staff completed relevant risk assessments for each patient on admission or arrival, using nationally recognised tools which were reviewed regularly, including after any incident. Patients identified as being at risk were flagged on the electronic system using a RAG (Red, Amber and Green) rated risk system which is used within the NHS to classify risk, with red being the most severe.

During the inspection, we saw evidence that staff used the national early warning score (NEWS2) tool to identify deteriorating patients and we saw examples in patient notes where appropriate escalation had taken place to ensure patient safety. Patients identified with a NEWS2 score of 5 or above had a red sticker placed in medical and nursing records which showed the time of the recording and who the concern had been escalated to. Staff told us they could refer to critical care outreach (CCOT) services for advice and support regarding patients at risk of deterioration.

The most recent sepsis audit data highlighted that all wards had consistently recorded patient NEWS2 scores. Compliance rates for NEWS2 training were consistently high across the medical division. However, the most recent sepsis audits completed by the trust highlighted some significant inconsistencies with overall standards, particularly regarding the completion of the sepsis screening tool where compliance ranged between 0% and 61% and obtaining patient observations as per trust policy, where compliance ranged from 23% to 100%.

Waterlow pressure damage assessments were present in patient records. In addition to this, ward managers advised us that staff would complete a body map for patients admitted onto the ward as a further means of monitoring patient skin integrity. Patient records also contained SSKIN bundle documentation, a nationally recognised skin integrity assessment tool, which was consistently completed across all wards. Furthermore, staff compliance rates with tissue viability training were consistently high across all wards.

We saw evidence that falls risk assessment and management plans (FRAMP) were completed upon admission to wards. Other steps had also been taken across multiple wards, such as the allocation of a computer on wheels (COW) and the allocation of staff members to patient bays to ensure enhanced levels of observation were available to monitor patients potentially at risk of falling. Data provided by the trust showed trust-wide compliance for trips, slips and falls training was consistently high across all medical wards. However, some staff told us that visibility in some of the side rooms on specific wards was poor and it was necessary to ensure patients deemed a high risk of falls were not allocated to these specific rooms.

Patient documentation included use of the malnutrition universal screening tool (MUST), a five-step screening tool used to identify adults who are malnourished, at risk of malnutrition or obese.

Staff told us that 24-hour access to mental health liaison and specialist mental health support was available if required and staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Although there could sometimes be delays accessing resources due to overwhelming demand within the trust.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe which included any issues with nutrition and hydration, pressure sores and patient falls.

Nurse staffing

It was recognised by senior management that the service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from the risk of avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and efforts were made to increase staffing levels for each shift. However, this did not always provide established safe levels of staffing.

Due to national shortages of nursing and support staff the service did not always have enough nursing and support staff to keep patients safe. All wards inspected had vacancies for qualified nurses and healthcare assistants. The trust had recently employed internationally recruited nurses and staff were able to explain the mentorship and support the recruits required. However, staff in the areas we inspected told us they were often short of qualified nursing staff.

During the inspection, staffing information displayed on multiple wards we visited highlighted that actual staffing, which included registered nurses and healthcare assistants, did not meet the planned numbers. Ward leaders were not always supernumerary due to low staffing numbers.

We visited an escalation ward on inspection and saw 3 registered agency nurses had been allocated to dayshift, one of which was a newly appointed agency nurse on their second day in post. The trust had appointed a new manager to this ward, with the post due to be filled at the end of June 2023. At the time of the inspection, managerial oversight was provided by 2 deputy ward managers from other areas within the hospital.

On the same ward, senior leaders told us the trust had recruited healthcare assistants to assist within some clinical areas. Six of the healthcare staff on duty during the inspection were newly appointed.

Staffing shortfalls were evident on other wards we visited. On one of the elderly general medicine wards, there was staffing gaps for both established registered nurses and healthcare assistants. The ward had 27 patients, with one patient requiring one to one support due to high risk of falls. The ward manager had requested additional support from the enhanced care team via escalation to the senior leadership team. However, no additional support was available and ward staff had to support the needs of the patients requiring one to one supervision.

Ward managers could adjust staffing levels daily according to the needs of patients. However, staff shortages were not always met. Staff told us they reported staffing shortages on the incident reporting system to ensure that themes and trends with staffing were highlighted accordingly.

Staff members that we spoke with expressed their frustrations at the ward moves their team encountered due to short staffing across the entire medical care division. Staff told us that staff shortages often impacted on patient care as gaps in staffing were not always filled.

Medical care (including older people's care)

Additional data provided by the trust highlighted a total of 22 staffing level incidents were raised between March 2023 and May 2023 making reference to inadequate nursing cover within the medical care department.

The most recent data provided by the trust for April 2023 showed a trust-wide overall vacancy rate of 4.46% for band 5 and above qualified nursing staff. This had reduced from 6.07% in March 2023.

The most recently logged trust-wide staff turnover rate was recorded as 8.1% in March 2023.

The trust told us that a formal nurse staffing establishment review had not been completed since the previous staffing establishment uplift was approved by the trust board in February 2022 and the focus moving forward had been on reducing vacancy rates and supporting new staff. Staffing establishments had been uplifted as a result and the next staffing review would take place in July 2023.

The service continued to regularly use bank and agency nurses on the wards. However, managers tried to limit their use of bank and agency staff and requested staff who were either familiar with the service or had previous experience of working with West Cumberland Hospital.

Managers assured us that all bank and agency staff had a full induction and understood the service, with many of the current pool of bank staff having worked within the trust for a number of years.

Medical staffing

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

At the time of the inspection, the service had enough medical staff to keep patients safe. However, additional data provided by the trust highlighted two staffing level incidents were raised between April 2023 and May 2023 referring to inadequate doctor cover within the medical care department.

Senior managers told us that there was ongoing recruitment with a new substantive consultant joining the trust in July 2023 and further candidate interviews scheduled for summer 2023. Furthermore, the trust continued to advertise locum vacancies in an ongoing effort to boost medical staffing trust-wide.

The most recent data provided by the trust for medical staffing vacancies across the emergency care and medicine division for April 2023 highlighted a vacancy rate of 22.88% for consultants compared to 20.85% for March 2023. Vacancies for other medical grade staff had dropped to 20.3% in April 2023 compared to 27.23% in March 2023.

Sickness rates for medical staff for the period April 2022 until April 2023 was 2.44% which was below the trust target of 4%.

The most recently logged trust-wide staff turnover rate was recorded as 24% in March 2023.

The service had reducing rates for the use of bank and locum staff.

Managers could access locums when they needed additional medical staff and made sure a full induction to the service was provided before they started work.

Medical care (including older people's care)

The service had a good skill mix of medical staff on each shift and reviewed this regularly and consultant cover was available during evenings and weekends.

Records

Overall, staff kept detailed records of patient's care and treatment. However, the trust used a mix of paper and electronic records which at times impacted upon staff accessing key information in a timely manner. Records were still not stored securely which was highlighted as a must-do action at the last inspection. However, staff were able to promptly access notes to assist with the delivery of patient care.

During the inspection there was a lack of consistency with the storage of patient records and across most wards, these continued to not always be securely stored. On all wards we visited, notes trollies were mostly left unlocked and unattended, with patient notes stored underneath trollies and easily accessible to visitors. Some paper records on wards we visited were stored in folders outside of each bay, or in folders not stored securely in the bay. We also found two patient records which contained documentation belonging to different patients. This was flagged with ward managers during the inspection and immediately resolved.

We were not assured that the care group had oversight of the ongoing risk given as this had been flagged as a must do action at the last inspection in 2020.

We were also told that when patients were transferred across care groups, details regarding medications needed to be transcribed onto an alternative system which were both paper and electronic. As a result, there were concerns that errors could be inadvertently made when transcribing medication information.

The inspection team found some minor omissions in some patient records which included missing fluid balance totals and not all patient records were in date order.

The trust completed a robust audit programme for patient records whereby a sample of 15 randomly selected electronic and paper records would be scrutinised. Compliance levels were consistently good across all wards selected for the audit, with the most recent trust-wide score for May 2023 highlighting 91% compliance for paper records and 96% for electronic records. However, key areas of concern echoed those of the inspection team; legibility of notes, designation of author rarely printed alongside signature and paper records were often found to be in a poor state.

However, the records that we checked showed risk assessments had been completed appropriately and associated actions had been taken to promote patient safety.

Electronic whiteboards were used on all of the wards we visited which recorded key information about patient risks and treatment, including flags for patients living with dementia, learning disabilities, patient acuity and discharge plans. The boards ensured that staff had easy access to key information, such as reviews by other members of the multi-disciplinary team and clinical observations.

Medicines

The service used systems and processes to prescribe, administer, record and store medicines. However, this was not always done in-line with trust policy.

Unlike the automated key system used in Cumberland Infirmary, staff within the West Cumberland Hospital medical division accessed medicines via the use of a designated swipe card.

Medical care (including older people's care)

We found that staff did not always follow systems and processes to prescribe and administer medicines safely. During the inspection we had concerns with treatment provided to patients experiencing alcohol withdrawal, as this was not done so in-line with the trust policy. Post-inspection we were provided with the trust-wide alcohol withdrawal policy which had been last issued in August 2020 and was due for review. The trust informed us that work had been ongoing with the Integrated Care Board and Public Health to obtain funding for an alcohol support team and that a priority piece of work would be undertaken by this team to review policies pertaining to alcohol withdrawal treatment.

Data provided by the trust highlighted that staff did not always complete medicines records accurately. The prescribing and administration audit contained findings from a random sample of ten medicines charts which had been selected from medical, surgical and community hospital ward settings. The most recent findings highlighted poor compliance with staff recording their name and designation in patient records (24% compliance) and only 20% compliance with staff accurately signing and dating cancelled medications in patient records. Only 50% of the records included in the most recent audit had allergies clearly recorded.

Oxygen prescribing data provided by the trust, solely focused upon the Acute Medical Unit at Cumberland Infirmary. However, the trust provided us with assurances that work had been ongoing over both hospital sites to improve performance with oxygen prescribing and the new electronic system would now provide staff with prompts to ensure that oxygen prescribing protocol was being adhered to.

Trust-wide data from the controlled drugs audit showed a significant decrease in quality standards from 45% recorded in quarter 3 of 2022-2023, compared to 17% recorded in quarter 4. Common themes identified in the controlled drugs audit were lack of signatures in the controlled drugs order book, details of medication strength and form not written in registers and actions identified as part of the previous audit not being completed to drive improvement.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. National practice guidelines were also followed to check patients had the correct medicines when they were admitted, or they moved between services. In the records we looked at, medicines reconciliation had been completed. However, systems in place to record this made it difficult to assess the time frame from the point of admission until this had been completed. Data provided to us by the trust was not broken down by speciality or ward which meant we could not analyse the data for the medicine core service. The narrative accompanying this data also informed us that the information which demonstrates length of time between admission and medicines reconciliation could potentially be inaccurate due to the systems they use to record this on the wards.

Staff stored and managed all medicines prescribing documents safely. The most recent audit data provided by the trust highlighted only 27% compliance across the entire location with safe and secure handling of medicines audits. The Safe and Secure Handling of Medicines Audits are undertaken each year in all areas where medicines are stored. Feedback from these audits was shared with the ward manager or lead person responsible for storage of medicines on completion of the audit.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Incidents

Serious incidents which occurred within the trust were not always reported in-line with national guidance. However, when things went wrong, staff apologised and gave patients honest information and suitable support. Local managers investigated incidents and shared lessons learned with the whole team and the wider service.

Medical care (including older people's care)

We were not assured of senior management oversight of serious incidents reported within the trust. Although staff had been reporting incidents via the standard reporting channels, the trust informed us that they had identified discrepancies with the accurate grading of serious incidents involving patient falls since January 2023. As a result of this, the trust had made the decision to commence a retrospective review of incidents involving falls to determine the overall accuracy of reporting and whether any serious incidents should be declared in retrospect.

The trust had identified similar issues with serious incident reporting involving pressure ulcers. Senior leaders told us that an agreement had been put in place in 2017 with the Clinical Commissioning Group (CCG), whereby only grade 4 (full thickness tissue loss) pressure ulcers acquired in an inpatient setting would be declared as a serious incident. Over the last 12 months, the trust advised that there had been no acquired grade 4 pressure ulcers and that grade 3 (full thickness and skin loss) pressure ulcers may not have had the level of scrutiny required to determine whether a serious incident should have been raised. As a result, the trust advised us that they would completing a review of all grade 3 pressure ulcers acquired whilst under the care of the trust to determine whether any serious incidents should be declared retrospectively.

However, at ward-level, staff we spoke with could describe how to raise concerns and knew how to report incidents and near misses in line with trust policy. Each ward clearly displayed information for the previous month on the number of patients cared for and the number of incidents reported. Ward managers also ensured that information was displayed for the number of incidents which remained open and how many had been open for longer than 30 days.

We saw examples on display where learning had been shared with staff regarding serious incidents. Staff across all wards we visited stated that they received feedback from incident investigations and had the opportunity to discuss the feedback and look at improvements to patient care. For example, staff were able to recall a recent medicine incident which occurred in April 2023. The investigation had highlighted non-adherence to trust medicine management policy. Staff told us that incident feedback was discussed at safety huddles and staff meetings.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Is the service effective?

Requires Improvement ↓

Our rating of effective went down. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff had access to various policies and treatment guidelines, based on best practice from the national institute for health and care excellence (NICE), which were stored electronically and clearly displayed on staff notice boards on multiple wards visited as part of the inspection.

Medical care (including older people's care)

We saw examples of improvement measures being undertaken to improve the quality of care and support delivered to patients, such as improvement of skin integrity monitoring. This had been achieved through the use of visual aids for staff, whereby a laminated picture of a clock would be placed on the patient's whiteboard as a cue to ensure positional turns were completed in accordance with SSKIN bundle recommendations (Surface, Skin inspection, Keep patients moving, Incontinence/moisture and Nutrition/hydration).

Most staff could demonstrate an understanding of how to protect the rights of patients subject to the Mental Health Act. We saw examples within ward meetings where staff referred to the psychological and emotional needs of patients to support their wellbeing. However, during our inspection, we spoke with a mental health clinician based within a neighbouring trust who had been requested to complete a patient review. Their feedback highlighted inconsistencies with some staff understanding and awareness of mental health and felt additional training would help ensure a more consistent approach to supporting patients experiencing mental health difficulties.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Staff told us and we saw that individual wards used differing coloured water jug lids. Staff confirmed that they had instigated the use of differing-coloured lids to demonstrate the volume of water patients had consumed. The coloured lids resembled the traffic light system starting with red, amber and green. Staff told us this was a good visual aid to assist with the oversight of fluid intake.

There were regular recordings of blood glucose levels before mealtimes and appropriate Insulin given for patients with diabetes.

Staff told us that patients were provided with a red wristband to indicate whether they had an allergy to both food or medication, and we saw examples of this across multiple wards during the inspection.

On multiple wards we visited, we saw documentation which contained menus for every dietary need such as kosher, halal, low fat, dysphagia, vegan and nut allergies. This information would then be recorded on individual patient whiteboards located above their bed.

Staff used a nationally recognised screening tool, to monitor patients at risk of malnutrition and specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it.

During the inspection we saw posters on display promoting the nutrition and hydration needs of patients and guidance was on display for staff on how to complete fluid balance sheets.

The trust had also taken steps to gather feedback regarding the quality of food being provided to patients, which could be seen on display in the wards we visited.

However, staff did not always fully and accurately complete patients' fluid and nutrition charts where needed. We saw examples on fluid balance charts where totals had not been completed by staff and information on any fluid restrictions was not always logged. This was flagged with ward managers by our inspection team. Furthermore, managers told us that there were no audits completed for the fluid balance charts in order to monitor overall quality of records.

Medical care (including older people's care)

The most recent Audit of Meeting Nutritional Needs completed by the trust in April 2023 highlighted 70% compliance for the full completion of MUSTs within inpatient settings within the whole trust. Although this was a 32% increase on the previous compliance rate, the audit highlighted shortfalls with staff repeating a MUST for each week of the patient's stay and 100% compliance was not met in any area of the audit, with the highest inpatient compliance score being recorded as approximately 70%.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice and patients received pain relief soon after requesting it. Feedback from patients was positive regarding staff proactively supporting with pain management

Staff prescribed, administered and recorded pain relief accurately in patient records. Patient medication allergies were also observed in the random sample of records that we checked during the inspection.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service was working towards working under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits to monitor effectiveness of care and treatment. Outcomes of national audits were monitored by the clinical effectiveness and audit manager and team. Clinical audits and actions are reported monthly to all care groups and services within the trust. The clinical effectiveness and audit manager also attended care group level meetings to present and outline performance positions within the various care groups.

The trust continued to participate in the Sentinel Stroke National Audit Programme (SSNAP) which monitors the quality of care provided to stroke patients and the overall structure of stroke services available. A total of 44 key indicators are used which represent high quality stroke care. These indicators are then divided into 10 domains and graded from A to E. West Cumberland Hospital achieved an overall SSNAP level of E which was the lowest grade of other routinely admitting hospitals in the same integrated care system (ICS). However, we were advised by senior leaders that the main stroke pathway and resources such as the hyper-acute stroke unit for the trust were based at Cumberland Infirmary which holds a SSNAP rating of B.

The trust also participated in the Society for Acute Medicine Benchmarking Audit (SAMBA) which state that patients attending hospital between 08:00 and 20:00 should receive a consultant assessment within 6 hours and that patients attending hospital overnight between 20:00 and 08:00 should receive a consultant assessment within 14 hours. The results from the last SAMBA completed in June 2022 showed that consultant review occurred within the outlined time period on 70% of a sample of 38 patients, meeting the national median. The next scheduled SAMBA would be due for completion at the end of June 2023.

Other national audits which the trust engaged in included audit of Inpatient falls, National Diabetes inpatient audit, National lung cancer audit, Chronic obstructive pulmonary disease audit and National audit of dementia. Outcomes for patients were positive, but data provided by the trust highlighted that overall quality standards did not always meet national benchmarks.

Medical care (including older people's care)

We saw evidence on the wards we inspected that managers and staff carried out a comprehensive programme of repeated audits to check improvement over time and the information gathered was used to improve care and treatment. Managers told us that audits would be delegated to members of staff on the ward and reviewed by the ward managers and deputies and action plans created to address any shortfalls. The outcomes of audits would then be shared within governance meetings, newsletters, or posters to ensure all staff were aware of any learning and changes to practice.

Matrons also carried out monthly 'quality rounds' of all their areas of responsibility, which gave an additional level of external assurance wards. Findings from the matron audits would then be shared at the Care Group monthly governance meeting.

Competent staff

Recruitment of healthcare assistants and internationally recruited nurses meant the trust had a mix of differing staff with competency and skill set. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. However, completion rates for appraisals were inconsistent across the medical care division.

The trust had recently employed internationally recruited nurses and staff were able to explain the mentorship and support the recruits required. However, staff in the areas we inspected told us they were often short of qualified nursing staff and healthcare assistants with the right skills and competency to care for patients within the medicine speciality.

Most wards we visited during inspection had high numbers of newly appointed internationally recruited nurses and healthcare assistants. Staff told us this impacted on the wards due to inconsistent levels of competency and skill-set of the differing staff on duty. Individual staff were requested to complete mandatory training which covers core skills for both healthcare staff and registered nurses.

Managers told us that all new staff a full induction tailored to their role before they started work and support from clinical educators was also available. International nurses were granted a period of 3 to 4 months supernumerary status to enable them time to settle into their new roles. However, due to the recent influx of newly qualified staff within the trust, we were not always assured that staff had the relevant experience or right skills and knowledge to meet the needs of all patients. Particularly due to the ongoing need for staff to be redeployed within the trust to ensure adequate staffing on sometimes unfamiliar ward environments. On one ward we visited; six new health care assistants had been allocated to the overall staffing numbers. We asked for confirmation that an induction had been completed and that there was managerial oversight of staff members' training and competencies to ensure patient safety. Senior staff members we spoke with were unable to provide this at the time of the inspection. Senior leaders within the trust were able to inform us after we visited the ward that all staff on duty had completed an induction and the ward was being supported by a matron and clinical educator. However, the ward staff were not aware of this. As a result, we were not assured that leaders within the trust had full oversight of the competency and skill-set of staff on this particular ward, especially given the acute nature of the patients being cared for.

The trust also acknowledged that there were challenges with the rota for senior decision maker (SDM) medical staff cover. Data provided by the trust showed that there was ongoing recruitment for speciality doctors, speciality trainee doctors (ST4) and royal college of emergency medicine (RCEM) accredited senior advanced care practitioners to ensure consistent SDM cover would be available trust-wide.

Medical care (including older people's care)

Managers supported staff to develop through yearly, constructive appraisals of their work. Most of the wards we visited displayed current appraisal rate completion, with most attaining the trust target. However, data provided by the trust highlighted some shortfalls across the medical division where nurse staffing appraisal completion was as low as 6% to 22%logged for medical staff appraisal completion within stroke care.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work.

Managers supported medical staff, at all levels, to develop through regular, constructive clinical supervision of their work via internal and external support networks.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge and support from a clinical educator was available to support this and identify any specialist training which could support staff within their role. Feedback from staff was generally positive regarding continuous professional development.

Managers identified poor staff performance promptly and supported staff to improve.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care and patients had their care pathway reviewed by relevant consultants.

We saw examples of staff working across health care disciplines and with other agencies when required to care for patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health and crisis intervention was required.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards which included guidance on smoking cessation, alcohol awareness and dietary needs.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Upon discharge, some wards provided bags which contained a range of information and guidance leaflets appropriate to that patient's presenting needs.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff demonstrated that they had the knowledge and understanding to support patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. However, they did not always use measures that deprived patients of their liberty appropriately.

We visited multiple wards during inspection and noted entry and exit access was by staff swipe card only. Staff told us that deprivation of liberty safeguards (DOLS) were only in place for patients deemed to be lacking capacity and that the remaining patients had been deemed as fully capacitated. Senior managers advised us that there was use of blanket restrictions across multiple wards which had been implemented on the basis of ensuring patient safety. Staff would provide patients deemed to have capacity with information about the use of locked doors and told us that they would take relevant steps to enable capacitated patients to move freely from the ward. However, we were not assured that patients may have been inadvertently deprived of their liberty, particularly during busy periods where staff would be focused upon supporting the more vulnerable and frail patients.

Post-inspection, senior leaders told us work was still required to improve staff knowledge surrounding DOLS applications. The trust had doubled the number of DOLS applications and had improved information within them. DOLS facilitators were in place for staff to contact if they required support with an application.

Although the contents of mental capacity act (MCA) assessments and DOLS applications was robust across all wards, the inspection team and some staff members found it challenging to find where the applications were due to the mix of paper and electronic records in use.

Despite our concerns regarding the use of blanket restrictions and challenges locating relevant MCA and DOLS documentation as a result of the electronic and paper-based systems running alongside one another, staff we spoke with understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff also ensured that they gained consent from patients for their care and treatment in line with legislation and guidance. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

During our inspection we saw a noticeboards displayed within ward corridors which reminded staff about the process of assessing patients' mental capacity and the subsequent processes involving the use of DOLS and how to record this information using the trust's electronic system.

All staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Medical care (including older people's care)

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We also saw patient welcome packs on some of the wards we visited which were used to help patients adjust to the routines in place.

Patients said staff treated them well and with kindness and we saw multiple examples of compassionate care being delivered upon all the wards we inspected.

All patient's looked comfortable and during care interventions we observed the curtains being drawn around patients to provide privacy and dignity.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff told us they would always try and care for patients who were at end of life in side rooms and would allow their relatives to stay overnight.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

The trust promoted all faith and no faith support to meet patient's and relatives religious and spiritual needs during their stay in hospital.

Medical care (including older people's care)

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

We saw examples in patient records where staff had supported patients to make informed and advanced decisions about their care.

Patient feedback was displayed on noticeboards within wards and was positive and complimentary about the care and support provided. All of the wards we inspected had various examples of "you said, we did" responses to feedback from both current and previous patients.

Friends and family feedback results across a range of wards for May 2023 showed that patients had either a very good or good experience during their stay in hospital. Key themes identified from compliments included the kindness and caring nature of staff.

Results in the most recent inpatient survey from 2021 compared favourably with the overall national picture with the mean score for 30 out of the 40 questions sitting in the mid-sixty percent for the national benchmark. Two of the mean scores were in the top 20% and only 8 in the bottom 20% of the national benchmark.

Is the service responsive?

Requires Improvement 

Our rating of responsive went down. We rated it as requires improvement.

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the changing needs of the local population.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. At the time of the inspection there were no mixed-sex breaches noted.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

Medical care (including older people's care)

The service had systems to help care for patients in need of additional support or specialist intervention, such as falls monitoring equipment which would alert staff when patients deemed to be a high risk of falls had mobilised from their stationary position.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff also had access to communication aids to help patients become partners in their care and treatment.

Patients were supported by staff to ensure their cultural and religious preferences were met at all times.

Access and flow

The trust faced ongoing challenges with access and flow which meant that they could not ensure people were always able to access care promptly. Waiting times from referral to treatment were not in-line with national standards. The trust continued to experience challenges with discharging patients from the service. Despite these pressures, staff worked hard to keep patients safe.

During the inspection we found that not all wards on-site had a set patient criteria for admissions. Two of the wards we visited had been set-up as escalation wards during the COVID-19 pandemic and over time had been adapted to become general admission/medical wards. We noted that the patients on these wards did not appear to fall under one particular umbrella of care and as a result we required further clarification on the admission criteria. The trust told us after the inspection that "patients [admitted to these wards] had a named dedicated medical senior consultant" and "They [the wards] are not set up to house medically optimised/ready for discharge patients only". Despite being provided with this definition by the trust, the inspection team remained uncertain about the specific admission criteria for these wards.

Access and flow across medical divisions nationally continues to present significant challenges for NHS trusts. Despite the challenges, managers monitored waiting times and made best efforts to enable patients to access services when needed. However, treatment was not always received within agreed timeframes and national targets.

Trust-wide data for March 2023 showed that 63.1% of patients were treated within 18 weeks of referral. This was below the regional average of 70.4%, but closer to the national average of 66.1%.

In March 2023, there were 628 patients waiting more than 52 weeks from referral for treatment, which had seen an improvement over the previous 18 months, which was in-line with other trusts in the same region.

At the time of the inspection, there were no patients waiting 78 weeks or over for treatment.

Medical care (including older people's care)

Managers and staff also worked hard to make sure patients did not stay longer than they needed to. The average length of stay for elective admissions for February 2023 was 3 days, better than the national average for the medical care sector which was 5.9 days.

However, during February 2023, the average length of stay for emergency admissions was 22.9 days, worse than the sector and provider average of 16 days.

The NHS specifies that patients have the right to commence consultant-led treatment within a maximum of 18 weeks of referral and is defined as referral to treatment (RTT). Measurement of performance excludes current backlogs of patients awaiting treatment and the ongoing work being implemented to reduce the number of patients waiting 52 weeks and 78 weeks respectively. The RTT percentage for trust-wide cardiology patients over the last year had been around 50% until the start of 2023 where it had risen to a maximum of 68.2% in May 2023, below the trust target of 92%.

The trust advised us that a business case had been submitted for the recruitment of additional

consultant and cardiology nursing staff in an attempt to improve performance with RTT.

At the time of the inspection, the renal medicine RTT performance was 96%. Data provided by the trust highlighted a slight drop in performance between Feburary 2023 and March 2023 which was attributed to temporary consultant shortages.

In February 2023, the average length of stay for emergency admissions was 8.3 days, which is worse than the ICS average of 6.6 days.

Performance had declined slightly for respiratory medicine over the previous 12 months from approximately 80% RTT in June 2022 to approximately 55% at the time of the inspection. The trust attributed this dip in performance to increased referrals and the loss of a locum consultant.

The trust advised that they had identified a new clinical area which may be utilised to enable a more efficient way of working. However, this would not be operational until 2024.

RTT performance within stroke care and rehabilitation medicine had been consistently at 100% since April 2023.

The average length of stay for emergency stroke admissions had consistently remained above the ICS average since August 2022, with the most recent data for February 2023 showing an average stay of 22.5 days compared to the ICS average of approximately 16 days.

RTT performance for elderly care had dropped from 100% in March 2023 down to 80% at the time of the inspection due to staff vacancies and sickness.

Following the inspection, the trust advised us that a new medical consultant and nurse consultants had been appointed within to address shortfalls in staffing within elderly medicine.

The service moved patients only when there was a clear medical reason or in their best interest and staff supported patients when they were referred or transferred between services, in-line with national standards.

Medical care (including older people's care)

Despite system-wide support and although managers and staff started planning each patient's discharge as early as possible and monitored the number of patients whose discharge was delayed, the trust continued to experience significant challenges with discharging patients from the service. The trust had logged 1,157 incidents on the national reporting and learning system (NRLS) and strategic executive information system (STEIS) for the period 01 April 2022 to 28 February 2023 which had been categorised as 'Access, admission, transfer and discharge' challenges. A total of 891 (77.0%) of these were delays and failures relating to discharges.

Managers worked to minimise the number of medical patients on non-medical wards and at the time of the inspection there were only four medical outliers across both medical divisions at West Cumberland Hospital and Cumberland Infirmary.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns and the service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and we saw examples of learning and identified themes on display across multiple wards we visited, which included patients being moved at night without family being notified and occasional lack of communication in regards to treatment plans.

Staff knew how to acknowledge complaints and patients received feedback in a timely manner from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how patient feedback had been used to help improve daily practice.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had oversight of the service as a whole; however, we were not always assured that leaders understood the priorities and risks the service faced at ward level. Staff told us they were not always visible and approachable in the service for patients and staff. However, they supported staff to develop their skills and take on more senior roles.

We were not fully assured that ward managers had full oversight of environmental risks on individual wards, specifically in relation to the safe and secure storage of hazardous cleaning products and dangerous items such as sharps and maintenance equipment. The inspection team were required to escalate concerns regarding the unsafe storage of equipment on one particular despite a member of the senior management team having already visited the ward prior to our arrival to review staffing and the environment.

During the inspection we were not always assured that senior managers had full oversight of staffing establishments and overall skillset of staff redeployed to wards with higher acuity patients. Some newly qualified members of nursing staff informed us that they had been regularly moved to other wards due to staffing shortages, despite them only having limited experience with patients requiring higher levels of care and support. Staff also told us that on specific wards there was not always consistent management support available to them due to ongoing recruitment.

Staff spoke positively of their allocated ward managers and when able to care for patients on their designated wards, felt supported within their roles.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

There was a clear vision in place which was on display within the department, with the provision of safe patient-centred care was at the core.

The vision and strategy also placed emphasis on promoting a positive working environment for all staff members, conducive to the delivery of safe care and treatment.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service promoted an open culture where patients, their families and staff could raise concerns without fear.

Staff continued to display resilience following the impact of the COVID-19 pandemic and wider system pressures. Senior leadership told us they recognised the pivotal role staff resilience had played in maintaining care standards despite the tremendous pressure it was under.

Despite the challenging circumstances, staff were positive about working within the service and praised the ethos of teamwork. Although, there could be frustration at times when redeployment to other wards was required on a frequent basis.

Staff felt there was good support from ward management.

Promoting staff wellbeing was on the departmental managers' agenda and there was information on display within staffing areas to encourage awareness of mental health and emotional wellbeing.

Nursing and medical staff we spoke with described a positive working relationship between both parties.

Medical care (including older people's care)

The trust advised us that they had engaged in the listening into action (LIA) project following disappointing results in the most recent NHS staff surveys which was completed in 2021 and 2022. Although the results highlighted that the trust performed close to the benchmark median in key areas, the trust acknowledged that improvement was required.

The trust told us that they had made use of the regular staff pulse survey to gather feedback on how and where to make improvements and had also recruited 100 LIA Pioneers to run a total of 10 transformation projects across the trust to drive improvement. At the time of the inspection, a further 14 improvement projects had been identified by the new cohort of LIA Pioneers. The trust were hopeful that the ongoing transformation work would help boost morale and instil a “can do” attitude.

Governance

Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their individual roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The management team had not identified the lack of accurate reporting of falls and hospital-acquired pressure ulcers. These discrepancies had been highlighted during routine engagement with CQC. As a result of this, we were not assured that governance processes were working effectively to highlight risks within the service.

Staff we spoke with clearly understood their role within the wider team and took responsibility for their actions.

Information boards within staffing areas clearly displayed specific learning and development requirements, as well as outcomes from departmental audits which served as visual aids for staff members.

We saw evidence of the use of governance processes to monitor standards of performance at both departmental level and trust-wide. The trust had sight of where improvements were required as a result of ongoing audit and monitoring.

The trust continued to hold monthly governance meetings for each department on-site and information would be passed on to ward staff to ensure they were kept up to date. We were told that during the COVID19 pandemic a number of meetings had been stood down in order to focus upon clinical duties. During the transition to the current way of working post-pandemic, we were told that the governance meetings had not been routinely minuted due to a lack of administrative support. However, we were provided with the minutes for meetings held in March 2023 to May 2023, all of which were comprehensive and contained a clear agenda and ownership of action points.

The trust continued to work with partner agencies within the integrated care system to monitor and improve performance and to ensure patient safety was upheld at all times.

Management of risk, issues and performance

Leaders and teams used systems to manage and evaluate performance. However, they did not always have effective oversight of relevant risks and issues and identified actions to reduce their impact.

Data provided by the trust showed that monthly performance meetings for each care group were held focussing upon areas such as staffing, audit results, budgetary constraints and key performance indicators and performance action plans specific to the care group. A performance accountability log was also created as part of the departmental performance review process which linked in with the CQC key lines of enquiry.

At ward-level, we observed noticeboards displaying weekly risks, action points, audit results and total number of open incidents. Patient feedback and learning points were also clearly displayed for staff members, patients and visitors.

Despite an ongoing recruitment drive, staff in the areas we inspected told us they were often short of qualified nursing staff and healthcare assistants with the right skills and competency to care for patients within the medical care division. Most wards we visited during inspection had high numbers of newly appointed internationally recruited nurses and healthcare assistants requiring additional time to gain experience within their roles.

Although the trust held regular performance and risk monitoring meetings, we were not always assured that managers had oversight of environmental risks within the medical division, particularly in regards to adherence with COSHH guidelines. We also saw examples where there was limited senior management oversight of wards which were staffed by newly appointed health care assistants and agency staff with minimal experience of working on their allocated ward.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. However, the trust continued to use both electronic and paper-based record keeping systems which presented some difficulties with accessing specific patient information. Incident reporting was not always done in line with national guidance.

Feedback from staff highlighted that IT systems were not always responsive and there was a lack of computers on certain wards.

Paper records continued to not be stored securely across all of the wards we visited.

Some staff members had not been provided with a SMART card which caused delays accessing electronic patient records.

During a recent provider engagement meeting held between CQC and the trust, we were advised that discrepancies had been found with the accurate grading of serious incidents involving patient falls and skin integrity concerns since January 2023. As a result, the trust had made the decision to commence a retrospective review of incidents to determine the overall accuracy of reporting and whether any additional serious incidents should be declared in retrospect. As a result, we were not assured of senior management oversight of serious incidents reported within the trust.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust continued to work hard to improve the patient experience when accessing the service. This was based upon listening to patients and gathering feedback in order to align service delivery with the needs of the local population and to ensure the highest possible standards of care were being delivered.

Meetings were held at trust-level with other external organisations such as neighbouring local authorities and other third parties such as mental health, domestic violence and addictions services to help improve patient experience.

Medical care (including older people's care)

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Although mandatory training compliance rates were not always in-line with the trust target, there was evidence that the nurse managers, along with the clinical educators, had taken steps to promote a learning culture which adhered to both RCEM and NICE guidelines.

All of the wards visited during the inspection had a quality improvement theme for each month and we saw information and guidance on display in the staffing areas of the department to promote awareness of issues such as sepsis, safe prescribing of medication and domestic violence awareness. Feedback from the medical director and governance facilitators was also on display on various wards to highlight the positive work undertaken by staff in regards to end of life care.

Post-inspection we were provided with additional data that highlighted ward-level quality improvement projects within cardiology, renal medicine and respiratory care. These particular projects focused upon recruitment, sourcing additional workspace and introducing new equipment to optimise care for patients.

We were also provided with the trust-wide quality improvement report for 2022/23 in which 10 key areas of focus had been identified:

- Prevention of acute kidney injury
- Improvement of pathways for patients lacking capacity to consent
- Effective discharge summaries
- Improvement of patient involvement in their Care
- Effective modern ward rounds
- Improve results and follow-up for patients
- Falls
- Nutrition and Hydration
- Personal Care and Oral Hygiene
- IPC

There was evidence that progress was being made within the key areas of focus, particularly with the management of falls which the trust had identified as a significant issue across both hospital sites. Improvements and initiatives at ward-level, such as increased staff presence to monitor high risk patients and the introduction of additional equipment had helped to play a role in reducing the percentage of recorded falls resulting in moderate harm or above from 2.74% for 2021/22 down to 1.92% for 2022/23.

Medical care (including older people's care)

Along with the key areas of focus, the trust had identified 5 key principles to drive improvement with quality and safety of patient care at the heart of all work undertaken. There was also evidence of multi-disciplinary work being undertaken with third parties in order to drive improvement with optimising patient discharge.

Cumberland Infirmary

Newtown Road
Carlisle
CA2 7HY
Tel: 01228523444
www.ncic.nhs.uk

Description of this hospital

North Cumbria Integrated Care NHS Foundation Trust (NCIC) was created in October 2019 following an acquisition of North Cumbria University Hospitals NHS Trust (NCUH) by Cumbria Partnership Foundation Trust (CPFT).

The trust provides a range of acute hospital services based at the Cumberland Infirmary in Carlisle (CIC)

The trust serves a population of approximately 320,000 in the west, north and east of Cumbria, in the districts of Allerdale, Carlisle, Copeland, Eden Valley and South lakes and Furness for some community services. It also provides services to parts of Northumberland and Dumfries & Galloway. The community is spread over a large geographical area, with 51% of residents living in rural settings. Over 65s make up a larger proportion of the population than the national average. Deprivation is similar to the England average and about 11,700 children (14.5%) live in poverty.

Urgent and emergency services

Requires Improvement 

Is the service safe?

Requires Improvement 

Our rating of safe improved. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff, however not all staff had completed it.

Not all nursing staff received and kept up to date with their mandatory training. Following our inspection, the trust provided us with a breakdown of mandatory training compliance data as of the end of May 2023. Nursing staff were compliant with the trust 85% target in 13 of 21 modules. Shortfalls were found in the other 8 modules which included infection prevention & control L1, safeguarding children's level 1-3, safeguarding adults L3, moving and handling L2, basic life support, immediate life support adults and paediatric.

Not all medical staff received and kept up to date with their mandatory training. Data received from the trust showed shortfalls in 13 out of 14 modules. Overall compliance rates were 74% which was below the trust target.

The trust provided mandatory training data for staff in the paediatric emergency department. Both nursing and medical staff had achieved 92% which was above the trust target.

Compliance for the highest level of life support training had not been achieved. Data provided by the trust showed only 65% nursing, 63% of medical and 75% paediatric staff had completed advanced life support adults training. Furthermore only 60% nursing and 73% medical staff had completed advanced life support paediatric training except for paediatric staff that had achieved 100% compliance.

Only 44% of nursing staff had completed immediate life support adults training. Immediate life support paediatric training rates were nursing 50% and paediatric 71%. During the inspection we interviewed the clinical educator who told us there were training days scheduled for staff to achieve compliance.

The mandatory training was comprehensive and met the needs of patients and staff. The trust set a target of 85% for completion of mandatory training, except for information governance which was set at 95%. The trust delivered mandatory and statutory training aligned to the core skills training framework. Mandatory training subjects included Information governance, equality & diversity, fire safety, Infection, prevention and control level 1 & 2, conflict resolution, health and safety, safeguarding adults' level 1 to 3, safeguarding children level 1 to 3, moving and handling level 1 and 2, resuscitation level 1, basic life support, immediate life support adults and paediatric and prevent awareness.

The trust provided data that showed that nursing and paediatric staff had completed training specific to supporting patients with mental health needs, learning disabilities, autism, dementia, and end of life.

The trust had a recognition and management of sepsis policy and sepsis screening tools were used in both adults and paediatrics.

Data provided to us by the trust showed that out of 157 staff only 2 had completed sepsis training.

The trust provided us with data following our inspection which showed that some clinical staff had undertaken safer sharps training.

Staff had not completed training in de-escalation, conflict resolution or restraint.

Managers were able to monitor mandatory training and could alert staff when they needed to update their training. Staff were given time back for training.

Safeguarding

Staff did not always have the training on how to recognise and report abuse. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

Nursing staff received training specific for their role on how to recognise and report abuse. Data showed that nursing staff had achieved the trust target for safeguarding adults' level 1 and level 2 training. Level 3 safeguarding adults showed that the trust were slightly below the trust target.

Medical staff received training specific for their role on how to recognise and report abuse. Medical staffing compliance data showed that for safeguarding adults they had not met the trust target.

Only 74 % of medical staff had completed level three safeguarding children training. This was a concern and meant that not all medical staff may not recognise possible safeguarding concerns.

Paediatric staff had exceeded the trust training target for safeguarding adults and children.

Staff that we spoke with could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

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

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We reviewed 2 children safeguarding record and found a clear timeline of history, appropriate referrals, and escalations in both set of notes. However, both sets of triage notes stated that there were no safeguarding concerns. In one of the records the children had been placed on a police protection order. The nursing notes were not dated, or time stated.

Staff followed safe procedures for children visiting the department. Entry into the paediatric emergency department were accessible by a swipe system which was staffed and monitored 24/7.

Urgent and emergency services

Cleanliness, infection control and hygiene

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

Not all areas within the emergency department were clean. We observed that the triage room and clean utility to be dirty and cluttered. The clinical waste bin that was in the clean utility was overflowing and staff could not access the sink or handwashing facilities as boxes were stored directly around the sink. This posed a health and safety risk. We raised this whilst onsite, but this risk was not actioned.

The paediatric waiting room was found to be clean, tidy and clutter free. We checked the toys that were available in the waiting room, and these were clean. This had been an issue at the last inspection.

Cleaning records were not always up-to-date and did not demonstrate that all areas were cleaned regularly in the emergency department.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). We observed multiple occasions where staff did not wash their hands before, during or after patient contact.

We reviewed mandatory hand hygiene training data in February and March 2023 which showed that across both months the emergency department had not met the trust target of 95%.

Staff did not always clean equipment after patient contact. We observed several staff not cleaning equipment down after patient use.

Not all equipment was labelled to show when it was last cleaned.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment followed national guidance. Access to the emergency department was signposted. Hand gel was available for those attending the department although, at the time of the inspection, mask wearing was not mandatory.

The department operated a zonal working arrangement. Key zones in the emergency department include triage, Rapid Assessment Treatment (RAT), resus, majors, minors, and Paediatrics.

There was a separate paediatric emergency department for children up to the age of 18 years, which could be accessed 24 hours a day, which consisted of a waiting room, three cubicles one which doubled up as an isolation room and a separate mental health room.

The radiology department was located adjacent to the emergency department.

Patients call bells were in reach and we saw that staff responded quickly when called.

Urgent and emergency services

Staff did not always carry out daily safety checks of specialist equipment. We observed that mostly all oxygen ports within the ED and Paediatrics had a green dot sticker, but no dates were evident to show the test date. Some did have a date on to say when service was due however the dates had expired.

We observed 6 oxygen cylinders in the triage room which were not stored securely in cages or secure wall brackets in line with guidance. We raised this whilst onsite and we were told this was an ongoing issue.

There was a resuscitation trolley within the paediatric area which had been checked. Staff told us that if a child deteriorated whilst in the department, they would need to be transferred to the resus area in the main emergency department if there was a cubicle available as there was not a designated resus bay in paediatrics, potentially causing a delay in time critical treatment. This was not in line with Royal College of Paediatrics and Child Health 2018 standards.

The service had suitable facilities to meet the needs of patients' families. There were dedicated relative and bereavement rooms located within the department.

The service did have enough suitable equipment.

During the inspection we found that servicing of some of equipment was overdue.

At the last inspection we found that the microphone speakers in reception did not work properly. This was found to still be an issue. This meant that patients booking in at reception could be overheard by others. We observed staff and patients shouting through the reception glass. Others were able to overhear personal private information resulting in a lack of confidentiality, privacy,

and dignity for all patients. Staff told us that this had been escalated but had not been resolved.

During the inspection we observed sluice and storage room doors left open. This was a risk as stored substances such as alcohol solutions and cleaning products were left unlocked. Hazardous cleaning fluids were stored on work surfaces in the sluice rooms in large containers ready for use.

The emergency department had two mental health rooms for adult and paediatrics. We found the adults mental health room that were used to accommodate patients with mental health conditions was not fit for purpose. There were ligature points, heavy unsuitable furniture, and a room with no window. The rooms did not conform to Psychiatric Liaison Accreditation Network (PLAN) standards.

Directly outside the room there were large movable storage units that contained various items that could be used as a ligature poses a risk to vulnerable patients. The room was situated next to an unlocked exit directly onto the atrium, which meant that a patient could abscond from the department. This was flagged with the trust during the first day of the inspection. When we returned on the last day, we found that these risks had not been actioned.

There was evidence of back-up generators receiving regular essential service and testing across both sites.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff did not always complete risk assessments for each patient swiftly. They did not always remove or minimise risks and update the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

Urgent and emergency services

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. There was a clear streaming and triage process in place with all patients receiving an initial clinical assessment by a healthcare practitioner within 15 minutes of arrival. We saw examples of streaming being undertaken and the use of a nationally recognised streaming tool being used to support the process. Performance data demonstrated that greater than 70% of patients were triaged within 15 minutes of arrival.

Staff did not always complete risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. During our inspection, we saw that important risk assessments, such as venous thromboembolism (VTE), bed rails, falls risk, SSKIN (a resource pack to aid in the assessment and care planning for people at risk of pressure ulcers) and mental health were not completed in line with trust policy. This included missing checks, incomplete checks, and unlabelled documentation. We reviewed over 20 sets of patient records and found that 15 did not have the relevant checks.

We reviewed the most recent audit data for National Early Warning Score (NEWS2) which highlighted that from February 2023 to June 2023 they had consistently achieved compliance.

We reviewed the most recent compliance audit data for Paediatric Early Warning Score (PEWS) which showed that in the majority of areas they had achieved 100%. The audit data identified specific areas where compliance had dropped slightly to 90% however the department had already identified this as an area of improvement and was discussed at the daily safety huddles.

Staff knew about and dealt with any specific risk issues.

The service had 24-hour access to mental health liaison and specialist mental health support.

Staff did not always complete, or arrange, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide at triage.

Staff shared key information to keep patients safe when handing over their care to others.

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

Nurse staffing

Nursing staff had the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers reviewed staffing levels and skill mix daily. Bank and agency staff were given a full induction.

The service did not always have enough nursing and support staff to keep patients safe.

Staff told us that there were always two registered paediatric nurses on shift this was in line with the Royal College of Paediatrics and Child Health (RCPCH) standard.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

The department manager could adjust staffing levels daily according to the needs of patients. Staffing was monitored throughout the day and managers attended meetings twice daily in relation to staffing and capacity. If additional support was required in the department, this was escalated during these meetings and where possible, additional resources were supplied.

The number of nurses and healthcare assistants did not always match the planned numbers. Senior staff told us their usual staffing was down by 1 or 2 members of staff. We saw there were gaps in the roster.

The service had low vacancy rates, low turnover rates and low sickness rates for nursing staff.

The service had low and/or reducing rates of bank and agency nurses.

Managers limited their use of bank and agency staff and requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service before any shifts being allocated.

Medical staffing

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

The service had enough medical staff and skill mix of staff to keep patients safe. The emergency department had 14.9 whole time equivalent (WTE) ED consultants that worked cross site. This had improved since the last inspection but was slightly lower than the recommended numbers set by The Royal College of Emergency Medicine Consultant Workforce Recommendations (2018), of one whole time equivalent consultant to every 4000 new attendances. The current shortfall in ED Consultant numbers was mitigated using locum ED consultants employed to work weekend shifts.

The medical staff matched the planned number. We reviewed 4 weeks data of medical staff rotas. Consultants achieved the standards of being on site for 16 hours and then provided an on-call rota for the remainder of the time by an ST4 (specialist emergency department doctor) or above.

The department had dual trained emergency consultant however, we saw that this consultant covered both adults and children.

The service had low vacancy rates, low turnover rates and low sickness rates for medical staff.

The service had reducing rates for the use of bank and locum staff.

Managers could access locums when they needed additional medical staff and made sure they had a full induction to the service before any shifts were allocated.

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

There was always a consultant on call during evenings and weekends in line with RCEM guidance.

Urgent and emergency services

Records

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

Patient notes were not always comprehensive; however, all staff could access them easily. We were not assured of the quality of records produced and used by the department. The department used a combination of electronic and paper documents to record care and treatment of patients.

During the inspection we were made aware of a vulnerable young person who was known to the paediatric emergency department (PED) and had 60 previous admissions. We did not find evidence of any triage assessments, safeguarding checklists, mental health assessments or medical notes that had been completed, recorded and there was no evidence electronic records had been updated. We found the patient did not sign their self-discharge documentation and we did not find any follow up care had been undertaken for this patient. We escalated this onsite with the chief nurse immediately and were given assurance from the trust that the patient was safe.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were not always stored securely. We observed notes trolleys that contained patient records were mostly left unlocked and unattended and accessible to unauthorised personnel.

We also saw several computers left open with patients' details. This was not in line with trust policy and General Data Protection Regulations (GDPR).

Medicines

The service used systems and processes to safely prescribe and administer. However controlled drugs were not always stored and recorded in line with trust policies and procedures.

Staff followed systems and processes to prescribe and administer medicines safely. We reviewed three patient records in the department. All patients we looked at had received their medicines on time and as prescribed.

Controlled drugs were stored securely in all areas we looked at; however, we found on some occasions that controlled drug registers in the resuscitation department were not completed in line with trust policy. Data provided to us, by the trust showed pharmacy department-controlled drugs audits were taking place however none were provided for the main accident and emergency department.

We found no oversight of controlled drug discrepancies in the main department with senior staff informing us that there was no definitive process in place for escalation and this was something they were looking to improve. Whilst on inspection the automated dispensing cabinet where medicines were stored displayed an unresolved discrepancy which both senior staff, we spoke with were not aware of.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. There was currently no clinical pharmacy service in the emergency department however all staff we spoke with confirmed that should support be required it could be obtained by contacting the pharmacy department.

Staff completed medicines records accurately and kept them up to date.

Urgent and emergency services

We observed that staff did not always follow trust policy and procedure for the storage of controlled drugs and other medicines. During the inspection we found a controlled drug and other medications in an unlocked cupboard in the clean utility room. This was escalated to the nurse in charge, and the risk was addressed immediately.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Currently there was no clinical pharmacy support for the department to enable them to carry out medicine's reconciliation, although we were told that recruitment for a pharmacist for the emergency department was ongoing. We did however see evidence of medical staff obtaining a brief history regarding regular medications.

Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. We found no evidence of this whilst on inspection.

Incidents

Serious incidents which occurred within the trust were not always reported in line with national guidance. However, when things went wrong, staff apologised and gave patients honest information. Local managers investigated incidents and shared lessons learned with the whole team and the wider service.

Data showed that between March 2022 and February 2023 the department reported 8 serious incidents in urgent and emergency care.

Staff knew what incidents to report and how to report them.

Staff now knew how to raise concerns and report incidents and near misses in line with trust policy.

Staff did not always report serious incidents clearly and in line with trust policy. We saw evidence of this in the thematic review of missed fractures in the emergency department.

All staff were aware of the duty of candour, and they understood the importance of being open and honest when delivering care and gave patients and families a full explanation if and when things went wrong

Staff received feedback from investigation of incidents, both internal and external to the service.

Lessons were learnt following the investigation of incidents and learning was shared with staff via emails, shift handovers and safety huddles. There were examples on display where a range of staff shared learning about serious incidents. Several staff told us they had received direct verbal feedback. Staff told us that simulation training was delivered in response to incidents. The trust conducted a thematic review of missed fractures within the Emergency Department, recommendations for changes to practice were implemented.

Staff met to discuss the feedback and look at improvements to patient care. Staff now received feedback from investigation of incidents and had the opportunity to discuss the feedback and look at improvements to patient care. From reviewing clinical governance minutes and reports we saw evidence of incidents being monitored and discussed.

Urgent and emergency services

There was evidence that changes had been made as a result of feedback. Following a serious incident relating to a patient transfer from West Cumberland Hospital to Cumberland Infirmary, the service developed the High-Risk Transfer policy to support decision making around patient transfer which has implemented into practise. Whilst on inspection we reviewed a high-risk patient transfer which was appropriate and timely.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We saw evidence in investigation reports were kept informed and updated.

The clinical team debriefed and supported staff after any serious incident.

Is the service effective?

Requires Improvement 

Our rating of effective stayed the same. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff did not always protect the rights of patients subject to the Mental Health Act 1983.

Staff had access to and followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

The emergency care and medicines group participated in national benchmarking clinical audits and followed National Institute for Health and Care Excellence (NICE) guidelines. Baseline assessment tools were implemented following participation in NICE guidelines 108: Decision making and mental capacity. We saw evidence of further training and protocols had been developed since participation.

We reviewed data that showed that the emergency department worked towards the ten recommendations that is set out by the Royal College of Medicine (RCEM) report how to achieve safe, sustainable care in our emergency departments.

Staff did not always protect the rights of patients subject to the Mental Health Act and did not always apply and follow the code of practice.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural, and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients were given the option of hot and cold food whilst they were in the department. Staff were able to request snack packs for patients outside of mealtimes.

During inspection we observed that patients all had water jugs and cups.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Any specialist diets were colour coded and prepared separately and brought to the unit from the kitchen on a separate trolley. Dietary information was available that gave a breakdown of ingredients and nutritional information.

Drinks and snacks were available in the waiting room vending machines.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. However, staff did not always fully and accurately complete patients' fluid charts where needed.

Pain relief

Staff did not always assess and monitor patients regularly to see if they were in pain and did not give pain relief in a timely way.

Staff did not always assess patients' pain using a recognised tool and did not always give pain relief in line with individual needs and best practice. We saw in 15 patients records that no pain scores were recorded.

Patients did not always receive pain relief soon after it was identified and when they needed or requested it.

Staff prescribed but did not always administer and record pain relief accurately. We found occasions when pain relief was not given as prescribed. We saw no rationale was documented as to why prescribed doses had not been administered.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. The emergency care department took part in several national clinical audit reports in 2023 that had been completed and ratified.

Data from the Royal College of Emergency Medicine (RCEM) pain in children 2020/2021 showed that performance had significantly improved since the last audit in 2017/18 across all the three standards, and the trust was now performing above the national standard in most areas.

Data from the RCEM infection prevention and control national report 2020/21 identified two areas of improvement. Patients who are identified as vulnerable (for example immunosuppressed) are only isolated in a side room 37% of the time. Secondly patients identified as being potentially infectious, it typically took 45 minutes from arrival in the department to being placed in isolation. This was related to prolonged triage times and limited bed capacity to isolate patients.

Data reviewed from British Thoracic Society (BTS) Outpatient management of pulmonary embolism 2021 showed that the results were in line with national results and the recommendations from the national audit would apply.

At the time of the inspection the service told us that the 2022/23 cycle of the Seven Day Standards Audit was not available.

Urgent and emergency services

Outcomes for patients were positive, consistent, and met expectations, such as national standards. The emergency department did provide action plans following their clinical audit programme to outline how they would action and sustaining improvement and outcomes.

Managers and staff used the results to improve patients' outcomes.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The department had a planned comprehensive audit programme.

Managers used information from the audits to improve care and treatment. Managers told us that audits were used to identify areas of learning and improvements. Results from audit were linked to the department's education and training programme.

Managers shared and made sure staff understood information from the audits. Information from audits were disseminated across the emergency department.

The service had a lower-than-expected risk of re-attendance than the England average. The trust percentage of patients that reattended the A&E department within seven days of a previous attendance was generally similar to, or lower than, the England and regional averages from March 2021 to February 2023

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. Staff had the appropriate skills and knowledge to meet the needs of the patients. All nursing staff in the ED had either completed or working towards completion of the Manchester Triage Training (MTS). Data provided by the trust showed that paediatric triage compliance was 100% and adults 94%.

All adult and paediatric nursing staff completed the Royal College of Nursing Emergency Competency framework which included face to face training sessions, simulations and included paediatric sessions.

Staff attended annual study days for adults and paediatrics which were aligned to the Royal College of Nursing (RCN) competencies. We saw evidence of scheduled training dates and courses for the next 6 months.

Newly recruited staff members completed preceptorship training framework over a 23-month period.

The department had access to specialist link nurses for dementia, safeguarding, and sepsis.

Staff in the emergency department had not completed training for clinical safe holding techniques or positive behavioural support and were not able to deal with patients who presented with challenging behaviours. Managers gave all new staff a full induction tailored to their role before they started work. The department had a comprehensive induction which included competencies and equipment checklist. The clinical educators provided support and supervision to newly recruited staff. Staff that we spoke with were positive around the induction process and felt supported by the ED team.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. The trust did not provide data for nursing staff appraisals rates.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Appraisals rates for medical staff were 72%.

The clinical educators supported the learning and development needs of staff. The department each had a clinical educator who role was to support learning and development.

Managers made sure staff attended team meetings notes were disseminated when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Multidisciplinary working

Doctors, nurses, and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held daily multidisciplinary meetings to discuss patients and improve their care.

Staff referred patients to the Psychiatric Liaison Team (PLT) for mental health assessments service when they showed signs of mental ill health, depression, self-harm, or suicidal thoughts.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week. The emergency department was open 24 hours a day, seven days a week. Consultant cover was provided in line with RCEM Workforce Recommendations 2018.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. The department had developed patient information leaflets as an online resource and there were posters with quick response (QR) codes around the department so that patients could look at any leaflets that might be useful.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Urgent and emergency services

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff did not always support patients to make informed decisions about their care and treatment. They did not always follow national guidance to gain patients' consent. Staff did not always demonstrate the correct skills to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They did not always use agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. However, we observed that this was not always applied in practice.

Staff did not always gain consent from patients for their care and treatment in line with legislation and guidance.

When patients could not give consent, staff told us that they would make decisions in their best interest, taking into account patients' wishes, culture and traditions. We observed on inspection one incident where staff did not follow best interest decision making for the patient. We escalated this to the chief nurse at the time, however the response was not immediate but was later resolved.

Staff made sure patients with capacity to make decisions consented to treatment based on all the information available.

Staff did not always record consent in patients' records.

83% of nursing, medical, and paediatric staff had received and kept up to date with training in Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff that we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them.

Staff knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Policies could be accessed via the intranet and paper copies were available within the department.

Staff did not always implement Deprivation of Liberty Safeguards in line with approved documentation.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Privacy curtains were drawn when required protecting the patient's dignity.

Urgent and emergency services

We observed staff taking the time to positively interact and engage with patients and those close to them in a respectful and considerate way.

Patients and relatives told us staff treated them well and with kindness. During the inspection, we spoke with several patients and relatives. They told us that staff were helpful, kind, and considerate to their needs.

Staff did not always follow policy to keep patient care and treatment confidential.

Staff mostly understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We observed staff interactions with a patient who had presented requiring mental health support. The strategy used in this instance was to avoid any interaction with the patient. This patient was managed inappropriately which led to an escalation of symptoms.

Each member of staff was kind, showed empathy and was understanding to their needs.

Staff recognised, understood, and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs. There were posters in the department with details of religious and spiritual support that what was available for patient and how to access.

Emotional support

Staff provided emotional support to patients, families, and carers to minimise their distress. They understood patients' personal, cultural, and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed staff providing support to both patients and relatives.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. The department had a relative's room which could be used.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff had completed end of life and bereavement training as part of their induction process to help them when dealing with difficult situations. There was further additional staff training available.

Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them. Staff demonstrated that they were aware of emotional and social factors and what impact it could have. Staff could refer and signpost patients to other services and external agencies.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families, and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. We observed staff across all areas of the department explaining to patients their plan of care and answering any questions that patients asked. We spoke with several families. They told us that staff had explained what was happening and kept them updated.

Staff talked to patients in a way they could understand, using communication aids where necessary.

Urgent and emergency services

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The trust sends all patients who have attended the emergency department a SMS text message with a link to a patient experience tool which contains the friends and family questions.

Staff supported patients to make advanced decisions about their care.

Staff supported patients to make informed decisions about their care.

The feedback from the Emergency department survey test was positive. The feedback from the emergency department friends and family survey June data showed a positive response rate of 74%.

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement.

Service delivery to meet the needs of local people.

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. The ED service had a general practitioner (GP) streaming pathway for ambulatory patients that presented with a primary care complaint. Appointments were provided between 9am- to 5pm. Cumbria Health on Call (CHOC) provided out of hours support appointments Monday to Friday 6:30pm to 8am and 24 hours at weekends. This is in line with recommendation 1 set out in RCEM report “How to achieve safe, sustainable care in our Emergency Departments”.Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The emergency department had single bed bays for patients.

Facilities and premises were appropriate for the services being delivered.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia. Psychiatric Liaison Team (PLT) were available 24/7 for support and assessment. The department had link specialist nurses available for support.

The emergency department had systems to help care for patients in need of additional support or specialist intervention.

The service relieved pressure on other departments when they could treat patients in a day.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Urgent and emergency services

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. The emergency department used 'This is me' and passports to support patients who had particular needs as a result of a learning disability. These booklets, owned by the patients, detailed personal preferences, likes/dislikes, anxiety triggers and interventions, all of which were helpful in supporting patients during difficult periods.

The service had information leaflets available in languages spoken by the patients and local community. Information for patients was available in a range of formats, including easy read information and large print.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Access to translation and interpretation services were available. Sign language interpreters could also be provided for patients with hearing or speech-impairment who required a qualified communicator, 24 hours a day.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Access and flow

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

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets.

In March 2022 to December 2022 the trust averaged 8,800 attendees per month however in January and February 2023 this dropped below 8,000 to 7,634. There has been an increase in March 2023 to 8,731, which replicated the trend last year.

Cumberland Infirmary saw a reduction in the percentage of ambulance handovers taking more than 60 minutes from 19.7% in December 2022 to 2.2% in April 2023. This was very similar to the reduction seen for the regional ambulance service, Northwest Ambulance Service, overall.

The trust's median time from arrival to initial assessment was consistently shorter than the England average from March 2021 to June 2022. Between June 2022 and October 2022, the trust did not submit data. Once they did start to resubmit, performance was longer than the England average however it had improved in the last two months, seeing a return to national average.

Trust data showed that 62% of patients were seen within 4 hours in May 2023.Managers and staff worked to make sure patients did not stay longer than they needed to.

The number of patients leaving the service before being seen for treatments was low. The percentage of the trust's patients that left the ED before being seen for treatment was consistently lower than the England and regional averages for the last two years.

Data showed in February 2023 the trust percentage was 2.8% compared to the England average of 4.8% and regional average of 5.3%.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs, however they experienced significant challenges relating to access to other services for discharge.

Urgent and emergency services

The trust's percentage of patients waiting more than four hours from the decision to admit to admission had increased, which meant performance had deteriorated considerably from 36.0% in June 2022 to 60.8% in December 2022. This was much greater than the increase in the England and regional averages over the same period (from 35.0% to 44.1%). Since December this had improved but remained higher than both the England and the Northeast average.

There was a considerable increase in the number of the trust's patients waiting more than 12 hours from the decision to admit to admission from 199 in June 2022, to 728 in November 2022. This figure has declined since then but as of March 2023 is at 439. Overall, the last 12 months have seen an upward trend.

Staff supported patients when they were referred or transferred between services.

Managers monitored patient transfers and followed national standards.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives, and carers knew how to complain or raise concerns details of how to make a complaint were displayed in patient areas.

Staff told us that they understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. Complaints were investigated by the care group and assigned an investigating officer.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. We saw evidence that learning from incidents were disseminated across the team.

Staff could give examples of how they used patient feedback to improve daily practice. Staff that we spoke with could provide examples of complaints and what changes had occurred.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Urgent and emergency services

The department leaders had the relevant skills, knowledge, experience, and integrity to run the service.

The emergency department was part of the Emergency Care and Medicines care group. The care group had an associate director of nursing, associate medical director and an associate director of operations. Beneath this, was the service triumvirate team which comprising of a clinical director, matrons, and managers.

The care group met weekly and monthly to review operational oversight of risk, challenges, performance, and learning.

We identified ongoing issues with restraint training, the use of restrictive practices and environmental issues. We were not assured that leaders had addressed all the key concerns highlighted at the last inspection or had sufficient oversight of their progress to date.

Staff told us that at service level the triumvirate team were visible, supportive, and approachable, however the senior leadership were not widely recognised across both sites.

Staff told us the clinical director and consultants were very supportive to the ED medical and nursing team.

Staff were supported to develop their knowledge and skills and take on more senior roles.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

There was a clear vision in place which was on display within the emergency department to provide safe, high, quality care for every patient every time. The vision encompassed 4 values which included kindness, respect, ambition, and collaboration.

The service had a number of strategies that supported the trust vision.

The trust did not have mental health strategy; however, they had a service level agreement with another mental health trust.

Culture

Staff mostly felt respected, supported, and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear, however staff felt that not all managers and leaders were open and responsive.

Staff continued to display resilience following the impact of the COVID-19 pandemic and wider system pressures. Despite the challenging circumstances, staff were positive about working within the emergency department and praised the teamwork and educational ethos.

Frontline nursing and medical staff described a positive working relationship with each other.

Staff told us that they had raised concerns about the use of offensive language in meetings. Staff reported that the language used had been deemed as unacceptable, but this had not been followed up with meaningful action by the leadership team.

We reviewed the data from the national staff survey 2022 result which were disappointing. Results highlighted emergency care and medicine staff were at risk of burnout and required wellbeing support. Action plans have been developed.

The occupational health and wellbeing service provided an opportunity to reflect safely with colleagues, within their own team, on the challenges and experiences they had been facing.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Senior leaders and senior staff had clear roles and responsibilities for managing risk and incidents outlined in the emergency care and medicines group governance framework.

The emergency department appointed a consultant as the governance lead which included mortality. We reviewed the minutes from the emergency department clinical governance monthly meetings from March, April, and May 2023 which detailed a clear agenda and ownership of action points.

Information boards within staffing areas clearly displayed specific learning and development requirements, as well as outcomes from departmental audits which served as visual aids for staff members.

However, we found examples on inspection where processes were not undertaken in line with trust and national guidance which had been highlighted as concerns at the last inspection.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The emergency department had a risk register. We spoke to departmental leaders and staff, and they told us about their risks on the register and the strategies they were taking to address the concerns, however some of the risks they told us were not on the risk register.

The trust had a major incident framework which detailed how to appropriately respond to internal and external declared critical or major incidents which was in date and version controlled.

The trust had an electronic central alert system (CAS) policy and procedure to communicate and disseminate important patient safety and device alerts information.

Urgent and emergency services

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

During our inspection we found safeguarding information was recorded on both paper and electronic patient records. We found inconsistent recording of information which did not always correlate. This meant data was not always accurate in providing an overview of service activity and performance to ensure informed and effective decisions could be made to improve the service.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.

The emergency care and medicines group clinical governance disseminate a newsletter to all staff to publish key messages, patient experience and learning and quality improvement.

The emergency care and medicines group engage with staff by arranging away days, lunch and learn events for example following incidents around specific areas such as safeguarding.

The emergency department also received thank you cards and messages which staff were informed about when it was a personal compliment.

The trust continued to work hard to improve the patient experience when accessing the service. This was based upon listening to patients and gathering feedback to align service delivery with the needs of the local population and to ensure the highest possible standards of care were being delivered.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The department was committed to quality improvement by addressing incidents and complaints to improve patient safety.

The emergency department clinical educators had taken steps to promote a learning culture which adhered to both RCEM and NICE guidelines.

We spoke with the quality lead for the department who told us that staff were encouraged to lead on quality improvements projects and develop initiatives and further learning.

The trust had a quality improvement strategy delivery plan which focused on 10 quality improvement initiatives for 22/23.

Medical care (including older people's care)

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory Training

Although the service provided mandatory training in key skills, not all staff ensured that their training records were kept up to date.

Not all nursing staff kept up to date with their mandatory training. Data provided by the trust highlighted shortfalls with basic life support training (between 50% and 83% compliance), immediate life support training (between 55% and 71% compliance) moving and handling level 2 training (between 71% and 83% compliance).

Most medical staff kept up to date with their mandatory training. However, there were some shortfalls with the completion of fire safety awareness training and basic life support training within the medical staff cohort.

Managers were able to monitor mandatory training and could alert staff when they needed to update their training.

The mandatory training was comprehensive and met the needs of patients and staff.

The trust provided us with evidence following our inspection which showed staff completed training specific to supporting patients with mental health needs, learning disabilities, autism and dementia.

Safeguarding

Staff understood how to protect patients from abuse and the service worked with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing staff received training specific for their role on how to recognise and report abuse. However, at the time of the inspection there were some shortfalls with levels 2 and 3 safeguarding adults training

Medical staff received training specific for their role on how to recognise and report abuse and at the time of the inspection, compliance rates for safeguarding training were generally in-line with trust targets. However, there were some shortfalls with PREVENT awareness training and level 2 safeguarding children training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Despite some shortfalls in safeguarding training compliance, staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. However, on the wards we visited as part of the inspection, we did not always see safeguarding information and guidance on display for both patients and staff.

Cleanliness, infection control and hygiene

Although staff used equipment and control measures to protect patients, themselves and others from infection and kept equipment and the premises visibly clean, the service did not always follow infection prevention and control guidance in regards to suitable storage of materials to enable thorough cleaning of the premises.

Ward areas we visited were clean and had suitable furnishings which were clean and well-maintained.

The service performed well for cleanliness and cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Across all wards visited, staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff told us that they had collectively taken on responsibility to ensure that levels of cleanliness remained high upon their designated ward and specific times were allocated for staff to focus solely on cleaning. Furthermore, we observed regular on-site cleaning and domestic support being provided by a third-party contractor utilised by the trust.

The trust provided us with up-to-date versions of the policy for decontamination of reusable medical devices which was scheduled for review in June 2027.

Trust-wide IPC standards were consistently high with most wards achieving over 90% compliance with COVID-19 and clostridium difficile (CDiff.) audits. Where IPC action plans had been developed as a result of issues highlighted within audits, we saw evidence of progress made against these objectives to improve standards of IPC. Although general standards of cleanliness and IPC adherence were positive, data supplied by the trust highlighted inconsistencies with the submission rates for IPC audits over the entire medical division, with only four wards within the entire trust having a submission rate of 90% and above for May 2023.

All wards had access to hand gel on entrance with relevant guidance on promoting high levels of hand hygiene. We also saw multiple examples of signs displayed outside ward side rooms reminding staff about standard precautions of hand hygiene, effective cleaning and use of PPE for infection, prevention and control for patients who were infectious. One of the wards we visited had also received a trust-wide diamond award due to 730 days elapsing since its last hospital acquired infection. However, trust-wide compliance for hand hygiene training was only 78% against a target of 95%.

Staff mostly followed infection control principles including the use of personal protective equipment (PPE). However, during the inspection we saw storage of some consumable items in large boxes which was not in-line with infection control guidance, as they had been placed on the floor within stock cupboards instead of designated shelving.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff managed clinical waste well, however hazardous substances and sharps products were not always stored securely and safely. The trust also continued to experience challenges monitoring hazards associated with the main atrium within the hospital setting which had previously impacted upon patient safety.

Medical care (including older people's care)

All wards inspected had secure access. However, some staff told us they had concerns surrounding visitors accessing wards by tailgating staff at door entrances. We observed this happening and did not see staff challenge visitors. We also did not see information displayed at ward entrances highlighting the importance of secure restricted access.

During the inspection we observed storage doors left open on most wards we inspected. Doors had digi-locks in place; however, most doors were either left propped open or unlocked. Storage rooms contained consumables for the wards including, sharps, venflons, intravenous fluids (IV), meal replacements drinks and dietary supplements. We also found sluice rooms and storage rooms that stored substances such as alcohol solutions and cleaning products were left unlocked. Hazardous cleaning fluids were stored on work surfaces in the sluice rooms in large containers ready for use.

On multiple wards we saw several bottles of chemical cleaning solution stored on trollies in corridor areas. This was used for the cleaning of equipment, however, should be stored in locked storage cupboards, in-line with control of substances hazardous to health (COSSH) guidelines. This was a safety risk as patients and visitors had free access to the unlocked storerooms where these potentially hazardous items were stored. Some patients on the wards were vulnerable frail elderly with the potential for episodes of confusion and delirium.

We also found the inappropriate disposal of glass items within a sharps box on one of the wards where the lid had not been fully closed, presenting a potential needle-stick injury risk. We escalated our concerns to senior leaders on the day of inspection. However, we were not fully assured of safe and effective practice surrounding the storage of hazardous chemicals and sharps products.

The same concerns were escalated during the inspection with the senior leadership team for medicines, who told us that environmental audits were undertaken routinely and agreed that our concerns would be reviewed and actioned accordingly.

On a number of wards we observed oxygen cylinders which were not stored securely in cages or secure wall brackets in line with guidance.

We saw issues with some domestic appliances used by staff on the wards during refreshment and meal breaks, with some kitchen appliances not having relevant safety test stickers attached to them. Some staff also highlighted concerns regarding the discharge lounge kitchen and its non-adherence to fire safety standards. During the inspection we also observed fire doors which had been left open via the use of wall-mounted hooks and door stops, which was against fire safety protocol. We requested the fire risk assessment to gain further assurances regarding the ongoing safe use of this area which stated the current facilities were “tolerable”. However, the fire risk assessment also highlighted our concerns regarding fire doors being propped open by staff, with the recommendation that this must “cease”. At the time of the inspection, this had not yet been fully implemented by managers of the service.

Inappropriate storage of equipment also presented a potential fire risk, as we observed one storage area which was full of what appeared to be items of lost property.

Most patients could reach call bells; however, staff did not always respond quickly when called. On several differing wards we noted call bells were not always answered in a timely manner. We saw some delays impact on patient’s wellbeing, with some patients appearing to be visibly upset. On a range of wards inspected, we also observed several patients in bed with bed rails in use, without access to call bells. We escalated this at the time of inspection to ensure staff responded quickly to assist patients.

Medical care (including older people's care)

Prior to the inspection the trust had reported and investigated two serious incidents related to environmental factors within the hospital. Initial investigation findings highlighted the need to re-assess the safety of the balustrade surrounding the atrium of the hospital.

During the inspection, we saw two chairs left outside individual wards on each level of the atrium. On the final day of inspection, a patient bed had been left outside one of the wards on the first floor of the atrium. This presented a potential risk to patients and visitors who could use these to climb over the balustrade, we raised this with senior managers during the inspection.

We also observed large metal storage cages containing stock consumables left on the atrium corridors on both levels for over 90 minutes without staff oversight. There were differing stock items within the delivery; some consisting of clinical sharps. Whilst on-site, we were not assured the potential risk had been fully mitigated. Following the inspection, senior leaders told us an action plan was in place with ongoing review surrounding financial costings to extend the height of the balustrade. There was a working group in place and daily monitoring of the corridors to ensure staff kept corridors clear of equipment.

Although the trust continued to experience challenges monitoring risks associated with the current layout and design of the main atrium area within the hospital, the overall design of ward environments followed national guidance.

All departments within the hospital were clearly signposted and easy to find and entrances onto all of the medical wards were covered by an intercom service.

Although there were some concerns with the inappropriate storage of items in clean utility cupboards, all ward areas visited were tidy and clutter free.

There were dedicated relatives' rooms located either within or within close proximity of the wards we visited, all of which were suitably furnished and visibly clean, most of which provided access to a water cooler.

The service had enough suitable equipment to help them to safely care for patients and staff carried out daily safety checks of specialist equipment such as hoists.

We saw multiple resuscitation trolleys across a range of wards. All of which were suitably cleaned and maintained. Safety check logs for the resuscitation trolleys were requested from the trust post-inspection due to there being no historical checks held in paper form. Data provided after the inspection highlighted regular checks had taken place across a range of the wards we visited.

Clinical waste was managed in a way that kept people safe. Arrangements were in place for the segregation, storage and disposal of waste.

Most of the consumable items that we checked during our inspection were within their expiry date. However, we did find some syringes that had recently expired. These items were immediately removed by staff and disposed of accordingly.

Assessing and responding to patient risk

Although staff completed and updated risk assessments for each patient and quickly acted upon patients at risk of deterioration, they did not always remove or minimise all risks.

Medical care (including older people's care)

One serious incident which had been reported by the trust was in regards to the volume levels of the emergency alarm linked to patient monitoring equipment on one of the wards. During the inspection we received relevant assurances that learning had taken place to ensure the alarm would always be audible in the case of a patient emergency and that staff would be stationed near the monitoring station to ensure a constant level of observation.

We were told during inspection that despite ketone testing machines being available within the medical care division, staff continued to use machines allocated to other departments within the hospital. As an alternative means of testing for ketones in diabetic patients, staff could have have used a 'dip stick' to test for Ketones. Insulin chart guidelines state that should a patient's blood glucose readings be 15 mmol or over, a ketone test must be completed. However, we saw examples where no ketone testing had been undertaken, despite a reading of 15 mmol or over having been recorded, potentially putting the patient at risk of harm.

Staff completed relevant risk assessments for each patient on admission or arrival, using nationally recognised tools which were reviewed regularly, including after any incident.

During the inspection, we saw evidence that staff used the national early warning score (NEWS2) tool to identify deteriorating patients and we saw examples in patient notes where appropriate escalation had taken place to ensure patient safety. The most recent sepsis audit data highlighted that all wards had consistently recorded patient NEWS2 scores. Compliance rates for NEWS2 training were consistently high across the medical division with only some shortfalls noted across wards. However, the most recent sepsis audits completed by the trust highlighted some inconsistencies with overall standards, particularly regarding the completion of the sepsis screening tool where only two medical wards scored above 80% and obtaining patient observations as per trust policy, where compliance ranged from 5% to 100%.

Waterlow pressure damage assessments were present within patient records. In addition to this, ward managers advised us that staff would complete a body map for patients admitted onto the ward as a further means of monitoring patient skin integrity. Patient records also contained SSKIN bundle documentation, a nationally recognised skin integrity assessment tool, which was consistently completed across all wards. Furthermore, staff compliance rates with tissue viability training were consistently high across all wards.

We saw evidence that falls risk assessment and management plans (FRAMP) were completed upon admission to wards. Other steps had also been taken across multiple wards, such as the allocation of a computer on wheels (COW) and the allocation of staff members to patient bays to ensure enhanced levels of observation were available to monitor patients potentially at risk of falling. Data provided by the trust showed trust-wide compliance for trips, slips and falls training was consistently high across all medical wards.

The trust acknowledged that patient falls had been particularly problematic, and during the inspection we saw examples of work being undertaken to address this issue via the use of a falls prevention board. This would serve as a prompt for staff to ensure that enhanced observations could be undertaken to mitigate the risk of patients potentially falling. There was evidence of improvement as a result of this on the acute medical unit where no falls incidents had been recorded at the time of the inspection, compared to 10 for the previous month.

Patient documentation also included use of the malnutrition universal screening tool (MUST), a five-step screening tool used to identify adults who are malnourished, at risk of malnutrition or obese.

Staff told us that 24-hour access to mental health liaison and specialist mental health support was available if required and staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Although there could sometimes be delays accessing resources due to overwhelming demand within the trust.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe which included any issues with nutrition and hydration, pressure sores and patient falls.

Nurse staffing

It was recognised by senior management that the service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from the risk of avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and efforts were made to increase staffing levels for each shift. However, this did not always provide established safe levels of staffing.

Due to national shortages of nursing and support staff the service did not always have enough nursing and support staff to keep patients safe. All wards inspected had vacancies for qualified nurses and healthcare assistants. The trust had recently employed internationally recruited nurses and staff were able to explain the mentorship and support the recruits required. However, staff in the areas we inspected told us they were often short of qualified nursing staff. Senior leaders told us the trust had recruited healthcare assistants to assist in clinical areas. We saw evidence of this on one particular ward where 4 staff on duty were newly appointed.

During the inspection, staffing information displayed on multiple wards we visited highlighted that actual staffing, which included registered nurses and healthcare assistants, did not meet the planned numbers. Ward leaders were not always supernumerary due to low staffing numbers.

We visited an elderly medicine ward with 33 beds caring for frail elderly patients where staffing shortfalls for both registered nurses and healthcare assistants were evident. At the time of the inspection, the ward had 31 patients, with two patients requiring one to one support due to high risk of falls. The ward manager had requested additional support from the enhanced care team via escalation to the senior leadership team. However, no additional support was available and ward staff had to support the needs of the patients requiring one to one supervision.

Ward managers could adjust staffing levels daily according to the needs of patients. However, staff shortages were not always met. Staff told us they reported staffing shortages on the incident reporting system identifying themes and trends.

Staff members that we spoke with expressed their frustrations at the ward moves their team encountered due to short staffing across the entire medical care division. Staff told us that staff shortages often impacted on patient care as gaps in staffing were not always filled.

Additional data provided by the trust highlighted a total of 13 staffing level incidents were raised between March 2023 and May 2023 making reference to inadequate nursing cover within the medical care department.

Furthermore, staffing on the hyper-acute stroke unit (HASU) did not meet national institute for clinical excellence (NICE) guidelines of one registered nurse per two patient. We were told by staff that the approximate ratio on the day of the inspection was one nurse to seven patients, with support also available from health care assistants and a range of therapy professionals. Despite this, we did not have any concerns regarding immediate patient safety.

The trust provided us with copies of the Situation-Background-Assessment-Recommendation (SBAR) tool used to review staffing across all medical wards. The tool highlighted what normal staff establishment levels should be for each ward across the division, as well as specific risks associated with volume and complexity of patients. This enabled managers to make informed decisions regarding staff redeployment to promote patient safety.

The most recent data provided by the trust for April 2023 showed a trust-wide overall vacancy rate of 4.46% for band 5 and above qualified nursing staff. This had reduced from 6.07% in March 2023.

The most recently logged trust-wide staff turnover rate was recorded as 8.1% in March 2023.

The trust told us that a formal nurse staffing establishment review had not been completed since the previous staffing establishment uplift was approved by the trust board in February 2022 and the focus moving forward had been on reducing vacancy rates and supporting new staff. The next staffing establishment review would take place in July 2023.

The service continued to regularly use bank and agency nurses on the wards. However, managers tried to limit their use of bank and agency staff and requested staff familiar with the service.

Managers assured us that all bank and agency staff had a full induction and understood the service, with many of the current pool of bank staff having worked within the trust for a number of years.

Medical staffing

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

At the time of the inspection, the service had enough medical staff to keep patients safe. However, additional data provided by the trust highlighted a total of five staffing level incidents were raised between April 2023 and May 2023 referring to inadequate doctor cover within the medical care department.

Senior managers told us that there was ongoing recruitment with a new substantive consultant joining the trust in July 2023 and further candidate interviews scheduled for summer 2023. Furthermore, the trust continued to advertise locum vacancies in an ongoing effort to boost medical staffing trust-wide.

The most recent data provided by the trust for medical staffing vacancies across the emergency care and medicine division for April 2023 highlighted a rate of 22.88% for consultants compared to 20.85% for March 2023. Vacancies for other medical grade staff had dropped to 20.3% in April 2023 compared to 27.23% in March 2023.

Sickness rates for medical staff for the period April 2022 until April 2023 was 2.44% which was below the trust target of 4%.

The most recently logged trust-wide staff turnover rate was recorded as 8.1% in March 2023.

The service had reducing rates for the use of bank and locum staff.

Managers could access locums when they needed additional medical staff and made sure a full induction to the service was provided before they started work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly and consultant cover was available during evenings and weekends.

Records

Overall, staff kept detailed records of patient's care and treatment. However, the trust used a mix of paper and electronic records which at times impacted upon staff accessing key information in a timely manner. Records were still not stored securely which was highlighted as a must-do action at the last inspection. However, staff were able to promptly access notes to assist with the delivery of patient care.

During the inspection there was a lack of consistency with the storage of patient records across most wards, these continued to not always be securely stored. On all wards we visited, notes trollies were mostly left unlocked and unattended, with patient notes stored underneath trollies and easily accessible to visitors. Some paper records on wards we visited were stored in folders outside of each bay, or in folders not stored securely in the bay.

We saw medical records left out unattended in main corridors and also saw a doctor's office where the door had been wedged open and medical records had been left inside unattended.

We also saw several computer screens left open on differing wards, allowing easy access into confidential patient records. This was in breach of trust policy and General Data Protection Regulation (GDPR).

We were therefore not assured that the care group had oversight of the ongoing risk given as this had been flagged as a must do action at the last inspection.

Although patient notes were generally comprehensive across the wards we visited, some patient records sometimes lacked key details regarding patient risk assessments and fluid balance data. In the case of monitoring patient hydration, it was not always clear whether a patient's fluid intake was within normal range, and we did not always see the information written on the patient's whiteboard in relation to restrictions for nutrition and hydration recorded anywhere in the paper notes. Furthermore, there were inconsistencies with staff ensuring that they printed their name and role within medical record entries.

The trust completed an audit programme for patient records whereby a sample of 15 randomly selected electronic and paper records would be scrutinised. Compliance levels were consistently good across all wards selected for the audit, with the most recent trust-wide score for May 2023 highlighting 91% compliance for paper records and 96% for electronic records. However, key areas of concern echoed those of the inspection team; legibility of notes, designation of author rarely printed alongside signature and paper records were often found to be in a poor state.

Although staff were able to easily access patient notes, the wards used both a paper and electronic system which, on occasion, made it difficult for the inspection team to track patient's care and treatment as it was hard to navigate between the systems. For example, one patient record we observed referred to deprivation of liberty safeguards (DOLS) being in place in the paper notes. However, we could not find the DOLS documentation and supporting mental capacity assessment (MCA). Staff members we initially spoke with were also unable to locate the documentation until it was later found to be fully up to date and stored on the electronic system.

However, the records that we checked showed risk assessments had been completed appropriately and associated actions had been taken to promote patient safety.

Electronic whiteboards were used on all of the wards we visited which recorded key information about patient risks and treatment, including flags for patients living with dementia, learning disabilities, patient acuity and discharge plans. The boards ensured that staff had easy access to key information, such as reviews by other members of the multi-disciplinary team and clinical observations.

Medicines

Staff followed systems and processes to prescribe and administer medicines. However, we found prompt access to medicine storage areas across all wards inspected was inconsistent due to ineffective electronic key access.

Registered nurses used electronic battery powered keys to gain entry to clean utilities where medications were stored. Each clinical area had a locked box where individual registered nurses could access a key via a key coded combination. Staff told us and we saw that the key system was often unreliable. The keys did not always unlock clean utility doors impacting on staff time management and immediate access to stored medicines. Data provided by the trust showed that 15 incidents had been reported over the last 12 months in regarding ongoing difficulties with the use of the key system. At the time of the inspection, we were not assured that staff could always access medications in a timely manner.

We escalated this with senior leaders following inspection. Leaders told us the key system was on the risk register and the service level agreement was under review. Concerns were discussed at the patient safety group and medical management group where ongoing issues are monitored.

Staff followed systems and processes to prescribe and administer medicines safely. During inspection we observed the clean utility room temperature on one of the wards we visited was out of range. Staff had recorded the room temperature as 26 degrees and had reported this on the trust's electronic recording system to alert pharmacy and estates staff. The clean utility contained controlled drugs cabinets, medicine cabinets and large amounts of intra-venous fluids. We checked several fluid bags which had storage recommendations of under 25 degrees. We were not assured of the safe storage and management of medicines, specifically in relation to the impact the temperature may have on the efficacy of the products stored within this area. Staff told us this had been a consistent issue for the last 2 years and had not been addressed. However, data provided by the trust highlighted that only one incident had been reported in August 2022 highlighting concerns with the temperature.

We escalated this to senior management on the day of inspection, who advised us that this would be reviewed and actioned.

All other wards inspected had air conditioning within clean utility areas which was used to control room temperatures on individual wards.

Data provided by the trust highlighted that staff did not always complete medicines records accurately. The prescribing and administration audit contained findings from a random sample of ten medicines charts which had been selected from medical, surgical and community hospital ward settings. The most recent findings highlighted poor compliance with staff recording their name and designation in patient records (24%) and only 20% compliance with staff accurately signing and dating cancelled medications in patient records. Only 50% of the records included in the most recent audit had allergies clearly recorded.

There were also shortfalls identified in the most recent oxygen prescribing audit completed in November 2022 where only 35% of a sample of 36 patients based on the acute medical unit had completed oxygen prescribing documentation within their records. The trust provided us with assurances that work had been ongoing to improve performance with oxygen prescribing and the new electronic system would now provide staff with prompts to ensure that oxygen prescribing protocol was being adhered to.

Trust-wide data from the controlled drugs audit showed a significant decrease in quality standards from 91% recorded in quarter 3 of 2022-2023 to 65% recorded in quarter 4. Common themes identified in the controlled drugs audit were lack of signatures in the controlled drugs order book, details of medication strength and form not written in registers and actions identified as part of the previous audit not being completed to drive improvement.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. National practice guidelines were also followed to check patients had the correct medicines when they were admitted, or they moved between services. In the records we looked at, medicines reconciliation had been completed. However, systems in place to record this made it difficult to assess the time frame from the point of admission until this had been completed. Data provided to us by the trust was not broken down by speciality or ward which meant we could not analyse the data for the medicine core service. The narrative accompanying this data also informed us that the information which demonstrates length of time between admission and medicines reconciliation could potentially be inaccurate due to the systems they use to record this on the wards.

Post-inspection we requested the trust-wide alcohol withdrawal policy which had been last issued in August 2020 and was due for review. The trust informed us that work had been ongoing with the Integrated Care Board and Public Health to obtain funding for an alcohol support team and that a priority piece of work would be undertaken by this team to review policies pertaining to alcohol withdrawal treatment.

Staff stored all medicines prescribing documents safely. The most recent audit data provided by the trust highlighted 91% compliance across the entire location with safe and secure handling of medicines audits. The Safe and Secure Handling of Medicines Audits are undertaken each year in all areas where medicines are stored. Feedback from these audits was shared with the ward manager or lead person responsible for storage of medicines on completion of the audit.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Incidents

Serious incidents which occurred within the trust were not always reported in-line with national guidance. However, when things went wrong, staff apologised and gave patients honest information and suitable support. Local managers investigated incidents and shared lessons learned with the whole team and the wider service.

We were not assured of senior management oversight of serious incidents reported within the trust. Although staff had been reporting incidents via the standard reporting channels, the trust informed us that they had identified discrepancies with the accurate grading of serious incidents involving patient falls since January 2023. As a result of this, the trust had made the decision to commence a retrospective review of incidents involving falls to determine the overall accuracy of reporting and whether any serious incidents should be declared in retrospect.

The trust had identified similar issues with serious incident reporting involving pressure ulcers. Senior leaders told us that an agreement had been put in place in 2017 with the Clinical Commissioning Group (CCG), whereby only grade 4 (full thickness tissue loss) pressure ulcers acquired in an inpatient setting would be declared as a serious incident. Over

the last 12 months, the trust advised that there had been no acquired grade 4 pressure ulcers and that grade 3 (full thickness and skin loss) pressure ulcers may not have had the level of scrutiny required to determine whether a serious incident should have been raised. As a result, the trust advised us that they would completing a review of all grade 3 pressure ulcers acquired whilst under the care of the trust to determine whether any serious incidents should be declared retrospectively.

Staff we spoke with could describe how to raise concerns and knew how to report incidents and near misses in line with trust policy. Each ward clearly displayed information for the previous month on the number of patients cared for and the number of incidents reported. Ward managers also ensured that information was displayed for the number of incidents which remained open and how many had been open for longer than 30 days.

We saw examples on display where learning had been shared with staff regarding serious incidents. Staff received feedback from investigation of incidents and had the opportunity to discuss the feedback and look at improvements to patient care. For example, one of the wards had displayed information highlighting that there had been 10 falls recorded in May 2023. Two of the falls happened within eyesight of the nursing station and the other eight were unwitnessed from nursing stations. In response to this, the ward had implemented four key actions to mitigate further incidents reoccurring which included use of enhanced observations, ensuring patients had access to appropriate footwear, appropriate use of equipment (including falls alarms) and ensuring the correct categorisation of falls was followed on the electronic reporting system.

Learning points were not generic in nature and we saw other examples across wards where the main area of focus was upon ensuring patients' standing and sitting blood pressures were obtained to monitor for postural drop which had been identified as a significant contributing factor to falls on that particular ward.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Is the service effective?

Requires Improvement ↓

Our rating of effective went down. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff had access to various policies and treatment guidelines, based on best practice from the national institute for health and care excellence (NICE), which were stored electronically and clearly displayed on staff notice boards on multiple wards visited as part of the inspection.

We saw examples of improvement measures being undertaken to improve the quality of care and support delivered to patients, such as improvement of skin integrity monitoring. This had been achieved through the use of visual aids for staff, whereby a laminated picture of a clock would be placed on the patient's whiteboard as a cue to ensure positional turns were completed in accordance with SSKIN bundle recommendations (Surface, Skin inspection, Keep patients moving, Incontinence/moisture, Nutrition/hydration).

Staff could demonstrate an understanding of how to protect the rights of patients subject to the Mental Health Act. We saw examples within ward meetings where staff referred to the psychological and emotional needs of patients to support their wellbeing.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service could make adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Staff told us and we saw that individual wards used differing coloured water jug lids. Staff confirmed that they had instigated the use of differing-coloured lids to demonstrate the volume of water patients had consumed. The coloured lids resembled the traffic light system starting with red, amber and green. Staff told us this was a good visual aid to assist with the oversight of fluid intake.

There were regular recordings of blood glucose levels before mealtimes and appropriate Insulin given for patients with diabetes.

Staff told us that patients were provided with a red wristband to indicate whether they had an allergy to both food or medication, and we saw examples of this across multiple wards during the inspection.

On multiple wards we visited, we saw documentation which contained menus for every dietary need such as kosher, halal, low fat, dysphagia, vegan and nut allergies. This information would then be recorded on individual patient whiteboards located above their bed.

Staff used a nationally recognised screening tool, to monitor patients at risk of malnutrition and specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it.

During the inspection we saw posters on display promoting the nutrition and hydration needs of patients and guidance was on display for staff on how to complete fluid balance sheets.

The trust had also taken steps to gather feedback regarding the quality of food being provided to patients, which could be seen on display in the wards we visited.

However, staff did not always fully and accurately complete patient's fluid and nutrition charts where needed. We saw examples on fluid balance charts where totals had not been completed by staff and information on any fluid restrictions was not always logged. This was flagged with ward managers by our inspection team. Furthermore, managers told us that there were no audits completed for the fluid balance charts in order to monitor overall quality of records.

Medical care (including older people's care)

The most recent Audit of Meeting Nutritional Needs completed by the trust in April 2023 highlighted 70% compliance for the full completion of MUSTs within inpatient settings within the whole trust. Although this was a 32% increase on the previous compliance rate, the audit highlighted shortfalls with staff repeating a MUST for each week of the patient's stay and 100% compliance was not met in any area of the audit, with the highest inpatient compliance score being recorded as approximately 70%.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice and patients received pain relief soon after requesting it. Feedback from patients was positive regarding staff proactively supporting with pain management

Staff prescribed, administered and recorded pain relief accurately in patient records. Patient medication allergies were also observed in the random sample of records that we checked during the inspection.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had previously been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits to monitor effectiveness of care and treatment. Outcomes of national audits were monitored by the clinical effectiveness and audit manager and team. Clinical audits and actions are reported monthly to all care groups and services within the trust. The clinical effectiveness and audit manager also attended care group level meetings to present and outline performance positions within the various care groups.

The trust continued to participate in the Sentinel Stroke National Audit Programme (SSNAP) which monitors the quality of care provided to stroke patients and the overall structure of stroke services available. A total of 44 key indicators are used which represent high quality stroke care. These indicators are then divided into 10 domains and graded from A to E. Cumberland Infirmary achieved an overall SSNAP level of B which was approximately the same grade of other routinely admitting hospitals in the same integrated care system (ICS).

The trust also participated in the Society for Acute Medicine Benchmarking Audit (SAMBA) which states that patients attending hospital between 08:00 and 20:00 should receive a consultant assessment within 6 hours and that patients attending hospital overnight between 20:00 and 08:00 should receive a consultant assessment within 14 hours. The results from the last SAMBA completed in June 2022 showed that consultant review occurred within the outlined time period on 52% of a sample of 58 patients, meeting the national median. Additional data provided by the trust highlighted that the results from the most recent SAMBA had been used to make changes to the acute medicine consultant staffing model at Cumberland Infirmary, with 3 acute medicine consultants now available on a daily basis on-site. The next scheduled SAMBA would be due for completion at the end of June 2023.

Other national audits which the trust engaged in included audit of Inpatient falls, National Diabetes inpatient audit, National lung cancer audit, Chronic obstructive pulmonary disease audit and National audit of dementia. Outcomes for patients were positive, but data provided by the trust highlighted that overall quality standards did not always meet national benchmarks.

We saw evidence on the wards we inspected that managers and staff carried out a comprehensive programme of repeated audits to check improvement over time and the information gathered was used to improve care and treatment. Managers told us that audits would be delegated to members of staff on the ward and reviewed by the ward managers and deputies and action plans created to address any shortfalls. The outcomes of audits would then be shared within governance meetings, newsletters, or posters to ensure all staff were aware of any learning and changes to practice.

Matrons also carried out monthly 'quality rounds' of all their areas of responsibility, which gave an additional level of external assurance wards. Findings from the matron audits would then be shared at the Care Group monthly governance meeting.

Competent staff

Recruitment of healthcare assistants and internationally recruited nurses meant the trust had a mix of staff with differing competencies and skill-set. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. However, completion rates for appraisals were inconsistent across the medical care division.

The trust had recently employed internationally recruited nurses and staff were able to explain the mentorship and support the recruits required. However, staff in the areas we inspected told us they were often short of qualified nursing staff and healthcare assistants with the right skills and competency to care for patients within the medicine speciality.

Most wards we visited during inspection had high numbers of newly appointed internationally recruited nurses and healthcare assistants. Staff told us this impacted on the wards due to inconsistent levels of competency and skill-set of the differing staff on duty. Individual staff are requested to complete mandatory training which covers core skills for both healthcare staff and registered nurses.

Managers told us that all new staff a full induction tailored to their role before they started work and support from clinical educators was also available. Internationally recruited nurses were granted a period of 3 to 4 months supernumerary status to enable them time to settle into their new roles. However, due to the recent influx of newly qualified staff within the trust, we were not always assured that staff had the relevant experience or right skills and knowledge to meet the needs of all patients. Particularly due to the ongoing need for staff to be redeployed within the trust to ensure adequate staffing on sometimes unfamiliar ward environments.

The trust also acknowledged that there were challenges with the rota for senior decision maker (SDM) medical staff cover. Data provided by the trust showed that there was ongoing recruitment for speciality doctors, speciality trainee doctors (ST4) and royal college of emergency medicine (RCEM) accredited senior advanced care practitioners to ensure consistent SDM cover would be available trust-wide.

Managers supported staff to develop through yearly, constructive appraisals of their work. Most of the wards we visited displayed current appraisal rate completion, with most attaining the trust target. However, data provided by the trust highlighted some shortfalls across the medical division where nurse staffing appraisal completion was as low as 40% and 0% logged for medical staff appraisal completion within stroke care.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work.

Managers supported medical staff, at all levels, to develop through regular, constructive clinical supervision of their work via internal and external support networks.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge and support from a clinical educator was available to support this and identify any specialist training which could support staff within their role. Feedback from staff was generally positive regarding continuous professional development.

Managers identified poor staff performance promptly and supported staff to improve.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care and patients had their care pathway reviewed by relevant consultants.

We saw examples of staff working across health care disciplines and with other agencies when required to care for patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health and crisis intervention was required.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards which included guidance on smoking cessation, alcohol awareness and dietary needs.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle.

Upon discharge, some wards provided bags which contained a range of information and guidance leaflets appropriate to that patient’s presenting needs.

Medical care (including older people's care)

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff demonstrated that they had the knowledge and understanding to support patients to make informed decisions about their care and treatment. They followed national guidance to gain patient consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. However, they did not always use measures that deprived patients of their liberty appropriately.

We visited multiple wards during inspection and noted entry and exit access was by staff swipe card only. Staff told us that deprivation of liberty safeguards (DOLS) were only in place for patients deemed to be lacking capacity and that the remaining patients had been deemed as fully capacitated. Senior managers advised us that there was use of blanket restrictions across multiple wards which had been implemented on the basis of ensuring patient safety. Staff would provide patients deemed to have capacity with information about the use of locked doors and told us that they would take relevant steps to enable capacitated patients to move freely from the ward. However, we were not assured that patients may have been inadvertently deprived of their liberty, particularly during busy periods where staff would be focused upon supporting the more vulnerable and frail patients.

Post-inspection, senior leaders told us work was still required to improve staff knowledge surrounding DOLS applications. The trust had doubled the number of DOLS applications and had improved information within them. DOLS facilitators were in place for staff to contact if they required support with an application.

Although the contents of mental capacity act (MCA) assessments and DOLS applications was robust across all wards, the inspection team and some staff members found it challenging to find where the applications were due to the mix of paper and electronic records in use.

Despite our concerns regarding the use of blanket restrictions and challenges locating relevant MCA and DOLS documentation as a result of the electronic and paper-based systems running alongside one another, staff we spoke with understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff also ensured that they gained consent from patients for their care and treatment in line with legislation and guidance. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

During our inspection we saw a noticeboards displayed within ward corridors which reminded staff about the process of assessing patients' mental capacity and the subsequent processes involving the use of DOLS and how to record this information using the trust's electronic system.

All staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Medical care (including older people's care)

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness and we saw multiple examples of compassionate care being delivered upon all the wards we inspected.

All patient's looked comfortable and during care interventions we observed the curtains being drawn around patients to provide privacy and dignity.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff told us they would always try and care for patients who were at end of life in side rooms and would allow their relatives to stay overnight.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

The trust promoted all faith and no faith support to meet patient's and relatives religious and spiritual needs during their stay in hospital.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

We saw examples in patient records where staff had supported patients to make informed and advanced decisions about their care.

Medical care (including older people's care)

Patient feedback was displayed on noticeboards within wards and was positive and complimentary about the care and support provided. All of the wards we inspected had various examples of “you said, we did” responses to feedback from both current and previous patients.

Friends and family feedback results across a range of wards for May 2023 showed that patients had either a very good or good experience during their stay in hospital. Key themes identified from compliments included the kindness and caring nature of staff.

Results in the most recent inpatient survey from 2021 compared favourably with the overall national picture with the mean score for 30 out of the 40 questions sitting in the mid-sixty percent for the national benchmark. Two of the mean scores were in the top 20% and only 8 in the bottom 20% of the national benchmark.

Is the service responsive?

Requires Improvement 

Our rating of responsive went down. We rated it as requires improvement.

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the changing needs of the local population.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. During our inspection the HASU had mixed sex bays due to the overwhelming demand for a bed on the ward. The most recent data for trust-wide mixed-sex accommodation breaches showed a gradual increase from 15 recorded in December 2022 up to 21 for April 2023. Manager advised that this would only be adopted in extreme circumstances during periods of high pressure and measures would be taken to uphold patients’ dignity via the use of screens. Staff would also regularly monitor mixed-sex bays to ensure patients were as comfortable as possible.

Despite the safety concerns associated with the main atrium, the facilities and premises were appropriate for the services being delivered.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

The service had systems to help care for patients in need of additional support or specialist intervention, such as falls monitoring equipment which would alert staff when patients deemed to be a high risk of falls had mobilised from their stationary position.

Medical care (including older people's care)

The service attempted to relieve pressure on other departments through the implementation of “medical sleep-outs”, or short-term transfer of medically optimised patients from a medical ward to an outpatients department which had been converted and appropriately staffed to accommodate patients overnight. Only medically optimised patients with a clear discharge pathway, usually planned for the following day, would be considered for such a transfer. This process could potentially create bed vacancies for patients awaiting admission to a medical ward.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Wards were not always designed to meet the needs of patients living with dementia. On one of the wards we visited, staff told us that patients with dementia would regularly become confused by the pattern on the floor tiles due to experiencing perceptual disturbances associated with their cognitive impairment.

Despite some environmental challenges, staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff also had access to communication aids to help patients become partners in their care and treatment.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Access and flow

The trust faced ongoing challenges with access and flow which meant that they could not ensure people were always able to access care promptly. Waiting times from referral to treatment were not in-line with national standards. The trust continued to experience challenges with discharging patients from the service. Despite these pressures, staff worked hard to keep patients safe.

Access and flow across medical divisions nationally continues to present significant challenges for NHS trusts. Despite the challenges, managers monitored waiting times and made best efforts to enable patients to access services when needed. However, treatment was not always received within agreed timeframes and national targets.

Trust-wide data for March 2023 showed that 63.1% of patients were treated within 18 weeks of referral. This was below the regional average of 70.4%, but closer to the national average of 66.1%.

In March 2023, there were 628 patients waiting more than 52 weeks from referral for treatment, which had seen an improvement over the previous 18 months, which was in-line with other trusts in the same region.

At the time of the inspection, there were no patients waiting 78 weeks or over for treatment.

Managers and staff also worked hard to make sure patients did not stay longer than they needed to. The average length of stay for elective admissions for February 2023 was 3 days, better than the national average for the medical care sector which was 5.9 days.

However, during February 2023, the average length of stay for emergency admissions was 22.9 days, worse than the sector and provider average of 16 days.

The NHS specifies that patients have the right to commence consultant-led treatment within a maximum of 18 weeks of referral and is defined as referral to treatment (RTT). Measurement of performance excludes current backlogs of patients awaiting treatment and the ongoing work being implemented to reduce the number of patients waiting 52 weeks and 78 weeks respectively. The RTT percentage for trust-wide cardiology patients over the last year had been around 50% until the start of 2023 where it had risen to a maximum of 68.2% in May 2023, below the trust target of 92%.

The trust advised us that a business case had been submitted for the recruitment of additional consultant and cardiology nursing staff in an attempt to improve performance with RTT.

At the time of the inspection, the renal medicine RTT performance was 96%. Data provided by the trust highlighted a slight drop in performance between Feburary 2023 and March 2023 which was attributed to temporary consultant shortages.

In February 2023, the average length of stay for emergency admissions was 8.3 days, which is worse than the ICS average of 6.6 days.

Performance for respiratory medicine had declined slightly over the previous 12 months from approximately 80% RTT in June 2022 to approximately 55% at the time of the inspection. The trust attributed this dip in performance to increased referrals and the loss of a locum consultant.

The trust advised that they had identified a new clinical area which may be utilised to enable a more efficient way of working. However, this would not be operational until 2024.

RTT performance within stroke care and rehabilitation medicine had been consistently at 100% since April 2023.

The average length of stay for emergency stroke admissions had consistently remained above the ICS average since August 2022, with the most recent data for February 2023 showing an average stay of 22.5 days compared to the ICS average of approximately 16 days.

RTT performance for elderly care had dropped from 100% in March 2023 down to 80% at the time of the inspection due to staff vacancies and sickness.

Following the inspection, the trust advised us that a new medical consultant and nurse consultants had been appointed within to address shortfalls in staffing within elderly medicine.

The service moved patients only when there was a clear medical reason or in their best interest and staff supported patients when they were referred or transferred between services, in-line with national standards.

Despite system-wide support being available to the trust and managers and staff planning each patient’s discharge as early as possible and monitored the number of patients whose discharge was delayed, the trust continued to experience significant challenges with discharging patients from the service. The trust had logged 1,157 incidents on the national reporting and learning system (NRLS) and strategic executive information system (STEIS) for the period 01 April 2022 to 28 February 2023 which had been categorised as ‘Access, admission, transfer and discharge’ challenges. A total of 891 (77.0%) of these were delays and failures relating to discharges.

Medical care (including older people's care)

Managers worked to minimise the number of medical patients on non-medical wards and at the time of the inspection there were only four medical outliers across both medical divisions at Cumberland Infirmary and West Cumberland Hospital.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns and the service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and we saw examples of learning and identified themes on display across multiple wards we visited, which included patients being moved at night without family being notified and occasional lack of communication in regards to treatment plans.

Staff knew how to acknowledge complaints and patients received feedback in a timely manner from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how patient feedback had been used to help improve daily practice.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had oversight of the service as a whole; however, we were not always assured that leaders understood the priorities and risks the service faced at ward level. Staff told us they were not always visible and approachable in the service for patients and staff. However, they supported staff to develop their skills and take on more senior roles.

We were not assured that senior leaders had fully mitigated the risk to patients & visitors surrounding the glass balustrade height in the atrium of the hospital. Leaders told us the site had a working group to review and mitigate the risk. The concerns had been escalated to senior management and the risk was on the site risk register. Staff told us they instigated regular checks and audit of the corridors. The trust was in discussion with other trusts who had addressed similar concerns and were looking at differing funding options to instigate this.

However, on two separate days during inspection, we observed chairs, a patient bed and metal cages containing stores equipment for the wards placed outside wards on the atrium. We were not assured that the risk was fully mitigated.

We were also not fully assured that ward managers had full oversight of environmental risks on individual wards, specifically in relation to the safe and secure storage of hazardous cleaning products and dangerous items such as sharps.

However, ward managers demonstrated an understanding of the demands of the ward, needs of patients and risks associated with individual conditions.

Staff spoke positively of ward managers and felt supported within their roles.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

There was a clear vision in place which was on display within the department, with the provision of safe patient-centred care was at the core.

The vision and strategy also placed emphasis on promoting a positive working environment for all staff members, conducive to the delivery of safe care and treatment.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service promoted an open culture where patients, their families and staff could raise concerns without fear.

Staff continued to display resilience following the impact of the COVID-19 pandemic and wider system pressures. Senior leadership told us they recognised the pivotal role staff resilience had played in maintaining care standards despite the tremendous pressure it was under.

Despite the challenging circumstances, staff were positive about working within the service and praised the ethos of teamwork. Although, there could be frustration at times when redeployment to other wards was required on a frequent basis.

Staff felt there was good support from ward management.

Promoting staff wellbeing was on the departmental managers' agenda and there was information on display within staffing areas to encourage awareness of mental health and emotional wellbeing.

Nursing and medical staff we spoke with described a positive working relationship between both parties.

The trust advised us that they had engaged in the listening into action (LIA) project following disappointing results in the most recent NHS staff surveys which was completed in 2021 and 2022. Although the results highlighted that the trust performed close to the benchmark median in key areas, the trust acknowledged that improvement was required.

Medical care (including older people's care)

The trust told us that they had made use of the regular staff pulse survey to gather feedback on how and where to make improvements and had also recruited 100 LIA Pioneers to run a total of 10 transformation projects across the trust to drive improvement. At the time of the inspection, a further 14 improvement projects had been identified by the new cohort of LIA Pioneers. The trust were hopeful that the ongoing transformation work would help boost morale and instil a “can do” attitude.

Governance

Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their individual roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The management team had not identified the lack of accurate reporting of falls and hospital-acquired pressure ulcers. These discrepancies had been highlighted during routine engagement with CQC. As a result of this, we were not assured that governance processes were working effectively to highlight risks within the service.

Staff we spoke with clearly understood their role within the wider team and took responsibility for their actions.

Information boards within staffing areas clearly displayed specific learning and development requirements, as well as outcomes from departmental audits which served as visual aids for staff members.

We saw evidence of the use of governance processes to monitor standards of performance at both departmental level and trust-wide. The trust had sight of where improvements were required as a result of ongoing audit and monitoring.

The trust continued to hold monthly governance meetings for each department on-site and information would be passed on to ward staff to ensure they were kept up to date. We were told that during the COVID19 pandemic a number of meetings had been stood down in order to focus upon clinical duties. During the transition to the current way of working post-pandemic, we were told that the governance meetings had not been routinely minuted due to a lack of administrative support. However, we were provided with the minutes for meetings held in March 2023 to May 2023, all of which were comprehensive and contained a clear agenda and ownership of action points.

The trust continued to work with partner agencies within the integrated care system to monitor and improve performance and to ensure patient safety was upheld at all times.

Management of risk, issues and performance

Leaders and teams used systems to manage and evaluate performance. However, they did not always have effective oversight of relevant risks and issues and identified actions to reduce their impact.

Data provided by the trust showed that monthly performance meetings for each care group were held focussing upon areas such as staffing, audit results, budgetary constraints and key performance indicators and performance action plans specific to the care group. A performance accountability log was also created as part of the departmental performance review process which linked in with the CQC key lines of enquiry.

At ward-level, we observed noticeboards displaying weekly risks, action points, audit results and total number of open incidents. Patient feedback and learning points were also clearly displayed for staff members, patients and visitors.

Medical care (including older people's care)

Despite an ongoing recruitment drive, staff in the areas we inspected told us they were often short of qualified nursing staff and healthcare assistants with the right skills and competency to care for patients within the medical care division. Most wards we visited during inspection had high numbers of newly appointed internationally recruited nurses and healthcare assistants requiring additional time to gain experience within their roles.

Although the trust held regular performance and risk monitoring meetings, we were not always assured that managers had oversight of environmental risks within the medical division, particularly in regards to management of risk within the main atrium on-site and adherence to COSHH guidelines.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. However, the trust continued to use both electronic and paper-based record keeping systems which presented some difficulties with accessing specific patient information. Incident reporting was not always done in line with national guidance.

Feedback from staff highlighted that IT systems were not always responsive and there was a lack of computers on certain wards.

Paper records continued to not be stored securely across all of the wards we visited.

Some staff members had not been provided with a SMART card which caused delays accessing electronic patient records.

During a recent provider engagement meeting held between CQC and the trust, we were advised that discrepancies had been found with the accurate grading of serious incidents involving patient falls and skin integrity concerns since January 2023. As a result, the trust had made the decision to commence a retrospective review of incidents to determine the overall accuracy of reporting and whether any additional serious incidents should be declared in retrospect. As a result, we were not assured of senior management oversight of serious incidents reported within the trust.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust continued to work hard to improve the patient experience when accessing the service. This was based upon listening to patients and gathering feedback in order to align service delivery with the needs of the local population and to ensure the highest possible standards of care were being delivered.

Meetings were held at trust-level with other external organisations such as neighbouring local authorities and other third parties such as mental health, domestic violence and addictions services to help improve patient experience.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Medical care (including older people's care)

Although mandatory training compliance rates were not always in-line with the trust target, there was evidence that the nurse managers, along with the clinical educators, had taken steps to promote a learning culture which adhered to both RCEM and NICE guidelines.

All of the wards visited during the inspection had a quality improvement theme for each month and we saw information and guidance on display in the staffing areas of the department to promote awareness of issues such as sepsis, safe prescribing of medication and domestic violence awareness. Feedback from the medical director and governance facilitators was also on display on various wards to highlight the positive work undertaken by staff in regards to end of life care.

Post-inspection we were provided with additional data that highlighted ward-level quality improvement projects within cardiology, renal medicine and respiratory care. These particular projects focused upon recruitment, sourcing additional workspace and introducing new equipment to optimise care for patients.

We were also provided with the trust-wide quality improvement report for 2022/23 in which 10 key areas of focus had been identified:

- Prevention of acute kidney injury
- Improvement of pathways for patients lacking capacity to consent
- Effective discharge summaries
- Improvement of patient involvement in their Care
- Effective modern ward rounds
- Improve results and follow-up for patients
- Falls
- Nutrition and Hydration
- Personal Care and Oral Hygiene
- IPC

There was evidence that progress was being made within the key areas of focus, particularly with the management of falls which the trust had identified as a significant issue across both hospital sites. Improvements and initiatives at ward-level, such as increased staff presence to monitor high risk patients and the introduction of additional equipment had helped to play a role in reducing the percentage of recorded falls resulting in moderate harm or above from 2.74% for 2021/22 down to 1.92% for 2022/23.

Along with the key areas of focus, the trust had identified 5 key principles to drive improvement with quality and safety of patient care at the heart of all work undertaken. There was also evidence of multi-disciplinary work being undertaken with third parties in order to drive improvement with optimising patient discharge.