North Cumbria University Hospitals NHS Trust

West Cumberland Hospital

Quality Report

Homewood Road
Hensingham
Whitehaven
CA28 8JG
Tel: 01946 693181
Website: www.ncuh.nhs.uk

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out a follow up inspection between 6 and 9 December 2016 to confirm whether North Cumbria University Hospitals NHS Trust (NCUH) had made improvements to its services since our previous comprehensive inspection, in April 2015. We also undertook an unannounced inspection on 21 December 2016.

To get to the heart of patients' experiences of care and treatment we always ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so, we rate services' performance against each key question as 'outstanding', 'good', 'requires improvement' or 'inadequate'.

When we last inspected this trust, in April 2015, we rated services as 'requires improvement'. We rated safe, effective, responsive, and well-led as 'requires improvement'. We rated caring as 'good'.

At this hospital we rated services overall as 'requires improvement'. We rated surgery, critical care, services for children and young people, and outpatients and diagnostic imaging as 'good'. All other services, with the exception of medical care, were rated as 'requires improvement'. Medical care at this hospital was rated as 'inadequate'.

There were four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations at this hospital. These were in relation to staffing, safe care and treatment, person centred care, and assessing and monitoring the quality of service provision.

The trust sent us an action plan telling us how it would ensure that it had made improvements required in relation to these breaches of regulation. At this inspection, we checked whether these actions had been completed.

We found that the trust had improved in some areas. However, West Cumberland Hospital (WCH) remained rated as 'requires improvement' overall, with caring and effective rated as 'good' and safe, responsive, and well-led rated as 'requires improvement'.

Our key findings were as follows:

- Nursing and medical staffing had improved in some areas since the last inspection. However, there were still a number of nursing and medical staffing vacancies throughout the hospital, especially in medical care and surgical services, and children and young people services, including the special care baby unit.
- The trust had systems in place to manage staffing shortfall as well as escalation processes to maintain safe patient care. However, a number of registered nurse shifts remained unfilled despite these escalation processes. The 'floor working' initiative within medical care should be reviewed in order to support safer nurse staffing.
- Despite ongoing recruitment campaigns, the trust had struggled to recruit appropriate clinicians in some specialities, particularly in medical care and children and young people services. Medical staffing within these specialities remained reliant upon locum support, and with that, was vulnerable to changes in locum worker preferences or departures.
- However, within medical care services medical staffing had improved from the previous inspection with additional workforce assurance plans in place. This included securing long-term locum contracts, developing the composite workforce model, improving links with specialist trainees and securing cross-site support from divisional clinician colleagues at CIC.
- Compliance against mandatory training targets was an issue in some services.
- Access and flow, across the emergency department, medical care and surgical services, and outpatients remained a significant challenge.
- For an extended period, the hospital has failed to meet the target to see and treat 95% of emergency patients within four hours of arrival and it was failing to meet consistently a locally agreed trajectory to see and treat emergency patients within four hours of arrival which had been agreed in conjunction with regulators and commissioners.

Summary of findings

- We found patients experienced overnight delays in the emergency department whilst waiting for beds to become available in the hospital.
- Between 2015 and 2016 the trust cancelled 1,410 elective surgeries. Of these, 12% were not treated within 28 days. For the period November 2015 to November 2016 WCH cancelled 292 elective surgeries for non-clinical reasons.
- Referral to treatment time (RTT) data varied across specialities, particularly in surgical services.
- Patient flow initiatives within the medical division were not fully embedded and required improved coordination, ward staff engagement and more timely discharge plans implemented. Medical outliers accounted for a significant proportion of the in-patients beds at this hospital.
- Delays in obtaining suitable community care placements were causing access and flow difficulties, particularly in medical care services.
- Within outpatients, there were a number of clinics cancelled within 6 weeks of the clinic across the trust and there were no plans in place to address this issue. Turnaround times for inpatient plain film radiology reporting did not meet Keogh standards, which require inpatient images to be reported on the same day.
- There had been an improvement in record keeping standards throughout the hospital however, we identified some ongoing areas for improvement around accurate completion of fluid and food charts, risk assessments and completion of DNACPR forms which did not provide evidence of a best interest decision or a mental capacity assessment being undertaken and recorded where appropriate.
- There was some improvement in strengthening of governance processes across the hospital; however within some services, particularly medical care and maternity, there were gaps in effective capturing of risk issues, and in how outcomes and actions from audit of clinical practice was used to monitor quality.
  - Due to the public consultation taking place at the time of our inspection, it was noted that a preferred option and decision was yet to be taken by Cumbria Clinical Commissioning Group on the future of maternity and children and young people's services.

However:

- Staff knew the process for reporting and investigating incidents using the trusts reporting system. They received feedback from reported incidents and felt supported by managers when considering lessons learned.
- The policy and activity around critical care patient transfer to other hospitals, including children and babies, when required were good.
- The hospital had infection prevention and control policies in place, which were accessible, understood and used by staff. Patients received care in a clean, hygienic and suitably maintained environment.
- There were no cases of Methicillin Resistant Staphylococcus Aureus infection (MRSA) reported between November 2015 and October 2016. Trusts have a target of preventing all MRSA infections, so the hospital met this target within this period. The trust reported nine MSSA infections and 23 C. Difficile infections over the same period.
- Safeguarding processes were embedded throughout the hospital.
- We saw that patients were assessed using a nutritional screening tool, had access to a range of dietary options and were supported to eat and drink.
- Patients were positive about the care they received. Staff were committed to delivering high quality care. Staff interactions with patients were compassionate, kind and thoughtful. Patient privacy and dignity was maintained at all times.
- Patient feedback was routinely collected using a variety of measures, including real time patient experience.

We saw several areas of outstanding practice including:

- National Patient safety awards finalist for better outcomes in orthopaedics.
- The trust had the only surgeon between Leeds and Glasgow doing a meniscal augment in the knee.
- Honorary Professorship University of Cumbria received by a consultant for work on applying digital technologies in Health Care for elderly population in rural setting, a part of CACHET.

Summary of findings

- Multinational multicentre prospective study in the use of intramedullary nail in varus malalignment of the knee. The trust had the largest international experience of this technology for this application.
- WCH was one of only 18 Hospitals in England and Wales referred to in the first NELA audit for contributing examples of best practice in care of patients undergoing emergency laparotomy.
- There was real strength of MDT working and positive patient outcomes in the stroke service;
- The 'expert patient programme' and 'shared care initiative' in the renal business unit exhibited real patient integration, empowerment and care partnerships; and,
- There were a variety of data capture measures in use to monitor 'real-time' patient experience and collate patient feedback.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

In urgent and emergency services

- Meet the target to see and treat 95% of emergency patients within four hours of arrival linked to meeting the locally agreed trajectory to see and treat emergency patients within the standard agreed with regulators and commissioners.
- Ensure medical and nursing staff use the computer system fully as intended so that patient real time events are recorded accurately and this is demonstrated through audit.
- Take further steps to resolve the flow of patients out of the hospital.

In Medicine

- Ensure systems and processes are established and operated effectively to assess, monitor and improve the quality and safety of the services provided and evaluate and improve practice to meet this requirement. Specifically, improve the management of medical outliers by reducing the number of patients receiving care on a non-designated medical ward, improving repatriation processes and minimising service user moves after 10 pm.

In Surgery

- Must ensure the peri-operative improvement plan is thoroughly embedded and that all debrief sessions are undertaken as part of the WHO checklist to reduce the risk of Never Events.
- Improve compliance against 18 week referral to treatment standards for admitted patients for oral surgery, trauma & orthopaedics, urology and ophthalmology.
- Improve rate of short notice cancellations for non-clinical reasons specifically for orthopaedic surgery.
- Ensure patients whose operations are cancelled are treated within the 28 days.

In Maternity and Gynaecology

- Review staffing levels; out-of-hours consultant paediatric cover and surgical cover to ensure they meet the Royal College of Obstetricians and Gynaecologists (RCOG) guidelines (including 'safe childbirth: minimum standards for the organisation and delivery of care in labour')
- Ensure that systems are in place so that governance arrangements, risk management and quality measures are effective.

In Services for Children and Young People

- The trust must ensure children and young people services meet all Royal College of Paediatrics and Child Health (RCPCH) - Facing the Future: Standards for Acute General Paediatric Services (2015 as amended).

In End of Life Care

- Ensure that DNACPR forms are fully completed in terms of best interest assessments in line with the Mental Capacity Act.

In Outpatients and Diagnostic Imaging

- Address the number of cancelled clinics in outpatient services.
- Ensure that referral to treat indicators (RTTs) are met across outpatient services.

In addition the trust should:

- Ensure that levels of staff training continue to improve in the hospital so that the hospital meets the trust target by 31st March 2017.

In urgent and emergency services

- Increase the complement of medical consultant staff as identified in the accident and emergency service review
- Extend the scope and consistency of staff engagement.

In Medicine

- Continue to progress patient harm reduction initiatives;
- Ensure IPC compliance improvement and consistency in standards, in particular regarding catheter and cannula care;
- Ensure best practice guidelines for medicines related documentation is reinforced to all prescribers;
- Ensure oxygen prescribing is recorded and signed for accordingly;
- Ensure medicines management training compliance improves in line with trust target;
- Ensure all relevant clinical observations are recorded at the required frequent, NEWS scores are accurately calculated and trigger levels are adhered to (or document deviation/individual baseline triggers in the clinical records);
- Ensure care and treatment of service users is appropriate, meets their needs and reflects their preferences. Specifically, ensure the endoscopy pathway design meets service user preferences and care or treatment needs.
- Ensure staff are given time to complete all necessary mandatory training modules;
- Ensure all fields within medical and nurse clerking documentation are completed in full, in line with local policy and best practice guidelines;
- Ensure all equipment checks are completed in line with local guidance;
- Progress JAG accreditation application for new endoscopy suite at WCH;
- Continue to proactively recruit nursing and medical staff, considering alternate ways to attract, such as utilising social media;
- Ensure measures are put in place to support units where pending staffing departures will temporarily increase vulnerability;
- Progress the 'Composite Workforce Model' and further embed support from substantive medical colleagues at CIC;
- Ensure food satisfaction standards are maintained and where relevant improved;
- Work with partnership colleagues to address static diabetes patient outcomes;
- Evidence improvements in patient outcomes for respiratory patients around time to senior review and oxygen prescribing;
- Support staff development in line with organisational/staff appraisal objectives protecting/negotiating study time where required;
- Ensure appraisal rate data recorded at trust level coincides with figures at divisional/ward level;
- Ensure patients are given sufficient time to converse with staff regarding care related matters;
- Revisit the patient journey, booking and listing procedures at the endoscopy suite at WCH;
- Ensure where escalation beds are utilised, they are staffed accordingly with due consideration of existing ward staffing requirements;
- Consider local leads for patient flow initiatives and reinforce processes with staff;

Summary of findings

- Ensure processes seek to repatriate medical outliers at the earliest opportunity to minimise impact into surgical services;
- Continue to minimise patient moves after 10 pm;
- Ensure the ambulatory care suite is utilised as intended;
- Reinforce the dementia strategy across the division to ensure consistency of practice with support initiatives;
- Ensure reasonable adjustments available for visually impaired, those with hearing difficulties and those who require translation services are known to all staff;
- Consider options available to extend ambulatory care services across seven days;
- Ensure senior divisional staff make every reasonable effort to attend divisional governance meetings regularly;
- Ensure the risk register is current and reflects actual risks with corresponding accurate risk rating. Ensure all actions and reviews of risk ratings are documented;
- Ensure progress continues against QIP, realign completion dates and account for deadline breaches;
- Ensure staff feel involved and integrated into engagement activity for their benefit and ensure all staff are aware of existing provisions available to them;
- Ensure staff involved in change management projects are fully informed of the aims and objectives of the proposal and these are implemented and concluded in appropriate timeframes;
- Ensure divisional leads and trust leaders promote their visibility when visiting wards and clinical areas; and,
- Consider promoting divisional and trust wide success stories to share good news and positive outcomes to improve staff morale.

In Surgery

- Ensure robust recruitment and retention policies continue to improve staff and skill shortages.
- Continue to embed the perioperative quality improvement plan.
- Improve debrief in theatres post-surgery.
- Improve the proportion of patients having hip fracture surgery on the day or day after admission.
- Improve the rate of patients receiving a VTE re-assessment within 24 hours of admission.
- Improve cancellation rates.
- Ensure all mandatory training is completed by March 2017.
- Reduce the management of medical patients on surgical wards.
- Ensure bullying allegations in theatres are addressed.

In Critical Care

- Senior staff should continue to monitor the staffing shortfall an impact in the unit as a result of increased staff sickness. The action plan produced should be reviewed to ensure achievement of the key points. Staff should be able to provide assurance that the staffing ratios for intensive care are protected as per Intensive Care Society guidance.
- CCOR staff should not be moved to cover ward area staff shortage as part of routine escalation plans. This issue needs to be monitored and CCOR staff should be supported to provide the role across the trust as per practice in line with GPICS (2015), NICE CG50 and against the seven core elements of Comprehensive Critical Care Outreach, (C3O 2011).
- Take action to improve pharmacy staffing in line with GPICS (2015).
- The role of the supernumerary clinical coordinator should be protected as per GPICS (2015) standards. Currently this is not the case in the unit and should be in place to support the team in line with the standards.
- The clinical educator should provide a role in the WCH unit in order to meet GPICS (2015) standards for a unit of this size.

In Maternity and Gynaecology

- Ensure that processes are in place for midwives to receive safeguarding supervision in line with national recommendations.

Summary of findings

- Continue to improve mandatory training rates to ensure that trust targets are met by the end of March 2017.
- Ensure that there are processes in place so that record-keeping, medicine management, and checking of equipment are consistent across all areas.
- Review the culture in obstetrics to ensure there is cohesive working across hospital sites and improved clinical engagement.

In Services for Children and Young People

- Ensure a registered children's nurse (RCN) should support healthcare assistants working in the children's outpatient department with. Royal College of Nursing staffing standards for children in outpatients states a minimum of one RCN must be available at all times to assist, supervise, support and chaperone children. Healthcare assistances should also be trained and competent in weight management and documentation according to their level of responsibility.

In End of Life Care

- Arrange formal contract meetings with members of the Cumbria Healthcare Alliance to monitor that the service being commissioned and provided is of an appropriate standard in terms of quality and meeting patient need.
- Ensure that it is aware of the number of referrals to the SPCT within their hospitals.
- Ensure that it is aware of how many patients are supported to die in their preferred location and there is regular audit of the CDP to demonstrate this.
- Produce an action plan to address areas in national audits where performance was lower than the England average with key responsibilities and timelines for completion.

In Outpatients and Diagnostic Imaging

- Continue to ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed in order to meet the needs of the patients. Ensure mandatory training and safeguarding training completion rates and met in line with the trust target.
- Ensure there are sufficient staffing levels in place and ensure actual levels match planned levels.
- Ensure that equipment, such as refrigerators in diagnostic imaging, are checked as required.
- Consider ways of making performance and quality information available for use.

It is apparent that the trust is on a journey of improvement and progress is being made clinically, in the trust's governance structures and in the implementation of a credible clinical strategy. I am therefore happy to recommend that North Cumbria University Hospitals NHS Trust is now taken out of special measures.

Professor Sir Mike Richards Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Good	At our previous inspection, in April 2015, we rated this core service as 'requires improvement'. In December 2016 we rated the service as 'good' because:

- Risks to the delivery of care and treatment for patients were mitigated and a risk register for accident and emergency reflected identified key risks. Safeguarding procedures were in place.
- Patient care and treatment followed evidence based guidance and recognised best practice standards. Sepsis screening and management and other clinical guidelines were used effectively.
- Staff provided considerate and compassionate care for patients and treated them with dignity and respect. Staff interacted with patients empathetically and responses to their needs were prompt. Care and treatment was explained to patients in a way they understood. Patients were consulted and involved in decisions about their care and treatment and received emotional support.
- Patients with a learning disability, patients with dementia, and bariatric patients accessed emergency services appropriately and their needs were supported. Patients with mental health needs could access services in a joined up way.
- Patient's consent to care and treatment was documented and the requirements of the Mental Capacity Act were followed. Patients' nutrition and hydration needs were provided for and pain was managed effectively.
- Incident reporting had increased and serious incidents had reduced. Learning from the investigation of incidents was shared and duty of candour requirements were followed. Emergency preparedness arrangements were in place to respond to major incidents.

Summary of findings

- Public engagement included consultation events about changes to services and although few complaints were received they were investigated and learning was shared with staff.
- Staffing had improved and staff were deployed in the department effectively so that staffing levels were sufficient to meet patients' needs. Mandatory training had been completed by most staff. The learning and development of medical and nursing staff was supported and staff received an annual appraisal. Multidisciplinary teams operated effectively. An improved, positive culture was apparent in the emergency department and staff worked well together.
- The hospital was taking steps to address performance as part of its improvement plan for emergency care. A newly designated emergency floor had recently been opened which brought together acute admissions and ambulatory care patients. Seven day working was operated 24 hours a day throughout the year including some key support services, for example x-ray.
- Cleanliness, infection control and hygiene procedures were followed and standards were monitored. Equipment and medicines stocks were managed effectively.
- The department participated in relevant national audits and undertook regular local audits which supported consistent improvements in care and treatment for patients.
- Governance of the emergency department was more embedded and the vision and strategy for emergency care was understood. The department implemented innovation to benefit patients.

However:

- For an extended period, the hospital has failed to meet the target to see and treat 95% of emergency patients within four hours of arrival and the hospital was failing to meet consistently a locally agreed trajectory to see and treat emergency patients within the standard agreed with regulators and commissioners.

Summary of findings

- Emergency department waiting time data was incorrect. Staff were not fully utilising the computer system as intended so that the times recorded were not accurate.
- Material issues remained with patient flow in the hospital.
- Risks related to the transfer of patients needed to be added to the risk register.
- Changes in the operational nursing structure for the emergency department needed to become embedded.
- Staff engagement needed to be extended.

Medical care (including older people's care)

Requires improvement

The service was inspected as part of our comprehensive visit in March 2015. Overall, medical care at WCH was rated 'inadequate'. A number of areas for improvement were highlighted and the service was told to take action to:

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

During this inspection, we found the service had made improvements:

- While medical staffing was not at full substantive compliment at WCH, there had been recruitment and the division had secured longer term locum contracts. Divisional managers were progressing the 'composite workforce' model to bring additional stability to existing provision at WCH.
- Registered nurse vacancies remained at WCH however all wards reported an improved picture from the 2015 inspection. This was evidenced by

improved fill rates across the division. Staffing shortfall escalation procedures were more robust and the division continued to actively recruit.

- There was no evidence to suggest there were insufficient infusion pumps for patient use as and when required.
- Staff knowledge of the requirements of the Mental Capacity Act 2005 and the application of Deprivation of Liberty Safeguards was good. Staff completed capacity assessments to evaluate a patient's ability to make decisions and consent to treatment.
- Medical patients were cared for on a designated non-medical ward at WCH and were reviewed regularly by the responsible team. Care was progressed accordingly and staff stated there were no difficulties in having this cohort of patients reviewed out-of-hours.

We rated medical care (including older people's care) as 'requires improvement' overall because:

- Patient harms remained a concern across the division.
- There was variance in some infection prevention and control practices and medicines related documentation around antibiotic prescribing was not always compliant with recognised standards.
- Nurse staffing was exposed in some areas and medical staffing remained reliant on locum appointments. The recording of all key clinical observations to support decision making and care escalation needed reinforcement.
- Medical staffing remained reliant upon locum support, and with that, was vulnerable to changes in locum worker preferences or departures.
- Patient outcomes in national audits covering diabetes and respiratory care had remained static or fell below national average benchmarking. The division had not fully embedded seven day working across all areas against the NHS Services, Seven Days a Week

Summary of findings

Four Priority Clinical Standards. Staffing pressures and clinical responsibilities hindered access to non-ward based learning opportunities.

- Patients considered on occasions staff were often too busy, or did not have the necessary time to engage in meaningful care related dialogue, or did not prioritise this as an essential element of patient care.
- Staff considered service changes in the booking and list preparation processes in endoscopy did not meet local patient needs.
- Medical outliers accommodated a significant proportion of designated surgical beds, repatriation of this cohort was problematic and there were a number of patient moves after 10 pm. Patient flow initiatives were not fully embedded across the division at WCH. Reasonable adjustments implemented for vulnerable patient groups were not consistently applied.
- The divisional risk register did not correlate with top risks identified by divisional leads. Risk ratings were confusing and details of actions taken against the risks were limited. Divisional progress against the Quality Improvement Project objectives was incomplete and slow. Staff morale was variable and they considered engagement initiatives were driven by a management agenda.

However:

- Staff confidently reported incidents and the division had made considerable efforts to reduce patient harms from falls and pressure ulcers. Ward environments were clean and staff used personal protective equipment appropriately to protect themselves and the patient from infection exposure. Medicines management was good and clinical documentation, in particular, risk assessments and safety bundles, were completed thoroughly. Nurse staffing establishments figures were based on a recognised acuity tool and projects such as the 'composite workforce model' sought to bolster medical staffing.

Summary of findings

- The division was actively involved in local and national audit, which provided a strong evidence base for care and treatment. Patient outcomes in the national stroke audit and the renal registry report were good and there had been domain improvements in myocardial infarction and lung cancer audits. Multidisciplinary team working across the divisional wards was cohesive, progressive and inclusive. Staff had an understanding and awareness of consent issues, Mental Capacity Act and Deprivation of Liberty Safeguards.
- Staff were committed to delivering high quality patient care. Staff interactions with patients were compassionate, kind and thoughtful. Patient privacy and dignity was maintained at all times. Staff welcomed patient and carer partnerships in delivering care. Staff considered all aspects of holistic wellbeing and patient feedback on the care they received was positive.
- Estate improvements as a result of the new build and upgrading were clear and apparent. The division reported good results against 18-week standards across all specialisms. Divisional managers monitored access and flow through the division and were involved in a number of initiatives to improve flow processes. There had been improvements in the clinical review of patients being cared for on the non-medical ward at WCH and reducing numbers of bed moves. Ambulatory care services and rapid access clinics had been developed. Complaint numbers were low and response times to resolution were good.
- The division had a clearly defined strategy and vision, which was aligned to organisational aims and wider healthcare economy goals. Divisional leads had an understanding of the pressures and risks the service faced. Governance processes across the division were clinician driven and quality measures were monitored. There were defined leadership structures and staff affirmed there was a strong clinical leadership presence across the division. Cultural improvements had been made in the last 18 months evident by greater openness. Public engagement was good

Summary of findings

and utilised a variety of mechanisms to capture opinion. The staff engagement agenda had increased in particular, around health and well-being. The division were involved in a number of improvement projects targeting patient safety, patient experience and service efficiency.

Surgery

Requires improvement

The overall surgery rating from the 2015 inspection was good. During the December 2016 inspection we rated surgical services as 'requires improvement' because:

- The trust has reported their staffing numbers as of August 2016. These staffing numbers showed that the majority of surgical wards were below the nursing establishment levels. The data shows that ward 1 required 27.93 whole time equivalent (WTE) but had 23.21 WTE nursing staffing in post. Similarly, the day-case unit had 6.48 WTE but required 9.12 WTE.
- As of September 2016, the trust reported a nurse vacancy rate of 8.2% at WCH. WCH had the higher vacancy rate of the two sites. At WCH, General Theatres had the highest vacancy rate at 19.3%.
- Between July 2015 and November 2016, the Cumberland Infirmary reported seven incidents which were classified as a Never Event for surgery. There had been six Never Events between June 2015 and February 2016.
- We saw 26% (November 2016) of patients were re-assessed for venous thromboembolism (VTE) within 24 hours of admission. This is a decrease from October 2016 when 72% of patients were re-assessed with 24 hours of admission. September 2016 figures were 37%. The target is 95%.
- Surgical debrief as part of the five steps to safer surgery was undertaken 14% of the time. A trust audit had recommended further work on encouraging the team debrief through business unit governance meetings and dissemination of learning by governance leads.

Summary of findings

- We found that training such as fire safety (58%), hygiene for clinical staff (67%), trust doctors patient safety programme (31%), and duty of candour (45%) were below the trust target.
- The proportion of patients having hip fracture surgery on the day or day after admission was 68.3%, which does not meet the national standard of 85%. The 2015 figure was 75.1%.
- A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice. For the period Q2 2014/15 to Q1 2016/17 the trust cancelled 1,438 surgeries. Of these, 12% were not treated within 28 days. The overall trend is that the trust has a much higher percentage of operations not treated within 28 days compared to the England average. Performance improved from Q1 2015/16 to Q3 2015/16 however performance deteriorated again from Q4 2015/16 and is showing signs of deteriorating further.
- Cancelled operations as a percentage of elective admissions includes all cancellations rather than just short notice cancellations. Cancelled operations as a percentage of elective admissions for the period Q2 2014/15 to Q1 2016/17 at the trust were consistently greater than the England average. The trust trend has followed a similar pattern to the England average, although the peaks and troughs are far more pronounced, particularly the increase in Q3 2015/16 although it should be noted that junior doctor strikes were planned during this period and may have contributed to the sharp rise.
- For the period November 2015 to November 2016 WCH cancelled 292 surgeries for non-clinical reasons.
- Four Surgical specialties were below the England average for admitted RTT (percentage within 18 weeks).

Summary of findings

- An action on the quality improvement plan stated that the division aimed to achieve compliance with 18 week referral to treatment for the incomplete pathway standard by September 2016. The status of this action remained in progress as of December 2016.
- At trust level, general surgery had a longer average length of stay than the England average for both elective and non-elective admissions.
- At the time of inspection the perioperative improvement plan was in the early stages of implementation, impacting upon some areas but not yet fully embedded within the division.
- Staff morale was variable on the wards, theatres and recovery areas. Morale was affected by working in difficult circumstances during the last eighteen months to cover staff and skill shortages.
- We were advised of ongoing bulling allegations within the theatre departments.

However:

- The division held regular emergency surgery and elective care business unit meetings where serious incidents were discussed, investigations analysed and changes to practice identified.
- Senior nursing staff had daily responsibility for safe and effective nurse staffing levels. Staffing guidelines with clear escalation procedures were in place. Site cover was provided out-of-hours 24 hours per day, seven days per week by a team of senior nurses with access to an on-call manager. Numbers of staff on duty were displayed clearly at ward entrances.
- A 'red flag' and safer staffing system had been introduced to identify when lower than optimal staff numbers may impact upon patient care and to initiate mitigation. Escalation processes were in place through the matron, service manager and chief matron. Capacity bed meetings were held twice daily to monitor bed availability, review planned discharges and assess bed availability throughout the trust.
- All wards participated in the NHS safety thermometer approach to display consistent data to assure people using the service that the

ward was improving practice based on experience and information. This tool was used to measure, monitor, and analyse patient 'harm free' care.

- We looked at medical records across wards and saw they were appropriately completed, legible and organised consistently. All documentation checked was signed and dated, clearly stating details of the named nurse and clinician.
- Patients were treated in accordance with national guidance and enhanced recovery (fast track) pathways were used. Local policies were written in line with national guidelines. A range of standardised, documented pathways and agreed care plans were in place across surgery.
- During 2015/16, the surgical business unit participated in 12/14 national clinical audits covering a range of specialties, and completed 122 local audits. Outcomes from each audit were reported to Business Unit Governance Board (BUG Board).
- The perioperative surgical assessment rate was 92.4%, which does not meet the national standard of 100%. However, the 2015 figure was 62.4% showing considerable improvement.
- WCH was one of only 18 Hospitals in England and Wales referred to in the first NELA audit for contributing examples of best practice in care of patients undergoing emergency laparotomy.
- Patients admitted with a fractured neck of femur had their pain assessed immediately upon presentation at hospital and within 30 minutes of administering initial analgesia, hourly until settled on the ward and regularly as part of routine nursing observations throughout admission.
- A dedicated pain team was accessible to support with analgesia as required. The pain team visited patients when baseline pain relief was ineffective. Anaesthetists provided support with pain relief out-of-hours.
- Between March 2015 and April 2016, patients at WCH had a lower than expected risk of readmission for both elective and non-elective admissions.

Summary of findings

- The Friends and Family Test response rate for surgery at the trust was 38% which was better than the England average of 29% between November 2015 and October 2016. Ward level recommendation rates were variable although recommendation rates were generally high, being between 70-100% for the overall period across all participating wards.
- We observed the treatment of patients to be compassionate, dignified, and respectful throughout our inspection. Ward managers and matrons were available on the wards so that relatives and patients could speak with them as necessary.
- The trust was actively working with commissioners to provide an appropriate level of service based on demand, complexity and commissioning requirements.
- The division had an escalation policy and procedure to deal with busy times and matrons and ward managers held capacity bed meetings to monitor bed availability.
- Complaints were handled in line with the trust policy, and discussed at all monthly staff meetings. Patients or relatives making an informal complaint were able to speak to individual members of staff or the ward manager. Wherever possible the patient Advice Liaison Service (PALS) would look to resolve at a local level.
- We met with senior trust and divisional managers who had a clear vision and strategy for the division and identified actions for addressing issues within the division. The divisional leadership team detailed their understanding of the challenges associated with providing good quality care and identified actions needed.
- The trust had developed a quality improvement plan (QIP) and had identified specific objectives to improve the management of the deteriorating patient, the recognition, and initiation of treatment for patients with sepsis and ongoing development of the Mortality and Morbidity Framework.
- The division had also developed a perioperative improvement Plan in response to recent issues

identified within surgery. This aimed to enhance governance through learning from events and incidents, develop the workforce through a positive learning environment, and initiate external assessment and compliance.

- There was a systematic programme of clinical and internal audit, which was used to monitor quality and systems to identify where action should be taken. Monthly audits were undertaken and audit outcomes were published quarterly.
- The division's risk register was updated following the safety and quality meetings with risks discussed, controls identified, with progress against mitigation, risk grading, assurance sources, and gaps in control documented.

Critical care

Good

During our last inspection of critical care services at WCH, in July 2015, we rated good overall, We have rated the service as good overall after a comprehensive announced and unannounced inspection visit in December 2016, with evidence of ongoing improvement in the unit.

- There was ongoing progress towards a harm free culture. Staff we spoke with understood the incident reporting system and improvement in reporting culture had been noted by the critical care team. There was a proactive approach to the assessment and management of patient - centred risks and staff had a good understanding of the trust position related to learning from incidents, serious incidents and Never Events. The number of pressure sores recorded in the incident reporting system had shown significant improvement since our last inspection and staff reporting of pressure ulcer grading and level of harm was good.
- There had been no Never Events in critical care and one reportable serious incident at the WCH site. There had been 27 NRLS reported incidents and themes were monitored closely by grade and seriousness of harm.
- A 24/7 Critical Care Outreach Team (CCOR) was well established. We observed good practice for recognition and treatment of the deteriorating

Summary of findings

patient. One hundred percent of patients received follow up once discharged from the unit. Practice was in line with GPICS (2015), NICE CG50 and against the seven core elements of Comprehensive Critical Care Outreach, (C3O 2011) 'PREPARE'; 1. Patients track and trigger, 2. Rapid response, 3. Education and Training, 4. Patient safety and governance, 5. Audit and evaluation (monitoring patient outcome), 6. Rehabilitation after critical illness and 7. Enhancing service delivery.

- Medical staff we spoke with discussed good anaesthetic staffing levels and continuity for rotas and out-of-hours cover. Use of locum consultant staff at WCH for anaesthetic cover was lower than CIC (35%) at 9.4% for 2015/16. The demands of the service were very different since the move of major surgery to CIC, and this was reported as having a negative impact on recruiting new anaesthetic staff to the unit.
- The policy and activity around critical care patient transfer to other hospitals when required were good. The arrangements for the small numbers (seven in 2015/16) of paediatric admission for stabilisation for hours prior to transfer were also good, to include levels of staff training and competence and storage and checking of essential equipment. The unit were part of the 'North East Children's Transport and Retrieval' (NECTAR) new transport service. All senior staff were trained in paediatric life support.
- The emergency resuscitation equipment and patient transfer bags for both adults and children were checked daily with a good system in place as per trust policy. There was good provision of equipment in critical care, good storage and robust systems for medical device training.
- The unit was visibly clean, spacious and met Department of Health Building Note HBN-04.02 standards for new build units; standards of infection prevention and control were in line with trust policy. All patient rooms were large

single isolation rooms as the unit was modern in design and opened in September 2015 as part of the new hospital build plan since our last inspection.

- The team in the unit had invested in, and implemented an electronic patient record and prescription system specific to intensive care which we observed to be comprehensive and well understood by staff. All records checked in the system were complete and risk assessment, patient review and prompt systems and processes were good.
- Patients were at the centre of decisions about care and treatment. We reviewed consistent positive survey feedback and comments which gave evidence of a caring and compassionate team. There was also evidence of well-attended nurse led support groups for patients in the local community. Staff whom we observed and spoke with were positive and motivated and delivered care that was kind, promoted dignity, and focused on the individual needs of people. The improvements made towards the rehabilitation of patients after critical illness since our last inspection were comprehensive.
- The team in critical care services spoke highly of their local leadership and felt supported by matrons, consultants and senior matrons. A culture of listening, learning and improvement was evident amongst staff we spoke with in the unit. Staff we spoke with across the team were positive about their role. Governance arrangements were clear to the staff especially in view of reporting frequent changes in the senior team over the past five years. Staff expressed that they wanted a period of stability in the senior and executive team.
- We found that ICNARC data showed that patient outcomes were comparable or better than expected when compared with other units nationally, this included unit mortality. ICNARC data had been collected and submitted consistently at WCH. The data was available to the team and, during inspection, we were able to review consistent annual reports; however we reported to the critical care team that although

data had been published on the ICNARC website, that data was only for one unit. Staff we spoke with were not aware of this and could not explain why data had not been published for both units.

- Plans were in place to provide multidisciplinary follow up clinics across both units for rehabilitation of patients after critical illness, as recommended by NICE CG83 and GPICS (2015). These were for those patients who had experienced a stay in critical care of longer than four days. A small dedicated team was being led by the matron and senior physiotherapist and a health care assistant was recruited to deliver this standard and progress was good. Support groups had been well attended in the local community with staff organising a range of supportive and educational opportunities. The use of patient diaries had been embedded in practice.
- Patients received timely access to critical care treatment and consultant led care was delivered 24/7. Readmissions to the unit were monitored closely by the Consultant and CCOR team and were below National average. There was good evidence of analysis of reasons for readmission and we reviewed a summary of cases with no significant trends. Minimum numbers of patients were transferred out of the unit for non-clinical reasons. We found that patients were not cared for outside of the critical care unit when Level 2 or 3 care was required, and we did not see examples of critical care outliers in theatre recovery or ward areas.
- Patients in the critical care unit were discharged to the wards within 8 hours once a decision to discharge was made as per GPICS (2015). ICNARC data indicated a position that was comparable with the national performance against this target. There was good performance for patients discharged within 4 hours of the patient being ready for discharge. There were no incidents of single sex breaches, as the unit had single room provision for patients.
- We spoke with senior staff about concerns with nurse staffing levels and the actual and potential

impact on safety and staff morale created by the increase in long term sickness levels. Senior staff responded to our concerns with evidence of plans to ensure safe staffing levels and escalated recruitment plans for Band 6 and band 5 nurses. This included temporary bed closure and close monitoring of activity. Escalation policies were reissued to staff. This gave assurance that the senior team were supportive and managing the escalation of this short term staffing pressure.

However:

- During our inspection we found that the team were finding it difficult to maintain nurse staffing levels in the unit due to a recent significant increase in long term sickness levels in the unit. We observed that there had been occasions were there had not been sufficient numbers of staff to provide 1:1 nursing for a long term level 3 patients, in line with intensive care standards. We escalated concern to senior staff during the inspection around the impact of a recent spike of 12% in staff sickness, which increased potential risk to patient safety. We also highlighted the lack of supernumerary coordinator in line with GPICS (2015), and the limitations and pressure on nursing staff to be able to observe patients in single rooms. A comprehensive action plan was produced by the trust after an unannounced visit which provided further assurance that these issues were being closely monitored and managed. Nurse staffing had been good prior to September 2016 with sufficient staffing levels for provision of critical care standards.
- The CCOR team had been moved frequently to support shortfalls in staffing in other wards and departments. We spoke with staff who felt that this had presented a risk to patient safety across the trust when they were unable to provide a CCOR service. It had affected the morale of team however we did not see evidence or incident at the time of inspection that patient care or safety had been compromised i.e.; increased readmission rates or late admissions to critical care. Staff we spoke with told us that more recently senior support had changed and

improved. Protection of the CCOR cover had been prioritised since September 2015 and since the unit restructure under the Surgical and Anaesthetic directorate.

- There was no supernumerary clinical educator in the unit, in line with GPICS (2015). Staff provided support for training however it was recognised that the sickness in the senior, experienced team may impact on the team's ability to provide training and support to junior staff.
- The critical care pharmacist provision was well below GPICS (2015) standards. We spoke with staff in the unit who did not report any issues with management of medicines and pharmacy support, however pharmacists were not able to fulfil the critical care role, join ward rounds or deliver improvements in practice with only 0.2 WTE dedicated hours.
- Discharges out-of-hours, between 22.00hrs and 06.59hrs have been proven to have a negative effect on patient outcome and recovery. Critical care discharges out-of-hours were reported as 2.8% in 2015/16, against a national average of 2.0% as reported by ICNARC for 2015/16.

Maternity and gynaecology

Requires improvement

During the last inspection in April 2015 the service was rated as 'requires improvement' for being safe, effective and well-led. This was because of a lack of dedicated medical staff cover, no dedicated second theatre, mandatory training levels not being met, ineffective medicines management, insufficient governance and audit processes, staff not following guidelines and lack of cohesive working across hospital sites.

At this inspection although some improvements had been made the service remained as 'requires improvement' for being safe and well-led because:

- Some of the risks identified were still in place and sufficient actions to mitigate the risks had not yet been implemented particularly the lack of senior paediatric medical cover out-of-hours to manage advanced neonatal resuscitation and lack of surgical out-of-hours cover. Although there was no evidence of adverse outcomes this still presented a risk to patients.

Summary of findings

- **Due to the public consultation taking place at the time of our inspection, it was noted that a preferred option and decision was yet to be taken by Cumbria Clinical Commissioning Group on the future of maternity and children and young people's services.**
  Although there was some improvement in cross site working the cohesiveness of the two hospital sites for maternity services was not fully embedded. Certain elements of the obstetric team remained dysfunctional with a lack of clinical engagement and support. It was not clear what action was being taken to resolve this.
- There was some improvement in strengthening of governance processes but there were no indicators to ensure performance and understanding of risk or governance roles. There continued to be gaps in how outcomes and actions from audit of clinical practice were used to monitor quality, and in systems to identify where action should be taken.
- Not all staff in the service felt engaged in the reconfiguration of maternity services and felt that their opinions were not listened to.

However:

- Staff understood their responsibilities to raise concerns, to record safety incidents and near misses.
- Nursing and midwifery staffing levels were similar to the national recommendations for the number of babies delivered on the unit each year. Additional medical staff had been recruited to cover the obstetric rota.
- Care outcomes were meeting expectations in most areas, and where improvements were required the service had identified action.
- There were systems to ensure the safe management of medicines. Infection, prevention and control measures were in place.
- Most women were positive about their treatment by clinical staff and the standard of care they had received. They were treated with dignity and respect.

- Services were planned, delivered and co-ordinated to take account of women with complex needs, there was access to specialist support and expertise.
- Midwifery and medical staff worked together ensuring women received care which met their needs.

Services for children and young people

Good

We rated this service as 'good' because:

- The leadership, governance, and culture promoted the delivery of high quality person-centred care. Staff were competent and had the skills they needed to carry out their role effectively and in line with best practice. Managers were visible and there was a real strength, passion, and resilience across medical and nursing teams to deliver high quality care to children, young people and their families.
- Staff told us they were proud to work for the trust and promoted a patient-centred culture. Children, young people, and parents felt that medical staff communicated with them effectively, kept them involved and informed about care and treatment, promoted the values of dignity and respect, and were kind and compassionate.
- Staff protected children and young people from harm and abuse. Medical and nursing staff understood and fulfilled their responsibilities to raise concerns and report incidents, and managers took appropriate action to investigate and share learning.
- Medical and nursing staff followed appropriate processes and procedures to safeguard children and young people. The trust was represented at local safeguarding children board meetings and other sub-groups. Clinicians shared learning from serious case reviews and care records showed staff provided very good standards of care.
- Children and young people received effective care and treatment, planned and delivered in line with current evidence-based practice and legislation. Children's services participated in national and local audits, and other monitoring

activities including service reviews and accreditation schemes. Managers shared the outcomes from audits and actions plans were developed to address areas of concern.

- Children's services were organised to meet the needs of children and young people. Managers and healthcare professionals from the team worked collaboratively with partner organisations and other agencies to ensure services provided choice, flexibility and continuity of care.
- Nurse staffing on the children's ward and in the special care baby unit was compliant with recommendations from the Royal College of Nursing and the British Association of Perinatal Medicine.

However:

- The unit did not meet all Royal College of Paediatric and Child Health (RCPCH) – Facing the Future: Standards for Acute General Paediatric Services (2015 as amended) within contracted hours. Despite ongoing recruitment campaigns, the trust had struggled to recruit appropriate clinicians. The current paediatric consultant team voluntarily worked in excess of their programmed activities to ensure children and young people were safe, however staffing constraints meant this was done in their own time. In a letter to CQC, the trust formally acknowledged our concerns and outlined the actions taken to address the current shortfall, which included robust handovers and ward rounds, plus on-site consultant presence and out-of-hours support. The trust had also secured long-term contracts for consultant locums.
- Healthcare assistants worked within the children's outpatient department without support from a registered children's nurse. This was in breach of Royal College of Nursing staffing standards for children in outpatients as, most of the time; a healthcare assistant was the only

member of the nursing team in the unit. In addition, staff did not have documented competencies and had not received additional training.

End of life care

Good

During our last inspection of End of Life Care Services at Cumberland Infirmary in April 2015 we rated the service as 'requires improvement' overall. During this inspection there was evidence of ongoing improvement. We have rated the service as 'good' overall, with effective as 'requires improvement' because:

- The trust had developed a care of the dying patient (CDP) care plan that provided prompts and guidance for ward based staff when caring for someone at the end of life. We observed the use of these and saw that information was recorded and shared appropriately and that the plans were completed.
- Records within the mortuary were comprehensive and included processes for appropriate checking.
- The palliative care end of life communication training (Sage and Thyme) is part of the mandatory training for all staff at WCH.
- An early warning scoring system was in use throughout the trust to alert staff to deteriorations in a patient's condition. Patient's recognised as being at the end of life had their care plan transferred to the care of the dying patient framework when they were expected to die within a few days.
- The Trust had an organ donation policy, which adhered to national guidelines. The framework process made reference to specialist nurses, clinicians and nursing staff supporting the family throughout the process.
- Porters had face to face mortuary training that included the transfer of the deceased including promoting dignity and respect and an understanding of bereavement.
- Care plans for patients at the end of life included an assessment of nutritional needs and aspects of nutrition and hydration specifically relating to end of life care.

Summary of findings

- The trust ensured that there was timely identification of patients requiring end of life care on admission. Systems were in place where a patient admitted who was known to the palliative care team would generate an alert to the team.
- We observed staff caring for patients in a way that respected their individual choices and beliefs and we saw that records included sections to record patient choices and beliefs so that these were widely communicated between the teams.
- The chaplaincy team worked with ward staff and other professionals for patients receiving end of life care.
- An Integrated End of Life and Bereavement group was now in operation. This was headed by the Deputy Director of nursing the members of the group the SPCT, chaplaincy, the bereavement lead, education and training and consultant medical staff.
- Referrals to the SPCT could be made any time during a patient's treatment. This allowed early involvement of the SPCT and time to facilitate the most appropriate care and treatment. The SPCT encouraged referrals from nursing, medical and allied health professional staff from across the trust.
- The trust had developed "Welcome to Hospice at Home – West Cumbria" initiative. All services provided are free of charge This service included the provision daytime and night nursing care, Respite Care - day, evening or night and also volunteer support in the home They can also refer patients to other services within the organisation including complementary therapies for patients, carers and those bereaved, one to one or group support, bereavement support and Lymphoedema support. All services provided are free of charge
- The specialist palliative care team developed a care pathway tool for patients in all areas of the hospital. This was to ensure that patients who

required end of life care. Patients were identified at the earliest opportunity and to facilitate the most appropriate care in the most appropriate place for each patient.

- A clear vision had been established where 'All people who die in Cumbria are treated with dignity, respect and compassion at the end of their lives and that regardless of age, gender, disease or care setting they will have access to integrated, person-centred, needs based services to minimise pain and suffering and optimise quality of life
- The Lead Bereavement Nurse and the chaplain had leadership roles in terms of end of life care and raising awareness of aspects of their service across the trust. This involved attending meetings and working collaboratively across services and departments to raise awareness of end of life care issues.
- Staff were consistently positive about delivering quality care for patients at the end of life.
- There was a commitment at all levels within the trust to raise the profile of death and dying and end of life care. This included improving ways in which conversations about dying were held and engaging with patients and their families to ensure their choices and wishes were achieved.
- Discharge coordinators were available to support the process of rapid discharge at the end of life and the trust had recently implemented a community service where patients could be supported by trust staff in their own homes where care packages were difficult to access in the community.

However:

- For patients who did not have mental capacity, DNACPR forms we viewed at this inspection were inconsistently completed. We saw DNACPR forms that did not provide evidence of a best interest decision or a mental capacity assessment being undertaken and recorded. In a letter to CQC, the trust formally acknowledged our concerns and outlined the actions to be taken to address this issue.

Summary of findings

- The trust had not achieved two clinical indicators and three organisational indicators in the End of life care Audit: Dying in Hospital in 2016
- The trust had not produced an action plan with key responsibilities and timelines for achievement, to address areas where performance was lower than the England average.
- The trust could not provide the number of referrals to the SPCT.
- Both the SPCT and on general wards supported patient's to die in their preferred location. However the trust did not collate or hold the data that would demonstrate the percentage of patients who died in their preferred location. This information was held by the Clinical Commissioning Group; however the trust could not provide this information.
- There was no regular audit of the CDP to demonstrate that the trust supports patient's to die in their preferred location.
- Specialist palliative care was not provided across a seven day service.
- The trust did not have formal contract meetings with members of the Cumbria Healthcare Alliance to monitor that the service being commissioned and provided is of an appropriate standard in terms of quality and meeting patient need.

Outpatients and diagnostic imaging

Good

We rated this service as good overall, with responsive as requires improvement, because:

- There was an electronic system to report incidents in the services. Staff were aware of how to report incidents.
- The environment of the services were visited were found to be clean and tidy and hygiene standards were good. Equipment was mostly available, except for bariatric wheelchairs and a recliner chair in the phlebotomy clinic.
- Medicines were found to be securely stores and medicines checked were in date. Data for medical records showed the improvement made previously had been generally maintained,

Summary of findings

however a recent change in the storage of the medical records had led to some challenges such as notes arriving late for clinics. Data provided by the trust showed that in September 2016, 94.38% of notes were available at the start of clinic

- Outpatient and Diagnostic services were delivered by caring, committed and compassionate staff. Patients were positive about the way staff looked after them and the care received.
- Care was planned and delivered in a way that took account of patients' needs and wishes. Patients attending the outpatient and diagnostic imaging departments received effective care and treatment. Care and treatment was evidence based and followed national guidance.
- Staff had attended courses and further training to enhance competence in their services. Staff had access to the required information and systems, for example the electronic incident reporting system.
- Staff provided compassionate care and took into account the privacy and dignity of patients.
- The services had been responsive to the increasing demand for clinics by putting on addition clinics on a weekend where required. There had previously been issues with diagnostic six week waiting times; however there had been a steady trend of improvement at this inspection.
- There services had received a low number of complaints in the last 12 months.
- Outpatient managers were able to describe the risks to the services and what they action they were taking to mitigate the risks, however not all identified risks such as staffing levels were on the risk register.
- Staff were mostly positive about local leadership in the service. Staff we spoke with enjoyed their role and overall felt respected and valued by the trust. Staff described good team work and supportive teams.

However:

Summary of findings

- Safeguarding mandatory training completion rates were below the trust target. Mandatory training completion rates were generally below the trust targets.
- The imaging department quality assurance system had been suspended when new equipment was installed and not re-introduced until eight months later. Diagnostic imaging did not carry out daily refrigerator temperature checks.
- Orthopaedic practitioner staffing levels were not at the planned levels.
- Referral to treatment time (RTT) data varied across the specialities. The service did have patients which the see by date had been breached.
- There were a number of clinics cancelled within 6 weeks of the planned clinic date across the trust, and there was no current action plan in place to address cancelled clinics in outpatients. The trust did not measure how many patients waited over 30 minutes to see a clinician in outpatient departments.
- Turnaround times for inpatient plain film radiology reporting did not meet Keogh standards, which require inpatient images to be reported on the same day.

West Cumberland Hospital

Detailed findings

Services we looked at

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

Detailed findings

Contents

Background to West Cumberland Hospital

West Cumberland Hospital (WCH) is part of North Cumbria University Hospitals NHS Trust (hereafter referred to as the Trust), which was created in 2001 by the merger of Carlisle Hospitals NHS Trust and West Cumberland NHS Trust and became a University Hospital Trust in September 2008.

WCH is a provider of acute hospital services serving mainly the Whitehaven and West Cumbria areas. It recently underwent phase one of a £90 million redevelopment, with the new building opening in October 2015. Planning for phase two of the redevelopment is underway. It is a general hospital providing 24-hour A&E, a consultant-led maternity unit and special care baby unit, a range of specialist clinical services and outpatient clinics. It has 239 beds (191 of which are inpatient).

The consultant-led emergency department at West Cumberland Hospital, Whitehaven is open 24 hours a day, seven days a week to provide an accident and emergency service for children and adults. In the year September 2015 to August 2016 35,639 patients attended the accident and emergency department at West Cumberland Hospital, Whitehaven. Paediatric attendances (children age 0 to16) represented 25% of these patients. The hospital was not a designated trauma unit. Since our 2015 inspection the emergency department had relocated to the new building at West Cumberland hospital and the environmental facilities of the department had been considerably improved. The major's area was comprised of six cubicles and the minor's area of eight cubicles, including an observation area for observation of patients with mental health needs, with some safety features fitted. Three rooms were designated for "see and treat" and one rooms was situated adjacent to the paediatric area, providing flexibility for both adult and paediatric patients. The paediatric area included a separate waiting room. A spacious resuscitation area contained three bays, one of which was also equipped for paediatric patients. The department also housed a relatives' room, and an ambulatory care area with two beds and seating. Emergency care was situated adjacent to the radiology department.

The medical care service at the trust provided care and treatment across two sites, Cumberland Infirmary (CIC) situated in Carlisle and West Cumberland Hospital (WCH) situated in Whitehaven. The medical care service was managed by a single management team covering both sites under the division for medicine and emergency care ("the division"). The trust provided 334 medical inpatient beds and 50 day-case beds located across 16 wards covering 14 medical specialities. The medical service accounted for over 50% of the overall trust in-patient bed capacity.

The West Cumberland Hospital (WCH) provided surgical services for general surgery, head and neck, ENT,

orthopaedics, gynaecology and ophthalmology. There was one large ward, an operating suite, a day-case unit, and recovery area. In total, the surgical division had 80 day case and 157 inpatient beds.

The trust has a total of 15 adult critical care beds and the Intensive Care National Audit and Research Centre (ICNARC) data indicates that there are around 1150 admissions a year, with 300 at the WCH site. Across two sites there are eleven 'intensive care' (ITU) beds, for complex level 3 patients, who require advanced respiratory support or at least support for two organ systems; and four 'high dependency' (HDU) beds, for level 2 patients who require very close observation, pre-operative optimisation, extended post-operative care or single organ support and this includes care for those 'stepping down' from level 3 care. Beds are used flexibly with the resources to increase and decrease the numbers of either ITU or HDU admissions.

West Cumberland Hospital (WCH) in Whitehaven provided care and treatment for maternity and gynaecology patients in the West Cumbria area. The maternity services comprised outpatient clinics, a day ward, a ward for post-natal and ante-natal care and a delivery suite. Community midwifery services were provided by midwives employed by the trust. For gynaecology patients there was a women's outpatients department, and inpatient beds on a surgical ward. There was a termination of pregnancy service which operated on specific days of the week. There were 13 maternity beds located across three wards for antenatal and postnatal care. The gynaecology ward had 8 inpatient beds.

Services for children and young people at WCH included a 14-bed children's ward and there was a special care baby unit (SCBU) with 9 commissioned cots. The children's outpatient department was situated within the main outpatient department.

The Specialist Palliative Care Team (SPCT) service at NCUH Palliative care is commissioned by Cumbria Clinical Commissioning Group and is delivered in the Trust by staff from Cumbria Partnership Trust. The Specialist Palliative Care Team (SPCT) at WCH comprised of one 0.8 whole time equivalent (WTE) consultant post shared with the community and the Loweswater Suite with two sessions per week of hospital support. One 0.8 WTE staff grade doctor who mainly worked in the Loweswater Suite, and two WTE Macmillan nurse. An End of Life Care team was established at NCUH and consisted of a Lead Bereavement Nurse, chaplain and a bereavement officer.

The outpatient departments held clinics for various specialities throughout the trust across the different hospital sites. Diagnostic imaging was available at Cumberland Infirmary and WCH. Clinics were held in the main outpatient department and departments such as Ophthalmology.

WCH had been in the newly built outpatient department for around 12 months at the time of our inspection. Most outpatient clinics had moved to the newly built unit, however there were a small number of clinics still offered in the previous building. We were told during the inspection these were being moved out of the previous building in 2017.

Diagnostic imaging services were mainly provided from two locations: Cumberland Infirmary and West Cumberland Hospital with a limited service at Workington Community Hospital, Penrith Hospital and Cockermouth Community Hospital. Diagnostic imaging at WCH provided plain film x-rays, ultrasound, CT, MRI, and interventional treatments. The acute clinical work including fluoroscopy was concentrated at the two main sites; Cumberland Infirmary and West Cumberland Hospital that offered a range of diagnostic imaging, image intensifiers in theatres, and interventional procedures.

Our inspection team

Chair: Ellen Armistead, Deputy Chief Inspector of Hospitals, Care Quality Commission

Head of Hospital Inspections: Amanda Stanford, Care Quality Commission

Detailed findings

The team included two CQC Inspection Managers, nine CQC inspectors, an Expert by Experience and a variety of specialists including consultant medical staff, senior nurses, allied health professionals and governance experts.

How we carried out this inspection

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

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

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

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

Prior to the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These organisations included Cumbria CCG, Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges, Overview and Scrutiny Committees and the local Healthwatch.

We interviewed members of staff and talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment. We used all of this information to help us decide what aspects of care and treatment to look at as part of the inspection.

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

Facts and data about West Cumberland Hospital

In the year September 2015 to August 2016 35,639 patients attended the accident and emergency department at WCH. Paediatric attendances (children age 0 to16) represented 25% of these patients.

The trust had 38,352 medical admissions between April 2015 and March 2016. Emergency admissions accounted for 19,658 (51%), 1,248 (3%) were elective, and the remaining 17,626 (46%) were day case. 13,918 (36%) of these admissions were reported from WCH. Admissions for the top three medical specialties were: General Medicine: 18,487, Gastroenterology: 8,294 and Clinical Oncology: 4,259.

Across the surgical division the trust had 24,171 surgical admissions between April 2015 and March 2016. Emergency admissions accounted for 6,469 (26.8%), 13,210 (54.7%) were day operations, and the remaining 4,492 (18.6%) were elective.

Detailed findings

Across the surgical division the trust had 24,171 surgical admissions between April 2015 and March 2016. Emergency admissions accounted for 6,469 (26.8%), 13,210 (54.7%) were day operations, and the remaining 4,492 (18.6%) were elective.

The trust has a total of 15 adult critical care beds and the Intensive Care National Audit and Research Centre (ICNARC) data indicates that there are around 1150 admissions a year, with 300 at the WCH site.

Between April 2015 and March 2016, there were 1,274 births at WCH. Across the trust, the percentage of births to mothers aged 20-34 and percentage of births to mothers aged 20 and under was slightly higher than the England average.

WCH is part of North Cumbria University Hospital Trust (NCUH). Patients at the end of life were nursed on general hospital wards. Between April 2015 and March 2016 there had been 1,185 in-patient deaths across the three hospital sites within the trust as a whole.

The trust had 488, 353 outpatient appointments between April 2015 and March 2016. Of these, 321, 336 appointments were held at Cumberland Infirmary and 124, 856 appointments were held at WCH. All other appointments were held at other trust hospitals such as Workington community hospital, Penrith hospital and Cockermouth Community Hospital.

The trust provided diagnostic imaging figures for all sites for each modality; WCH staff carried out 10024 CT scans, 5632 MRI Scans, 9002 non-obstetric ultrasound scans, 6266 obstetric scans, 774 nuclear medicine procedures, 881 fluoroscopy procedures, 32312 plain film x-rays.

Our ratings for this hospital

Our ratings for this hospital are:

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

Urgent and emergency services

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

Information about the service

Urgent and emergency services were provided at two hospitals within North Cumbria University Hospitals NHS Trust. The consultant-led emergency department at West Cumberland Hospital, Whitehaven, is open 24 hours a day, seven days a week, to provide an accident and emergency service for children and adults. In the year September 2015 to August 2016 35,639 patients attended the accident and emergency department at WCH. Paediatric attendances (children age 0 to16) represented 25% of these patients. The hospital was not a designated trauma unit.

Since our 2015 inspection the emergency department had relocated to the new building at WCH and the environmental facilities of the department had been considerably improved. The major's area was comprised of six cubicles and the minor's area of eight cubicles, including an observation area for observation of patients with mental health needs, with some safety features fitted. Three rooms were designated for "see and treat" and one rooms was situated adjacent to the paediatric area, providing flexibility for both adult and paediatric patients. The paediatric area included a separate waiting room.

A spacious resuscitation area contained three bays, one of which was also equipped for paediatric patients. The department also housed a relatives' room, and an ambulatory care area with two beds and seating. Emergency care was situated adjacent to the radiology department.

During our inspection in December 2016 we visited the accident and emergency department at WCH hospital on 7 December. We spoke with 15 members of staff which included managers, doctors, nurses, therapists, non-clinical, and student staff, as well as ambulance staff and volunteers. We reviewed 12 patient records. Inspectors met with 10 patients and relatives, observed the interaction of staff with patients and observed team meetings in progress. We reviewed comments from people who contacted us to tell us about their experiences, and we reviewed performance information for the hospital.

Urgent and emergency services

Summary of findings

At our previous inspection, in April 2015, we rated this core service as 'requires improvement'. In December 2016 we rated the service as 'good' because:

- Risks to the delivery of care and treatment for patients were mitigated and a risk register for accident and emergency reflected identified key risks. Safeguarding procedures were in place.
- Patient care and treatment followed evidence based guidance and recognised best practice standards. Sepsis screening and management and other clinical guidelines were used effectively.
- Staff provided considerate and compassionate care for patients and treated them with dignity and respect. Staff interacted with patients empathetically and responses to their needs were prompt. Care and treatment was explained to patients in a way they understood. Patients were consulted and involved in decisions about their care and treatment and received emotional support.
- Patients with a learning disability, patients with dementia, and bariatric patients accessed emergency services appropriately and their needs were supported. Patients with mental health needs could access services in a joined up way.
- Patient's consent to care and treatment was documented and the requirements of the Mental Capacity Act were followed. Patients' nutrition and hydration needs were provided for and pain was managed effectively.
- Incident reporting had increased and serious incidents had reduced. Learning from the investigation of incidents was shared and duty of candour requirements were followed. Emergency preparedness arrangements were in place to respond to major incidents.
- Public engagement included consultation events about changes to services and although few complaints were received they were investigated and learning was shared with staff.
- Staffing had improved and staff were deployed in the department effectively so that staffing levels were sufficient to meet patients' needs. Mandatory training had been completed by most staff. The learning and development of medical and nursing staff was supported and staff received an annual appraisal. Multidisciplinary teams operated effectively. An improved, positive culture was apparent in the emergency department and staff worked well together.
- The hospital was taking steps to address performance as part of its improvement plan for emergency care. A newly designated emergency floor had recently been opened which brought together acute admissions and ambulatory care patients. Seven day working was operated 24 hours a day throughout the year including some key support services, for example x-ray.
- Cleanliness, infection control and hygiene procedures were followed and standards were monitored. Equipment and medicines stocks were managed effectively.
- The department participated in relevant national audits and undertook regular local audits which supported consistent improvements in care and treatment for patients.
- Governance of the emergency department was more embedded and the vision and strategy for emergency care was understood. The department implemented innovation to benefit patients.

However:

- For an extended period, the hospital has failed to meet the target to see and treat 95% of emergency patients within four hours of arrival and the hospital was failing to meet consistently a locally agreed trajectory to see and treat emergency patients within the standard agreed with regulators and commissioners.
- Emergency department waiting time data was incorrect. Staff were not fully utilising the computer system as intended so that the times recorded were not accurate.
- Material issues remained with patient flow in the hospital. Patients experienced overnight delays in the emergency department whilst waiting for beds to become available in the hospital and some patients experienced long delays whilst waiting for transfer to Cumberland Infirmary.
- Risks related to the transfer of patients needed to be added to the risk register.

Urgent and emergency services

- Changes in the operational nursing structure for the emergency department needed to become embedded.
- Staff engagement needed to be extended.

Are urgent and emergency services safe?

Good

At our previous inspection, in April 2015, we rated safe as 'requires improvement'. In December 2016 we rated safe as 'good' because:

- The emergency department had moved to new facilities which had addressed previous environmental concerns.
- Incident reporting had increased and serious incidents had reduced. Staff knew how to report an incident and could describe the action they took following an incident. Learning from the investigation of incidents was shared. Emergency care staff were conversant with the duty of candour requirements.
- Risks to patients in the department were kept under review by medical and nursing staff working together and children were prioritised.
- Safeguarding procedures were in place and there were no open safeguarding alerts. Patient records were maintained.
- Medical and nursing staffing had significantly improved and staff shortages were managed proactively. Staff were deployed in the department effectively and staffing levels were sufficient to meet patients' needs. The department was recruiting more staff, including paramedics in development roles. Mandatory training had been completed by most staff.
- Cleanliness, infection control and hygiene procedures were followed and standards were monitored. Medicines management was in order including controlled medicines.
- Emergency preparedness arrangements were in place to respond to major incidents. Robust arrangements were in place which took account of hazardous facilities at the nearby nuclear industry site.

However:

- The accident and emergency service review had identified a shortfall of three whole time equivalent consultant staff due to increasing patient demand. This was only partially filled by locum consultant staff.

Incidents

- Following our 2015 inspection, the trust was required to improve the rate of incident reporting. For emergency

care, we found there had been an increase in incident reporting and a reduction in the number of serious incidents. Staff knew how to report an incident and could describe the action they took following an incident. Staff reported incidents readily and provided examples of incidents they reported, which included staffing shortages, patients delayed in the department and other risks to patients.

- Reportable incidents in emergency care were recorded using an electronic reporting system widely used in the NHS. Incidents were graded according to risk rating and severity of harm in accordance with the trust incident management policy (including the management of serious incidents) published in February 2016.
- Incidents were categorised according to severity ranging from no injury, low, moderate, major or catastrophic. Managers and the patient safety panel reviewed submitted incidents and grading of harm. Staff escalated serious incidents.
- Incident trends and themes were monitored. In accordance with the Serious Incident Framework 2015, the trust reported 15 serious incidents (SIs) in emergency care between October 2015 and September 2016 which met the reporting criteria set by NHS England Eight of these incidents were reported for West Cumberland. Of these, the most common type of incident reported was treatment delay.
- Never events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. Between October 2015 and September 2016, the trust reported no incidents which were classified as Never Events for urgent and emergency care.
- Investigation reports provided a full summary of the investigation process, the background leading to the investigation, a checklist of critical concerns, and a detailed timeline of events, organisational factors, and care and service delivery issues, involvement of the patient or family and areas of good practice. The reports detailed action plans, feedback mechanisms and processes in which lessons learnt could be embedded.
- Learning from the investigation of incidents was shared. Managers discussed the outcomes of investigations at divisional meetings and learning was shared with staff at team meetings. The safety newsletter was re-launched in November 2016 and the division proposed holding safety summits on a monthly basis. The division had appointed a safety clinical director who led on programmes to improve clinical safety and learning methods. Learning from incidents was included in a monthly safety newsletter which set out what worked well and what went wrong, so that learning was shared.
- The patient safety thermometer was used to record the prevalence of patient harm, and to provide immediate information and analysis for teams to monitor their performance in delivering harm free care. Data collection took place one day each month.
- Data from the patient safety thermometer showed that between September 2015 and September 2016 for emergency care the service reported eight pressure ulcers, 12 falls with harm and six catheter urinary tract infections. There was an increase in pressure ulcers in February 2016 and June 2016. There was an increase in falls with harm in March 2016. There was an increase in catheter urinary tract infections in March 2016 and June 2016. During our visit the emergency department reported three days without a falls incident.
- We were informed that following an independent audit of duty of candour during 2016, the trust introduced a new policy for duty of candour. Emergency care staff were conversant with the duty of candour requirements and of the trust being open policy. Staff understood that this involved being open and honest with patients. Managers were aware of the duty of candour and some staff explained to us that they had been involved in investigating and responding to patients and families under this duty.
- The division held monthly mortality and morbidity review meetings. The meeting considered case summaries, reviewed outcomes and identified key lessons.

Cleanliness, infection control and hygiene

- The emergency department was visibly clean and tidy. Cleaning rotas were in place for both clinical and non-clinical areas and equipment was visibly clean, although items of equipment did not have a label to indicate it was clean and ready for use. We observed that equipment was cleaned between patients. Clean utility areas and treatment rooms were visibly clean and tidy. We observed clinical waste and sharps were disposed of appropriately.

- Staff used personal protective equipment including disposable gloves and aprons. Staff washed their hands between patients and followed the bare below the elbow policy.
- Emergency care followed infection control procedures. The trust healthcare associated infection prevention and control strategy followed national guidelines and infection prevention and control policies to manage and monitor infection essential for patient and staff safety.
- Emergency care was involved in monthly infection prevention and control audits to monitor compliance against quality measures including hand hygiene and cleanliness of equipment. The hospital scored above 95% for hand hygiene compliance. Managers confirmed best practice was confirmed following infection prevention and control audits and where findings were below standard; action was taken to improve compliance in follow-up audits.
- The emergency department contributed to a monthly environmental audit. In 2016, the cleaning audit score for the emergency department at WCH, Whitehaven was consistently 100%. We observed cleaning staff in the emergency department and, for example, cleaning of the resuscitation area was very thorough. We found that action was taken if any deterioration in cleaning standards was observed.
- The division provided data for the quarterly reports on clostridium difficile infections in Cumbria published by Public Health England. Infection prevention and control staff investigated all c.difficile cases through root cause analysis. Themes, trends and learning outcomes were disseminated. Staff reviewed confirmed cases at weekly health care associated infection meetings and at infection prevention and control and safety and quality groups.
- The trust reported eight c.difficile cases between August and October 2016, of which six (75%) originated from the medical division. The division also completed audits of methicillin resistant staphylococcus aureus (MRSA) screening, although no MRSA cases were reported in the previous 12 months and no infection was attributed to emergency care. We found staff received training annually in isolation procedures.
- Infection prevention and control training was mandatory and 70% of staff in the medical division had completed this training in the last 12 months.

Environment and equipment

- Since our 2015 inspection the emergency department had relocated to the new building at West Cumberland hospital, Whitehaven and the environmental facilities of the department had been considerably improved.
- The major's area was comprised of six cubicles and the minor's area of eight cubicles, including an observation area for observation of patients with mental health needs, with some safety features fitted. Three rooms were designated for "see and treat" and one rooms was situated adjacent to the paediatric area, providing flexibility for both adult and paediatric patients. The paediatric area included a separate waiting room which was brightly decorated and well equipped with TV and toys.
- A spacious resuscitation area contained three bays, one of which was also equipped for paediatric patients. The department also housed a well-furnished relatives' room, and an ambulatory care area with two beds and seating. Emergency care was adjacent to the radiology department and portable x-ray equipment was also used in the department.
- At our 2015 inspection we required the hospital to ensure equipment was stored correctly, decontaminated effectively and all single use items were within expiry date. Since our 2015 inspection the department had reviewed the storage arrangements for equipment and supplies. Adequate stocks of sterile single use equipment were available and within date. A trolley fitted with an x-ray plate had been obtained for the use of bariatric patients.
- Checklists of the equipment on the resuscitation trolleys and in cubicles were completed for a daily, weekly and monthly cycle of checks. We checked equipment in the resuscitation and paediatric areas. A separate equipment checklist was used for the paediatric resuscitation bay. Equipment checklists for the current and previous months were completed.
- Electrical and mechanical equipment was maintained appropriately and faulty equipment was repaired or replaced. We reviewed evidence that planned preventative maintenance for the department was fully completed over the previous two years. We reviewed the minutes of the medical devices committee for September 2016 which confirmed the action taken if the planned preventative maintenance schedule fell behind and after root cause analysis of accidental damage to medical devices, the department was incentivised to minimise causes of damage. Items of equipment we

checked were within their maintenance dates and clearly labelled. Trolleys were clean and labelled ready for use. Electrical equipment was portable appliance tested and within date.

- The division contributed to the trust Patient-Led Assessments of the Care Environment ("PLACE") 2016 audit. Performance improved in all four aspects of PLACE from 2015 to 2016. The greatest performance improvement in 2016 compared to 2015 was related to facilities which improved by 19%.

Medicines

- Emergency department staff were aware of local policy, professional standards for medicine management and for the storage and administration of controlled drugs. Staff we spoke with knew how to report incidents involving medicines. A dedicated clinical pharmacy service was available to the department. Pharmacy staff maintained stock levels and checked medicine expiry dates.
- At our 2015 inspection we required the hospital emergency department to provide safe and secure storage for medication with access limited to qualified staff only. At our 2016 inspection we found medicines were appropriately stored and access was restricted to authorised staff. Medicines which required refrigeration were stored appropriately. Staff completed daily checks of fridge temperatures and an audit of fridge temperatures was completed weekly. Staff informed us when a temperature reading was outside the upper or lower limit, they contacted the pharmacy department for guidance.
- Staff managed controlled drugs securely and maintained accurate records in accordance with trust policy, including regular balance checks. We undertook a random check of controlled medicines in the resuscitation area and found medicines were within their expiry date and was securely stored and disposed of appropriately. .
- The department participated in an audit of controlled medicines for the medicines division in September 2016. The division's overall reported compliance was 94%. Some improvements to documentation were identified from the audit.
- The department received quarterly medicines safety data to identify individual actions and to encourage learning. Reports included medicine safety results, reconciliation figures, allergy status compliance, medication omission rates, controlled drug audits, antibiotic audits, patient experience, education and training and discussed key incidents to share wider learning from other hospital areas.

Records

- An electronic patient record system used elsewhere in the NHS was used in the department. Since our 2015 inspection we were informed the electronic patient record system had been updated to improve data entry.
- Staff used the system in conjunction with the completion of paper records. The record followed the patient through the department. The initial set of patient observations were recorded using the electronic system. Paper records were printed from the system in the form of an emergency department card. The patient cards and supporting assessment records were subsequently scanned onto the electronic system. Records were kept securely and confidentially.
- We reviewed the records for seven patients in the department. The records were kept up-to-date with details completed of their assessment, risk review, diagnosis, plans for care and treatment and the involvement of the patient. Multi-disciplinary team involvement was documented. We found the paper records were well completed and collated consistently with the exception of minor inconsistencies related to the recording of allergies, where these were also recorded in the electronic system. In a small number of instances we did not find evidence of ongoing nursing assessment being recorded.
- The division completed annual case note audits for the NHS Litigation Authority. The key clinical content indicators were mainly in place however the audit identified some issues with legibility of entries, fully completed patient details on all pages and some signatory omissions.

Safeguarding

- The trust had designated an executive lead and organisation level staff team with responsibility for safeguarding. The division and department were represented by senior staff who attended safeguarding board meetings.
- Staff we spoke with in the emergency department were aware of the trust's safeguarding policy. Staff were confident in identifying concerns and escalating these

where appropriate, both within and out-of-hours. Safeguarding records were well documented. The emergency department had no open safeguarding alerts at the time of our inspection.

- Staff completed a safeguarding key in the patient's clinical assessment record for each child who attended the emergency department. The electronic patient record system alerted staff to any previous safeguarding issues. Records contained the appropriate triggers and a safeguarding referral file was also available in the department. We reviewed the record of a paediatric patient safeguarding assessment, which we found followed the recognised safeguarding process.
- Safeguarding policies and procedures we observed were displayed in designated staff areas. Safeguarding information included guidance as to where to seek specialist advice and provided key contact details for escalation. Staff also accessed safeguarding information and guidance on the trust intranet.
- For the division which included emergency medicine, the trust had in place a target of 95% for completion of mandatory safeguarding training by the end of March 2017. Prior to our inspection we found the medical staff group in emergency services had not reached the trust target for any of the safeguarding training courses. Training compliance for nursing and health care assistant staff in emergency services achieved the trust target for safeguarding adult's level 1 and safeguarding children level 2. Managers confirmed that for staff who had not attended their refresh training, a date was arranged before the end of the year.

Mandatory training

- Mandatory training modules covered core subjects including information governance, fire safety, equality and diversity, infection control, health and safety and basic life support. For staff in emergency care, a range of additional training modules in specialist clinical competencies was included in mandatory training. Staff in the department received training in basic and advanced life support covering adults and paediatrics, advanced and immediate and paediatric immediate life support.
- At our 2015 inspection we stated that the hospital emergency department should improve its rate of completion for mandatory training. At our 2016 we found the division including emergency medicine adhered to the trust mandatory training target of 95% by the end of March 2017. As of August 2016, compliance for medical staff ranged from 83% for equality and diversity and 50% for basic life support. Nursing staff compliance rates were better ranging from 97% for equality and diversity to 59% for fire safety. Managers confirmed that where shortfalls in training compliance were identified, staff were arranged to attend the relevant session.
- Staff we spoke with at West Cumberland hospital had completed their mandatory training. Staff in a focus group confirmed that the trust had placed an emphasis on their completion of mandatory training. Staff were allocated time to compete mandatory training. Staff in the focus group confirmed they had completed their training.

Assessing and responding to patient risk

- Patients were prioritised in order to see the sickest patients first. Walk-in patients with mainly minor injuries arrived at the emergency department reception and were seen promptly by a member of reception staff to receive initial signposting. We observed the initial assessment of patients on arrival. The receptionist used recently revised guidance to direct the patient depending on the apparent seriousness of their condition, so that more urgent patients were seen first, rather than in the order they arrived. Patients under 18 years were directed to a separate paediatric waiting room. Patients arriving by ambulance used a separate entrance and were seen promptly on arrival.
- In the triage area, children were seen first of all, and then adult patients were called from the main waiting room. A triage system widely used in the NHS was used. A qualified triage nurse undertook observational screening and discussed their history with the patient to assess their condition. The triage nurse offered the patient pain relief if this was indicated, and other minor treatment needs could be dealt with directly by the triage nurse. The triage nurse may request initial blood tests or x-rays immediately so that the patient's results were available when they were seen by a doctor. The triage nurse recorded the patient's details on the electronic system.
- Following their triage the patient was allocated to a red, yellow or green category depending on the initial assessment of their risk. Patients were directed or

escorted to minors, majors or another department in the hospital. The electronic admissions system alerted staff when patients had previously attended the hospital and the emergency department.

- We found that the senior nurse and doctor worked closely together in managing the flow of patients through the department so that the most unwell patients were prioritised. When significant patient delays in the department were experienced which risked patients waiting more than one hour, medical staff commenced assessment and treatment so that the patient by-passed the nurse triage. The medical intervention was used to ensure risks to patients were managed. Every two hours the nurse in charge undertook rounding of the department to review the risks to patients.
- Emergency department staff used a range of tools to assess, monitor and respond to patient risk. The emergency department completed the national early warning score (NEWS) for each patient treated in the majors area of the department. NEWS scores the patient's vital signs and was used for identifying patients who were deteriorating clinically. NEWS was part of the patient record and included directions for escalation. Since our 2015 inspection, the emergency department had held a NEWS rapid improvement workshop which aimed to improve NEWS compliance.
- Since our 2015 inspection the emergency department had also introduced a nursing assessment based on the situation, background, assessment and recommendation (SBAR) technique. SBAR was not completed for each patient, but for patients identified for admission to hospital. We were informed SBAR had been developed as a result of audit, with the objective of improvements in handover and in consistency of care. We saw some evidence that audits had been undertaken which demonstrated this.
- Since our 2015 inspection the emergency department had introduced a recognised (ROSIER) triage score for suspected stroke patients, with the objective of improved stroke recognition and treatment.
- The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust met the standard for 12 months over the period August 2015 to July 2016.
- At the December 2016 inspection we were informed that changes to the triage process since our previous inspection had increased the number of patients triaged within 15 minutes. The improvement was evidenced by performance information in the emergency care dashboard for 2016-17.
- An escalation policy was in place for the emergency department which was displayed in the reception staff area. Bed management meetings were held regularly to review and escalate risks that could impact on patient safety, including staffing, bed capacity and patient flow in the hospital. The emergency department matron was able to escalate concerns. The emergency department operations policy included guidance on how to escalate patient pathway delays or other concerns in order to meet the needs of patients.
- The emergency department at WCH had an arrangement with the air ambulance service for emergency department medical consultants to be available to support seriously unwell patients.

Nursing staffing

- We found the trust had made progress with its emergency department nursing staffing compared with our 2015 visit. Since our 2015 inspection the trust had obtained approval to recruit staff to an agreed level and the emergency department had improved staffing levels. Shift patterns had been changed to increase staffing levels at times of high patient demand. A paramedic had been deployed on the nursing rota to work in resuscitation and triage roles.
- The emergency department did not use a recognised staffing acuity tool to determine the nursing establishment. Departmental data was analysed and local knowledge and clinical experience was used to take account of fluctuations in attendances to inform staffing numbers. Staffing levels met these criteria except when the department was very busy.
- Qualified and unqualified nursing staff of different grades were assigned to each of the patient areas within the emergency department. The department had in place planned nurse to patient ratios for the triage, minors, majors, paediatric and resuscitation areas. Staffing arrangements were flexible between these areas and additional qualified nursing and healthcare assistant staff were used for the four busiest evening shifts. Other qualified and senior staff were allocated to triage and nursing supervision of the department.
- Since our 2015 inspection the staffing duty rota was managed using an e-roster system introduced in May

2016. Staff told us this system provided improved monitoring of nursing staff resource. Three sisters (Band 7) had joined the department since 2015. We obtained evidence from the emergency department to confirm that a process was followed for managing staffing levels and escalating staff shortages. Staff confirmed patients were safe and not at risk, although they felt a more formal review of staffing was needed following the move to the new department. The recruitment of nurse practitioner staff was being reviewed at the time of our inspection.

- We were informed that three daily nursing handover meetings took place in emergency medicine. A daily multidisciplinary meeting was held which included medical and reception staff. Because of different shift change times for medical and nursing staff, separate handovers were also held where staffing requirements were reviewed.
- Between April 2015 and March 2016, the trust reported for emergency care an average turnover rate of 31%, and a sickness rate of 5%. We reviewed evidence that the turnover rate had decreased substantially. As at September 2016, the trust reported a vacancy rate of 2.6% in emergency care.
- At the time of inspection the emergency department were recruiting a clinical matron, a paramedic and two registered nurses for emergency care. Senior managers in a focus group told us the trust reviewed each vacancy in emergency care to check whether there was a more efficient way of replacing staff that had left. The service was working with the university to co-ordinate nursing recruitment.
- Cover for staff absences at short notice was provided by bank staff from the existing nursing team or by agency nursing staff. Agency staff were subject to vetting checks and received training in delivering emergency care before working in the department. Between April 2015 and March 2016, West Cumberland hospital reported a bank and agency usage rate of 1.53% in urgency care.

Medical staffing

- At our 2015 inspection we required the trust to ensure that medical staffing was sufficient to provide appropriate and timely treatment and review of patients at all times including out of hours and that medical staffing was appropriate at all times including medical trainees, long-term locums, middle grade doctors and consultants.
- We found medical staffing for the division which included emergency medicine had improved since our inspection in 2015. Senior and medical staff in a focus group gave examples of progress since the last inspection. The accident and emergency service review had identified a shortfall of three whole time equivalent consultant staff due to increasing patient demand. This was only partially filled by locum consultant staff. Medical rotas were more resilient to change and some medical consultant staff had returned to the trust and gave positive feedback about the progress achieved. The organisation had a high retention rate for existing medical staff.
- Medical staffing in the emergency department consisted of three substantive consultants. Of the vacancies for three further consultants, these posts were held by locum consultants of whom one was long term. A dedicated consultant worked on the emergency floor all day and also middle grade medical staff. A paediatric consultant was on-call from the paediatric department in the hospital. A composite workforce was being established with the appointment of four emergency nurse practitioners to cover middle grade medical staff roles. A consultant role had been developed in collaboration with the air ambulance service and recruitment was in progress at our inspection.
- Between April 2015 and March 2016, the trust reported a bank and locum usage rate of 20% in emergency care. The emergency department locums were seen as stable and well embedded in the role. The department had found it difficult to recruit to substantive consultant posts. Existing vacancies and shortfalls were covered by locum, bank or agency staff when required. All agency and locum staff received a local induction before they were permitted to work in the department. Locum consultants required current advanced life support training and were required to support the consultant staff rota.
- Consultants held handovers between medical staff at their change of shift. When we observed a medical handover we saw that staffing arrangements to cover shortages were included in the discussion. Medical staff confirmed that colleagues were ready to support them with clinical advice during the night if required.
- Between April 2015 and March 2016, the trust reported a sickness rate of 0.01% in emergency care, with 0.00% reported for West Cumberland hospital.

Urgent and emergency services

Major incident awareness and training

- Emergency care was included in trust arrangements for major incident planning and business continuity and we found an emergency preparedness policy was in place. The lead for major incidents was a member of consultant medical staff in the emergency department. An emergency department sister was responsible for coordinating equipment checks.
- Staff we spoke with were familiar with the major incident policies and were able to access guidance on the trust intranet which included key risks that could affect the provision of care and treatment. The resilience team for the trust undertook regular exercises to challenge emergency response procedures and communications from the team were shared with staff.
- The department had in place decontamination facilities and equipment to deal with patients who may be contaminated or otherwise exposed to hazardous substances. Staff undertook simulated chemical, biological, and radiological training and were familiar with procedures to follow in the event of a major incident alert. Robust arrangements were in place which took account of hazardous facilities at the nearby nuclear industry site. Senior staff confirmed they had undertaken the major incident training.
- The department also collaborated with the mountain rescue service.

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

Good

At our previous inspection, in April 2015, we rated effective as 'good'. In December 2016 we rated effective as 'good' because:

- Patient care and treatment followed evidence based guidance and recognised best practice standards. Clinical audits were used to assess how well NICE and other guidelines were followed. Sepsis screening and management and other clinical guidelines were used effectively.
- The department contributed to the Royal College of Emergency Medicine's (RCEM) clinical audit programme, participating in most national audits for which it was eligible. The department also undertook regular local audits which supported consistent improvements in care and treatment for patients.
- The service supported the learning and development of both medical and nursing staff. All staff new to the department received an induction and all staff received an annual appraisal.
- Staff collaborated effectively within multidisciplinary teams to support the planning and delivery of care.
- Patient's consent to care and treatment was documented in their records. The requirements of the Mental Capacity Act were followed where this was appropriate.
- Patients' nutrition and hydration needs were monitored and provided for and their pain symptoms were managed promptly and effectively.
- Information supported the coordination of services for patients and was exchanged readily with other departments in the hospital.
- Seven day working was operated 24 hours a day throughout the year with arrangements for most key support services including x-ray facilities.

Evidence-based care and treatment

- Since our inspection in 2015 we found improvements in evidence based care in the emergency department. The introduction of new nursing documentation had improved clinical indicators. An external tool to support the collection and reporting of electronic data for local audit had been used in the department.
- We found care and treatment in the emergency department was evidence-based and followed recognised national guidelines including the National Institute for Health and Care Excellence (NICE) and College of Emergency Medicine (CEM) guidelines. Local policies reflected up-to-date clinical guidelines and were available on the trust intranet. Staff referred to a range of NICE, CEM guidelines and patient group directions to support best practice in the provision of care and treatment provided for patients.
- The division including emergency medicine had in place a range of evidence based condition specific care pathways to enable standardised and improved patient care and service flow. The department used clinical

guidelines including trauma, stroke, pneumonia and fractured neck of femur which were developed for local use alongside recognised national and international standards.

- The division including emergency medicine had adapted guidance for sepsis screening and management. For patients with symptoms of sepsis, the department followed the sepsis care bundle. The sepsis care pathway flowchart provided guidance in treating severe sepsis.
- The clinical guidance group for the hospital oversaw the development of the clinical guideline policy and the preparation and revision of clinical guidelines. We found clinical guidance was discussed at governance meetings where the impact that guidance made to staff practice was considered.
- The division which included emergency medicine had developed a range of evidence based condition specific care pathways to standardise and improve patient care and service flow. For example, we saw an abscess referral flowchart for an abscess referral pathway for the hospital which was used in the department to support referrals to ambulatory care. We observed that operational pathways for asthma, sepsis, meningitis and other procedures were displayed in the department.
- The emergency department undertook clinical audits to assess how well NICE and other guidelines were followed. The clinical audit plan for 2016-17 showed that national audits of violence and aggression and of assessment of transient loss of consciousness were in progress in emergency care and aimed to check practice in relation to NICE guidelines. Examples of other audits current in emergency medicine at our inspection included vital signs in children and procedural sedation in adults.
- The hospital's clinical effectiveness and improvement programme was supported by continuous data collection for national audit. An external tool to support the collection and reporting of electronic data for local audit was used in the department. The audit of NICE guidance and 10 national audits were supported, which included for example sepsis, asthma and consultant sign-off. A consultant was assigned to each audit with responsibility for monitoring actions taken. The division used national audit findings to develop action plans which supported compliance with evidence-based care and treatment. Audits resulted in changes in practice to improve patient care in staff training.

Pain relief

- In the CQC accident and emergency survey, the trust scored 5.82 for the question "How many minutes after you requested pain relief medication did it take before you got it?" This was about the same as other trusts. The trust scored 8.09 for the question "Do you think the hospital staff did everything they could to help control your pain?" This was also about the same as other trusts.
- The division which included emergency medicine participated in the trust wide pain management audit. The audit considered four clinical indicators (pain assessment, care plan, analgesia administration and pain reassessment) with a benchmarking compliance of 95%. Between September and November 2016, the division reported overall compliance at 96%.
- We observed staff in their care and treatment of patients who required pain relief. Patients were assessed for pain relief as they entered the emergency department. During the initial assessment, the patient was asked about their level of pain and whether they required medicine to relieve their pain symptoms. We observed that a pain scoring system was used and if the patient scored zero, this was also recorded in their assessment. A paediatric pain chart was used to score children.
- Of the eight patients we reviewed who needed pain relief, medication was given very promptly. For example, we saw that the triage nurse ensured patients were given relief for pain symptoms. Patients we spoke with confirmed they had been given medicine for pain relief if they required it.

Nutrition and hydration

- In the CQC accident and emergency survey, the trust scored 6.91 for the question "Were you able to get suitable food or drinks when you were in the emergency department?" This result was about the same as other trusts.
- The emergency department was equipped with a food fridge for patients. Staff checked whether patients were not permitted refreshments for medical reasons before offering them. Patients were offered a limited choice of food and drink and could order hot food from the hospital kitchen.

- The division contributed to the Patient Led Assessment of the Care Environment (PLACE) 2016 survey. In the food category, the hospital achieved an 83% satisfaction rate, which was worse than national average of 88%.

Patient outcomes

- Since our 2015 inspection the emergency department had achieved some improvements in patient outcomes which were confirmed by national audit. The department participated in Royal College of Emergency Medicine (RCEM) audits to measure its performance against other trusts. A consultant lead was assigned for each audit in the emergency department. Work was in progress for national audits on trauma, asthma, sepsis, dementia and consultant sign-off.
- In the 2014-15 RCEM audit for assessing cognitive impairment in older people, WCH was in the upper quartile compared to other hospitals for one of the six measures and was in the lower quartile for one of the six measures. Three of the measures were not applicable as the sample size was zero. The site did not meet the fundamental standard of having an Early Warning Score documented however it did perform in the upper quartile for this measure (99%).
- In the 2014-15 RCEM audit for initial management of the fitting child, WCH was in the lower quartile compared to other hospitals for two of the five measures and was in the upper quartile for none of the five measures. The site did not meet the fundamental standard of checking and documenting blood glucose for children actively fitting on arrival.
- In the 2014-15 RCEM audit for mental health in the emergency department, WCH was in the upper quartile compared to other hospitals for two of the six measures and was in the lower quartile for two of the six measures. Of the two fundamental standards included in the audit, the site did not meet the fundamental standard of having a documented risk assessment taken. The site did not meet the fundamental standard of having a dedicated assessment room for mental health patients.
- Between August 2015 and July 2016, the trust's unplanned re-attendance rate to accident and emergency within seven days was generally worse than the national standard of 5% and generally about the same as the England average apart from in April 2016 when there was a sharp rise to 53%. In the latest period, July 2016, trust performance was 7.2% compared to an England average of 7.9%.

Competent staff

- Before they commenced work in the emergency department, staff received an induction specific to their role in accident and emergency care.
- Between April 2015 and March 2016, 43% of medical and nursing staff in accident and emergency at the hospital had received an appraisal. However, the executive confirmed that 94% of staff had received an appraisal, which compared with 48.75% in 2015-16. We saw evidence that 96% of staff in the West Cumberland hospital emergency department had received an appraisal in the previous 12 months. Staff we spoke with confirmed they had received an annual appraisal in the previous 12 months and that they received regular appraisals.
- Staff in a focus group told us they were allocated time for regular supervision. We found nursing staff met with their line manager weekly. Members of staff in emergency medicine were allocated a buddy. Staff were supported to access external mentoring.
- Nursing and medical staff we spoke with were positive as to the support they received with their learning and development. Nursing staff had been supported through the role of a practice educator in the department linked to preceptorship and the development of clinical competencies linked to mandatory and developmental training. Healthcare assistant staff were also supported to develop extended skills. Staff received mentorship and chose their own mentor.
- Staff employed by the trust and working in the division were required to meet their professional continual development obligations. A range of on-line and in-house courses were available for staff. The division also had strong links with higher education establishments, medical schools and universities. Newly qualified staff employed by the trust and working in the division were subject to a period of preceptorship and supervision which varied according to the area worked and subject to competency sign-off.
- Nursing staff confirmed they received support from the trust about their Nursing and Midwifery Council (NMC)

revalidation. Medical staff told us clinical supervision was in place and adequate support was available for revalidation. Information about revalidation was displayed in the staff area of the department.

Multidisciplinary working

- Within multidisciplinary teams of medical, nursing, allied health professional and support staff we observed that staff collaborated to support the planning and delivery of care. Daily meetings took place which included medical and nursing staff and therapists to provide oversight of staffing needs in the department.
- The department liaised with medical and surgical areas of the hospital and medical and nursing staff discussed patient needs with the ward staff to support effective handover. The department liaised with a specialist crisis team to provide support for patients with mental health needs.
- The division was represented on the multi-agency steering group which with adult social care supported a multi-agency discharge policy. The group were reviewing discharge procedures. However, staff in a focus group told us better liaison was needed between the accident and emergency department and other specialties.
- A member of nursing staff had developed a pro-forma document and discharge letter so that nursing information about the patient could be shared with residential care homes when the patient was discharged. The initiative had resulted in improved communication with residential care about patients' health care needs.
- In consequence of the remoteness of the Whitehaven location, the emergency department at West Cumberland hospital had in place collaboration arrangements with the ambulance and air ambulance services to support the medical needs of seriously injured patients.

Seven-day services

- The emergency department operated 24 hours a day throughout the year. The emergency department also collaborated with the on call out of hours services.
- Consultant, middle grade, specialist and junior medical staff in the emergency department covered the rota 24 hours a day, 365 days a year. Consultant medical staff worked a series of shifts between 9am and 9pm five days a week and a consultant was on call through the night until 9am. Weekend cover was provided by locum consultant staff. Middle grade medical cover was provided 24 hours and day seven days a week and included acute clinical practitioners. Junior doctors also provided cover 24 hours an day seven days a week.
- Each member of medical staff covered shortfalls in rotas over a 24 hour period and was on call during out-of-hours and weekends. Medical staff confirmed that colleagues were ready to support them with clinical advice during the night if required.
- Reception staff worked a 12 hour shift and the receptionist rota covered 24 hours a day, seven days a week.
- The radiology department was open for x-ray services 24 hours a day seven days a week. Staff in the emergency department were trained in radiology to support 24 hour availability of the service.
- Pharmacy services were not available 7 days a week, but a pharmacist was available on call out of hours. The department held a stock of frequently used medicines which staff could access out of hours.
- The trust monitored its current working scheme against NHS services, seven days a week clinical standards. The division for medicine and emergency care provided evidence which addressed the four priority clinical standards: time to first consultant review, diagnostics, interventions and on-going review.

Access to information

- Clinical Information and guidance was available to staff through the trust intranet, which included operational policies and procedures for the emergency department. A monthly safety newsletter was published for staff by the patient safety team, linked to a monthly safety summit. The chief executive kept a weekly blog to update staff.
- The computer information system used in the department was widely used in the NHS and supported data including waiting times so that the patient's progress through the hospital could be tracked. We observed that the computer screen displayed details of all patients in the department.
- Information which supported the care and treatment of patients in the emergency department and included the patient's medical details, assessment and test results was exchanged readily with other departments in the

hospital. Information was available to support the coordination of services. Staff we spoke with raised no concerns about being able to access patient information or investigation results in a timely manner.
- A hospital arrivals screen with information about patients to support their arrival in the department was linked to the main ambulance service. We observed that the department was pre-alerted with a red flag when patients were due to arrive following a suspected cardiac arrest or with symptoms of sepsis.
- In the CQC In-Patient Survey 2015, patients rated various criteria around information sharing. Patients found information shared about continuity of care (6.8 out of 10), medications (8.1 out of 10), danger signals (5.3 out of 10) and details provided to family and friends (6.0 out of 10) to be in line with national average for similar trusts.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The emergency department used the trust policy which informed staff about the consent process. The policy included how to obtain consent where patients may have capacity issues and included guidance on the Mental Capacity Act (MCA). Staff we spoke with were aware of the safeguarding policies and procedures and had received training. We observed that staff gained the patient's consent prior to carrying out care or treatment.
- MCA and Deprivation of Liberty Safeguards (DoLS) training was part of mandatory training. The trust reported that as at August 2016 MCA level 1 training has been completed by 84% of medical, nursing and health care assistant staff in urgent and emergency care. DoLS training has been completed by 62% of staff in urgent and emergency care.
- Staff shared examples of DoLS, and explained the steps taken to support patients who may not have the capacity to consent. We saw examples of mental capacity assessments completed in patient records.

Are urgent and emergency services caring?

Good

At our previous inspection, in April 2015, we rated caring as 'good'. In December 2016 we rated caring as 'good' because:

- Staff provided considerate and compassionate care for patients and treated them with dignity and respect.
- Staff interacted with patients empathetically and responses to their needs were prompt.
- Patients spoke positively about the care and treatment the department provided. Patients and their families were happy about their care and treatment. Relatives of children being seen in the paediatric area said their children had positive experiences of attending the department.
- Care and treatment was explained to patients in a way they understood. Staff explained to paediatric patients and their relatives in an easily understandable way what was to happen next about their treatment.
- Patients received emotional support to allay anxiety. Staff provided reassurance and comfort to patients who were worried, as part of their care.
- Patients were consulted and involved in decisions about their care and treatment.

Compassionate care

- The performance in the friends and family test was positive, although the emergency department's performance was mostly worse than the England average. The friends and family test performance (% recommended) for emergency care was generally worse than the England average between September 2015 and August 2016. However there was a trend of improvement from April to July 2016. In the latest period, August 2016 trust performance was 82% compared to an England average of 87%, which showed that most patients would recommend the department.
- We spoke with several patients and their relatives to seek their views of care in the department, and observed care being delivered. We observed as staff

provided considerate and compassionate care for patients. We observed that staff interacted with patients empathetically and responses to their needs were prompt.

- Patients, carers and relatives spoke positively about the care and treatment the department provided. Patients said staff treated them with patience and compassion. Patients and their families said they were happy about their care and treatment. We spoke with relatives of children being seen in the paediatric area who told us their children had good experiences of attending the department. Staff told us about the positive feedback they received from patients and family members.
- For the CQC emergency department survey 2014 response to the questions "Were you given enough privacy when discussing your condition with the receptionist?" and "Were you given enough privacy when being examined or treated in the emergency department?" the trust scored about the same as other trusts.

Understanding and involvement of patients and those close to them

- The results of the CQC emergency department survey 2014 showed that the trust scored about the same as other trusts in 22 of the 24 questions relevant to caring, which included the question, "While you were in the emergency department, how much information about your condition or treatment was given to you?"
- The trust scored better than other trusts in the two remaining questions relevant to caring: "If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?" and "If you needed attention, were you able to get a member of medical or nursing staff to help you?"
- Patients told us that their care and treatment was explained to them in a way they understood. In the children's area, staff explained to patients and their relatives in an easily understandable way what was to happen next about their treatment. Relatives said they were happy with the explanations they had been given.
- We observed that patients were given information to support their care and treatment when they were discharged from the department.

Emotional support

- We observed staff as they provided emotional support. We observed staff interactions with patients to allay anxiety. Staff provided reassurance and comfort to patients who were worried. In the children's area, toys were provided. Certificates of bravery were available to give to children.
- A relatives' room was available for people who had experienced trauma. Information about bereavement was available. We reviewed a folder of information for staff about providing support for the bereaved child. Patients received emotional support from chaplaincy and bereavement services, support groups, charity workers and volunteer staff.
- Staff could access counselling services for additional support, for example after they had assisted with trauma or another distressing event.

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

(for example, to feedback?)

Requires improvement

At our previous inspection, in April 2015, we rated responsive as 'requires improvement'. In December 2016 we rated responsive as 'requires improvement' because:

- For an extended period, the hospital has failed to meet the target to see and treat 95% of emergency patients within four hours of arrival
- The hospital was failing to meet consistently a locally agreed trajectory to see and treat emergency patients within four hours of arrival which had been agreed in conjunction with regulators and commissioners.
- Emergency department waiting time data was incorrect. Staff were not fully utilising the computer system as intended so that the times recorded were not accurate.
- Material issues remained with patient flow into the hospital. We found patients experienced overnight delays in the emergency department whilst waiting for beds to become available in the hospital and some patients experienced long delays whilst waiting for transfer to Cumberland Infirmary.

However:

- The hospital was taking steps to address performance as part of its improvement plan for emergency care and the accident and emergency service undertook a strategic service review during 2016.

- The emergency department had relocated to the new building at the West Cumberland hospital and a newly designated emergency floor had recently been opened which brought together acute admissions and ambulatory care. The emergency department worked in conjunction with the ambulatory care service for patients who met certain referral criteria so that admissions to the emergency department were kept to a minimum.
- The trust's system suppliers had been engaged to make changes required to the system to coincide with the completion of staff retraining in March 2017. The trust arranged to commence from February 2017 an internal audit of the actual time that the decision to admit (DTA) was recorded and the true DTA time to compare results of real-time data entry.
- Patients with a learning disability, patients with dementia, and bariatric patients accessed emergency services appropriately and their needs were supported. Patients with mental health needs could access services in a joined up way.
- Although few complaints were received they were investigated promptly and learning was shared with staff.

Service planning and delivery to meet the needs of local people

- The medicine and emergency care division supported the trust in planning services to meet the needs of the people of Cumbria in collaboration with local commissioners. Divisional managers attended meetings with commissioners as part of the local health network to plan for service improvements which met the needs of local people.
- The development of emergency services within the sustainability and transformation plans was in development and consultation with commissioners and neighbouring providers of care. Divisional managers worked with partners involved in the “Success Regime” established in 2015 to review healthcare services across the region and to support the trust's longer term development of its emergency medical service pathways.
- Since our 2015 inspection the emergency department had relocated to the new building at the West Cumberland hospital and the environmental facilities of the department had been considerably improved. At our inspection a newly designated emergency floor had recently been opened which brought together acute admissions and ambulatory care. The emergency department worked in conjunction with the ambulatory care service for patients who met certain referral criteria so that admissions to the emergency department were kept to a minimum.
- During 2016 the accident and emergency service undertook a strategic service review in collaboration with other divisional managers of service delivery across key specialities. The review included current service configuration, activity trend, quality and workforce issues, financial position, future clinical model proposals, sustainability issues and organisational options. Business units were considering recommendations at the time of our inspection. .
- The hospital was not a designated trauma unit and in consequence of the remoteness of the Whitehaven location, the emergency department at West Cumberland hospital had developed collaboration arrangements with the ambulance and air ambulance services to support the medical needs of seriously injured patients.

Meeting people’s individual needs

- For vulnerable patients and those with complex needs, the division of medicine and emergency care took all reasonable steps to ensure the care they required was uncompromised. For example, a trust specialist link nurse was available to support patients with special needs.
- Divisional managers confirmed that in planning services, the needs of all patients, irrespective of age, disability, gender, race, religion or belief were taken into account. For non-English speaking patients, emergency department staff could access a telephone interpreter service. Staff told us translation services were easy to use. A chaplaincy service was available.
- The division used the “This is me” passport document to support patients with a learning disability. The passport was completed by the patient or their representative and included key information about the person’s preferences. Patient passports for patients with a learning disability may be completed by care providers prior to admission. Senior nursing staff in the emergency department told us they tried to prioritise patients with learning disabilities. The division had access to trust specialist nurses for patients in vulnerable groups including learning disabilities.

- The trust had in place a dementia strategy and lead nurses for patients with dementia. A dementia working group for the trust was in place. The emergency department had a lead nurse for dementia. Three members of nursing staff and a member of non-qualified staff had received additional training in caring for patients with dementia. We observed that the butterfly symbol was used to identify patients with dementia.
- Patients with mental health needs could be referred to psychiatric liaison services. Specialist support teams were available during daytime hours. The community out-of-hours crisis team provided cover at other times. We observed pathway guidance and protocols were available in the department to support these patients. Staff told us the psychiatric liaison service was effective.
- For bariatric patients, specialised equipment was available in the hospital. We observed that bariatric equipment stored in the emergency department was in order and available for patient use. (Bariatric is a branch of medicine which deals with the causes, prevention and treatment of obesity).
- For patients with special visual and hearing needs, we were informed that there were no particular additional adjustments or services made available. Staff told us that the patient's visual or hearing needs were considered as part of their assessment for care and treatment.

Access and flow

- At our 2015 inspection we reported that the WCH should improve performance against the Department of Health target for emergency departments to admit, transfer or discharge patients within four hours of arrival.
- At the December 2016 inspection we found the trust had agreed with regulators and commissioners an improvement trajectory target to achieve the four hour target. The hospital's performance against the four-hour target was monitored on a daily basis. Staff in a focus group told us that although the trajectory target had not been achieved consistently to date, the hospital was taking steps to address performance as part of its improvement plan for emergency care.
- At the December 2016 inspection we reviewed performance information in the emergency care dashboard for 2016-17, observed the progress of a selection of patients through the emergency department and tracked the times that patients arrived at each stage of their assessment and treatment. We compared our observed times with those recorded in the hospital's real time patient tracking computer system.
- When we compared times we had observed with recorded times, we found there were unexplained discrepancies in the data. For example, when medical or nursing staff commencing seeing a patient, a time was recorded on the system which did not coincide with the actual time they saw the patient.
- We observed that when the patient triage was undertaken and a time input to the computer system, the staff undertaking triage could change the recorded time, so that the information was not accurate. Medical and nursing staff may assign the patient to themselves as they arrived, rather than when treatment was commenced. When we revisited the computer system information later in the day to review times for doctor intervention, we found most times had changed from those displayed earlier in the day. The time to treatment taking into account all patients was not as stated. The times patients were seen was recorded manually on the patient's card.
- After discussion with the trust, a larger selection of data (for November 2016) was reviewed and the trust also conducted its own analysis of the data and of the outputs from the computer system. The trust concluded from its own analysis of emergency department waiting times that the data was incorrect. The trust deduced that staff were not fully utilising the computer system as intended so that the times recorded were not accurate.
- Following the inspection we requested the trust to explain the steps it had taken to resolve the issues identified with the computer system and its application and use in the emergency department. The trust informed us that the system configuration required review and some re-build to improve and streamline the recording of workflow. The trust's system suppliers had been engaged to make changes required to the system to coincide with the completion of staff retraining in March 2017. The trust revised its specification for some parts of the system, particularly for treatment and decision to admit times. Changes to the recording of decision-to-treat were being made to ensure appropriate information was displayed on the tracking screen.
- The trust also arranged to deliver a programme of retraining for staff in the use of the system during

February and March 2017 to address inaccuracy in recording. The emergency department medical and nursing staff teams were closely involved to ensure DTA entry was completed in real time.

- The trust arranged to commence from February 2017 an internal audit of the actual time that the decision to admit (DTA) was recorded and the true DTA time to compare results of real-time data entry.
- Between September 2015 and August 2016 there was an downward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at WCH. In July 2016 15 % of ambulance journeys had turnaround times over 30 minutes; in August 2016 the figure was 14%. There has been an overall downward trend since January 2016.
- A "black breach" occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. Between October 2015 and September 2016 the trust reported 556 black breaches. The trust reported 130 black breaches in January 2016 and 81 in February 2016. There was a downward trend in the monthly number of black breaches reported over the period since the peak in January 2016.
- At the December 2016 inspection we were informed that improvements in ambulance handover arrangements had reduced the time that ambulances waited for handover since our previous inspection. The improvement was evidenced by performance information in the emergency care dashboard for 2016-17. The ambulance information displayed in the emergency department showed that 88.2% of patients were handed over within 15 minutes.
- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department. The trust breached the standard continuously between September 2015 and August 2016.
- Between September 2015 and August 2016 performance against this metric showed a decline from September 2015 to January 2016. There was a general improvement from January 2016 to July 2016 however this declined again in August 2016. In the latest month, August 2016, the percentage of patients, admitted, transferred or discharged within four hours was 90.1 % compared with an England average of 91.0%.
- The emergency care dashboard for 2016-17 showed the hospital's performance against the four-hour waiting time target outturn for 2015-16 was 87.9%. Emergency department performance against the four hour waiting time target for West Cumberland hospital for September to November 2016, the three most recent completed months at our inspection was 92.5%, 94.8% and 93.7% respectively against the 95% performance standard. For December 2016 the performance against the four hour target for West Cumberland hospital was 92.7% compared with the trajectory target for the trust of 91% as agreed with regulators and commissioners.
- During our inspection we observed a display of current performance information in the department which showed performance against the four-hour target for the previous complete week in December 2016. The performance against the four-hour target was shown as 95.14%.
- The trust scored better than other trusts for the emergency department survey question, "Overall, how long did your visit to the emergency department last?
- Over 12 months, 10 patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours were in December 2015: three patients; January 2016: three patients, and March 2016: two patients.
- Following our inspection an incident occurred in the trust (on 12 December 2016) in which a patient waited longer than 12 hours for admission as an inpatient at the Cumberland Infirmary. The trust investigated this as a serious incident and shared the findings of the investigation with CQC. Although a secondary finding, the investigation concluded that decision to admit times and other additional data entries were added onto the computer system retrospectively and were therefore not being added in real time. The process the emergency department staff were following for determining the DTA and the entry of this information onto the computer system was not being consistently adhered to with data being entered retrospectively and changed.
- Whilst there were contributory factors, the root cause of the incident was determined as a failure to escalate from accident and emergency to the site co-ordinator in a timely manner a patient who was expected to breach 12 hours waiting in the department. The trust had

subsequently informed CQC that a weekly operational management meeting had been established since December 2016 to review emergency department performance, specifically targeting 12 hour breaches.

- At our 2015 inspection we required the trust to improve patient flow throughout both hospitals to ensure patients were cared for on the appropriate ward for their needs and reduce the number of patient bed moves, particularly in the medical division. At our 2016 inspection we found there were nine patients waiting overnight in the emergency department for medical beds to become available. We observed that patients had been transferred to a bed for their comfort. One patient had waited over five hours for transfer to Cumberland Infirmary, Carlisle, and four patients over two hours.
- The hospital had taken some steps to improve the flow of patients through the hospital through the provision of the emergency floor at West Cumberland hospital and more joined up working with ambulatory care to streamline patient flow. Cross-site bed meetings were held daily to address access and flow issues. Staff identified bottlenecks to patient flow and prioritised actions to remove obstacles for patient admissions and discharges. An admissions book was also used to record any delays a patient experienced in the department and the reasons for this. Delays for ambulance transfer and action taken were recorded.
- Staff in a focus group told us that delays in the transfer of care had an immediate adverse effect on operation of the emergency department and the wider hospital. The organisation told us it was taking steps to address access and flow issues in the local health economy in collaboration with external partners including adult social care. A daily flow meeting included patient transport, adult social care and community services to improve flow across the service.
- Between August 2015 and July 2016 the trust's monthly median percentage of patients leaving the trust's urgent and emergency care services before being seen for treatment was better than the England average. There was a slight increase in numbers in November 2015 but this was still below the England average.

Learning from complaints and concerns

- The trust reported 291 complaints between September 2015 and August 2016. During this period, 21 (7%) complaints were attributed to the medical division. Only one of these complaints was received at West Cumberland hospital. The majority of these (67%) related to treatment and care provided by a clinician or nurse and admission, discharge and transfer arrangements (14%).
- Ahead of the inspection we found there had been one complaint and two compliments received about the emergency department from October 2016. Staff confirmed that the department received very few complaints.
- The trust complaints policy included information about how patients could raise concerns, complaints, comments and compliments and included details of how to access the Patient Advice and Liaison Service (PALS). We found staff understood complaints procedures. We observed that leaflets and posters were displayed in the emergency department about how patients and their relatives and carers could complain about their care and treatment.
- Details of complaints were recorded on the trust computer system. Progress in the investigation of complaints was monitored and reported with performance quality indicators. The department responded to complaints according to the trust complaints policy timetable and concluded investigations within 21 working days at the West Cumberland hospital.
- Staff in a focus group told us that feedback from the investigation of complaints was shared during monthly team meetings where complaints were discussed and time allowed for reflection on things that could be done better. We observed information displayed in the department about changes that had been made as a result of investigating complaints.

Are urgent and emergency services well-led?

Good

At our previous inspection, in April 2015, we rated well-led as 'requires improvement'. In December 2016 we rated well-led as 'good' because:

- An improved, positive culture was apparent in the emergency department which reflected a changed culture in the trust. Staff worked well together.

- Risks to the delivery of care and treatment for patients were identified, managed and action taken appropriately to mitigate them. A risk register for accident and emergency was in place and reflected identified key risks for the department. The risk register was reviewed monthly, and actions taken.
- Senior staff in accident and emergency understood the vision and strategy for the emergency care service and how it linked with the trust vision and strategy at hospital and organisational levels.
- Arrangements for the governance of the emergency department had become more embedded. A daily operational meeting and a weekly governance meeting were attended by medical and nursing staff and a clinical governance meeting for the emergency department was held monthly, again attended by senior medical and nursing staff at which items for escalation and other actions were agreed.
- The emergency department engaged with the public through a range of methods and had held a number of public consultation events including consultation about changes to services.
- The department supported ideas for innovation from all grades of staff and examples of innovation had been implemented in the department.

However:

- Risks related to the transfer of patients needed to be added to the risk register.
- Changes in the operational nursing structure for the emergency department needed to become embedded.
- Staff engagement needed to be extended.

Vision and strategy for this service

- The medicine and emergency care division had a vision and strategic goals which reflected the aims and objectives of the trust, "To provide person centred world class quality health care services." The hospital had developed a detailed business plan which identified strategic priorities for the division aligned to trust principles and values.
- Since our 2015 inspection the service had developed its divisional strategy which included a clinical quality strategy for 2015-18 with priorities for 2016-17 linked to the trust strategy; short, medium and long term projections for performance improvement, partnership working and engagement. The divisional business unit plan 2016-17 included key strategic priorities relevant to each area.
- We found that senior staff in accident and emergency understood the vision and strategy for the emergency care service and how it linked with the trust vision and strategy at hospital and organisational levels. Staff were positive about the vision for the emergency floor at West Cumberland hospital and about the steps already in progress to progress this vision for the service.
- Managers and senior staff in a focus group were conversant with local divisional objectives and of the impact of the wider transformation agenda for the local and regional health economy. Staff expressed concerns as to how this agenda might impact on the provision of divisional services at West Cumberland hospital.

Governance, risk management and quality measurement

- The medicine and emergency care division had clearly defined governance channels into the trust's wider organisational management structure. A risk register for accident and emergency was in place and reflected key risks for the department. Staff informed us that risks related to the transfer of patients required to be added to the register. The risk register was reviewed monthly, and actions taken.
- Since our 2015 inspection a weekly governance meeting was held, attended by the lead matron for the emergency department, the business unit manager and deputy, senior medical staff and general managers. The agenda included local and corporate risks, incidents and complaints, audit results, patient survey results and staffing matters including appraisal, mandatory training and recruitment. We observed from a notice in the staff area that monthly meetings for nursing staff were planned for 2017.
- A daily operational meeting to review the previous day was attended by medical and nursing staff. Patient attendances, breaches of the four hour target, incidents, changes to policies or guidance, progress with local and national audits, medicines management, mandatory training, patient surveys and items for escalation were discussed. A record was kept in the department's communication book.
- A departmental governance meeting for the emergency department was held monthly and attended by all staff.

Our review of minutes showed that the accident and emergency risk register, incidents, complaints, and audit were reviewed and items for escalation and other actions were agreed. Agreed actions were followed up at the next meeting.

- Divisional governance, safety and quality board meetings were held monthly. Our review of the minutes of meetings held in 2016 showed the divisional risk register, incidents, service performance, clinical audit, policy review and items for escalation were discussed.
- Staff in a focus group told us that since 2015, the governance meetings attended in the department had become more embedded. Daily meetings including medical and nursing staff was very supportive of teamwork. Staff told us they were on a trajectory in an improving situation and were taking steps to mitigate the risks.

Leadership of service

- The division for medicine and emergency care had in place a clear management structure defining lines of responsibility and accountability. The division was led by an associate medical director, an associate chief operating officer and a chief matron. The senior management team covered each site.
- Emergency care and acute medicine was led by a clinical director, an associate clinical director and a business manager for the West Cumberland hospital. The division management structure also included three general managers and other senior management staff.
- The emergency department operational medical structure was led by three senior emergency consultants. Three nursing sisters had started during 2016. Each sister led a team of nursing staff and had responsibility for defined areas in the department. A clinical nurse manager (Band 8) was being recruited to provide nursing leadership following the retirement of the previous post holder. Some changes in the nursing structure were planned to take effect from January 2017, with the matron covering across sites.
- Staff in a focus group told us that since our 2015 visit, the executive team was more engaged. Managers were supported through an in-house leadership programme which was launched during 2016. Managers were seen to be more willing to seek external help and the executive supported this approach. Staff said managers were approachable.
- Staff considered communications from the divisional leaders could be more comprehensive and succinct. This was supported in the NHS Staff Survey 20156, where 21% reported good communication between senior management and staff (versus 31% national average).

Culture within the service

- Emergency care staff represented in focus groups spoke enthusiastically about their work, about the quality of care delivered across the division and of the improvements made in the trust since our last visit in 2015. Staff described how the organisational and divisional culture was evolving. Staff told us the culture had shifted to a more transparent and open philosophy and they considered this to be work in progress.
- Medical and nursing staff told us in focus groups that the emergency department operated in a positive culture in which staff worked well together. We observed very good team working in the emergency department. Staff told us it was a nice place to work and they enjoyed their job. Communication was better and senior staff could be approached with any concerns.
- Staff were still working under pressure as they had limited headroom. This view was supported by the results of the NHS Staff Survey 20156 which reported 85% of staff felt their role made a difference (lower than national average of 90%).

Public engagement

- The medicine and emergency care division participated in face-to-face and real time surveys. Patients could also leave feedback on comment cards in the accident and emergency department and through the trust website.
- The trust's urgent and emergency care friends and family test performance (% recommended) was generally worse than the England average between September 2015 and August 2016. However there was a trend of improvement from April to July 2016. In August 2016 the trust performance was 82% compared to an England average of 87%. We observed that the results of the friends and family test were displayed in the department with the most recent scores in the range 93% to 100%.
- The division for medicine and emergency care used the "Two minutes of your time" survey each month to obtain the views of patients and their families on their experiences of using hospital services. Responses

consistently scored above 9 out of 10. The department displayed the results of "You said, we did" survey actions taken at the department entrances to inform patients of changes made in response to patient feedback.
- The medicine and emergency care division had developed links with a range of volunteer organisations, charities and national support groups involved with patients.
- The medicine and emergency care division supported the trust and wider health community with consultation as to the future of healthcare services in the region. The future of healthcare in West, North and East Cumbria was the subject of a public consultation document current at the time of our December 2016 inspection and we were informed that 17 public consultation events had been held.

Staff engagement

- In the NHS Staff Survey 20156, the trust performed better than other trusts in nine questions, about the same as other trusts in 17 questions and worse than other trusts in six questions. The positive trends related to staff having opportunities to progress in the organisation and incident reporting. Staff engagement scores and staff contributing to work related improvements were lower than the national average.
- The executive leadership team arranged staff forums and drop-in sessions for staff. The chief executive held cross-site roadshows with recent topics including staff support, staff morale and generating cost savings. Some staff told us they were not able to attend due to clinical duties.
- Staff in a focus group told us how there had been an increased effort by divisional managers and the leadership team to engage with staff cross-site.
- Emergency department staff at WCH were consulted about the design of the new accident and emergency department.
- Staff commented they had contributed to surveys about staff health and wellbeing. This had generated a number of action plans; in particular, organisational leaders were accessing physical activity schemes, physiotherapy services, and mental health initiatives and had appointed a health and wellbeing coordinator. Staff hoped to see this become a greater priority in the future.
- The leadership team and divisional leads had used staff surveys to seek opinion on the transformation regime proposals. Managers recognised how unsettling changes of this kind could be for operational staff and staff attended public consultation events.

Innovation, improvement and sustainability

- Since our 2015 inspection the emergency department had relocated to the new building at the West Cumberland hospital and the environmental facilities of the department had been considerably improved. At our inspection a newly designated emergency floor had recently been opened which brought together acute admissions and ambulatory care patients. The emergency department worked in collaboration with ambulatory care for patients who met certain referral criteria so that admissions to the emergency department were kept to a minimum and patient flow was improved.
- A joint project with a local university had commenced to develop and appoint allied nurse practitioners (occupational therapists) to support the nursing compliment across the division. In partnership with another university, the trust was supporting the development of a composite workforce to provide a cohort of acute care practitioners to support the medical staffing complement.
- A member of nursing staff had developed a pro-forma document and discharge letter so that nursing information about the patient could be shared with residential care homes when the patient was discharged. The initiative had resulted in improved communication with residential care about patients' health care needs.
- In the paediatric area of the emergency department, certificates of bravery were available to award to children visiting the department.

Medical care (including older people's care)

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

Information about the service

The medical care service at the trust provided care and treatment across two sites, Cumberland Infirmary (CIC) situated in Carlisle and West Cumberland Hospital (WCH) situated in Whitehaven. The medical care service was managed by a single management team covering both sites under the division for medicine and emergency care ("the division").

The trust provided 334 medical inpatient beds and 50 day-case beds located across 16 wards covering 14 medical specialities. The medical service accounted for over 50% of the overall trust in-patient bed capacity.

The trust had 38,352 medical admissions between April 2015 and March 2016. Emergency admissions accounted for 19,658 (51%), 1,248 (3%) were elective, and the remaining 17,626 (46%) were day case. 13,918 (36%) of these admissions were reported from WCH.

Admissions for the top three medical specialties were:

- General Medicine: 18,487
- Gastroenterology: 8,294
- Clinical Oncology: 4,259

WCH was the first hospital built following the creation of the NHS and officially opened in 1964. The hospital went through considerable redevelopment and upgrade with the new buildings opened in October 2015. Medical services at WCH were situated in both the new build and the original hospital structure.

The division provided 109 beds primarily located within five wards - wards 2, 3 and 4 (provided general medical, stroke, older persons and rehabilitative care), emergency admissions unit (EAU) and coronary care unit (CCU). The division also provided an endoscopy suite, ambulatory care services, oncology day care and renal dialysis treatment.

During our inspection, we spent time at WCH visiting all wards and clinical areas managed by the medical team. We spoke with 24 members of staff (including managers, doctors, nurses, therapists, pharmacists and non-clinical staff). Where appropriate we considered care and medication records (including electronically stored information) and completed 9 reviews. Our team met with 10 patients and relatives, observed shift handovers, multi-disciplinary team meetings (MDT), safety huddles, meal times and care being delivered at various time of the day and night.

Medical care (including older people's care)

Summary of findings

The service was inspected as part of our comprehensive visit in March 2015. Overall, medical care at WCH was rated 'inadequate'. A number of areas for improvement were highlighted and the service was told to take action to:

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

During this inspection, we found the service had made improvements:

- While medical staffing was not at full substantive compliment at WCH, there had been recruitment and the division had secured longer term locum contracts. Divisional managers were progressing the 'composite workforce' model to bring additional stability to existing provision at WCH.
- Registered nurse vacancies remained at WCH however all wards reported an improved picture from the 2015 inspection. This was evidenced by improved fill rates across the division. Staffing shortfall escalation procedures were more robust and the division continued to actively recruit.
- There was no evidence to suggest there were insufficient infusion pumps for patient use as and when required.
- Staff knowledge of the requirements of the Mental Capacity Act 2005 and the application of Deprivation of Liberty Safeguards was good. Staff completed capacity assessments to evaluate a patient's ability to make decisions and consent to treatment.
- Medical patients were cared for on a designated non-medical ward at WCH and were reviewed regularly by the responsible team. Care was progressed accordingly and staff stated there were no difficulties in having this cohort of patients reviewed out-of-hours.

We rated medical care (including older people's care) as 'requires improvement' overall because:

- Patient harms remained a concern across the division.
- There was variance in some infection prevention and control practices and medicines related documentation around antibiotic prescribing was not always compliant with recognised standards.
- Nurse staffing was exposed in some areas and medical staffing remained reliant on locum appointments. The recording of all key clinical observations to support decision making and care escalation needed reinforcement.
- Medical staffing remained reliant upon locum support, and with that, was vulnerable to changes in locum worker preferences or departures.
- Patient outcomes in national audits covering diabetes and respiratory care had remained static or fell below national average benchmarking. The division had not fully embedded seven day working across all areas against the NHS Services, Seven Days a Week Four Priority Clinical Standards. Staffing pressures and clinical responsibilities hindered access to non-ward based learning opportunities.
- Patients considered on occasions staff were often too busy, or did not have the necessary time to engage in meaningful care related dialogue, or did not prioritise this as an essential element of patient care.
- Staff considered service changes in the booking and list preparation processes in endoscopy did not meet local patient needs.
- Medical outliers accommodated a significant proportion of designated surgical beds, repatriation of this cohort was problematic and there were a number of patient moves after 10pm. Patient flow initiatives were not fully embedded across the division at WCH. Reasonable adjustments implemented for vulnerable patient groups were not consistently applied.

Medical care (including older people's care)

- The divisional risk register did not correlate with top risks identified by divisional leads. Risk ratings were confusing and details of actions taken against the risks were limited. Divisional progress against the Quality Improvement Project objectives was incomplete and slow. Staff morale was variable and they considered engagement initiatives were driven by a management agenda.

However:

- Staff confidently reported incidents and the division had made considerable efforts to reduce patient harms from falls and pressure ulcers. Ward environments were clean and staff used personal protective equipment appropriately to protect themselves and the patient from infection exposure. Medicines management was good and clinical documentation; in particular risk assessments and safety bundles were completed thoroughly. Nurse staffing establishments figures were based on a recognised acuity tool and projects such as the 'composite workforce model' sought to bolster medical staffing.
- The division was actively involved in local and national audit, which provided a strong evidence base for care and treatment. Patient outcomes in the national stroke audit and the renal registry report were good and there had been domain improvements in myocardial infarction and lung cancer audits. Multidisciplinary team working across the divisional wards was cohesive, progressive and inclusive. Staff had an understanding and awareness of consent issues, Mental Capacity Act and Deprivation of Liberty Safeguards.
- Staff were committed to delivering high quality patient care. Staff interactions with patients were compassionate, kind and thoughtful. Patient privacy and dignity was maintained at all times. Staff welcomed patient and carer partnerships in delivering care. Staff considered all aspects of holistic wellbeing and patient feedback on the care they received was positive.
- Estate improvements as a result of the new build and upgrading were clear and apparent. The division reported good results against 18-week standards across all specialisms. Divisional managers monitored access and flow through the division and were involved in a number of initiatives to improve flow processes. There had been improvements in the clinical review of patients being cared for on the non-medical ward at WCH and reducing numbers of bed moves. Ambulatory care services and rapid access clinics had been developed. Complaint numbers were low and response times to resolution were good.
- The division had a strategy and vision, which was aligned to organisational aims and wider healthcare economy goals. Divisional leads had an understanding of the pressures and risks the service faced. Governance processes across the division were clinician driven and quality measures were monitored. There were defined leadership structures. Cultural improvements had been made in the last 18 months. Staff and public engagement activity had improved. The division were involved in a number of improvement projects targeting patient safety, patient experience and service efficiency.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

We rated safe as 'requires improvement' because:

- A number of registered nurse vacancies remained. Nurse staffing in EAU was particularly exposed based on patient acuity, current and pending vacancies and a lack of wider specialised resource available. Escalation processes at WCH were robust and in the short term will ensure EAU is supported.
- Medical staffing remained reliant upon locum support, and with that, was vulnerable to changes in locum worker preferences or departures.
- The documenting and recording of National Early Warning Score (NEWS) observations to support clinicians in the identification of a deteriorating patient needs to be complete in full in all cases and any deviation from NEWS triggers needs to be detailed.
- Whilst there had been improvements to address the incidence of patient harm related incidents, there was a continuing number of patient related harms around pressure ulcers and falls.
- Some infection prevention and control (IPC) audit outcomes highlighted a variance in compliance against cannula and catheter care key performance measures.
- Auditors identified some medicines related documentation required improvement around recording of patient allergies and indications for antibiotic prescribing. Additionally, the signing for oxygen prescribing was poor. Medicines management training compliance required improvement.

However:

- Staff confidently reported incidents and had an awareness of the Duty of Candour regulations. There were no Never Events in the division and a reducing number of serious incidents related to patient harms.
- Staff were conversant with infection prevention and control guidelines. Staff used personal protective equipment appropriately, isolation-nursing procedures were followed and waste and sharps disposal was in accordance with trust policy. Ward cleanliness and hand hygiene audit findings were consistently good.
- Overall, the safe storage and dispensing of medicines against best practice guidelines and key performance indicators was good.
- Nursing and medical documentation standards were good. Risk assessment completion, individualised care bundles and care pathways were evidenced very well.
- Safeguarding knowledge and procedural understanding was good and mandatory training figures were on target to meet trust target.
- Staff responded to patient risk promptly using a combination of clinical judgment, early warning trigger tools and treatment pathways.
- Nurse staffing requirements were calculated using a recognised acuity tool. The division also cross-referenced staffing ratios and were actively recruiting registered nurses.
- Medical staffing had improved from the previous inspection and divisional managers considered additional workforce assurance projects to support the wards at WCH. This included securing long-term locum contracts, developing the composite workforce model, improving links with specialist trainees and securing cross-site support from divisional clinician colleagues at CIC.

Incidents

- The division reported incidents through the trust electronic reporting system.
- The division graded incidents according to risk rating and severity of harm in accordance with their incident management policy (including the management of serious incidents) published in February 2016.
- Such reported incidents were then categorised according to severity ranging from no injury, low, moderate, major or catastrophic. Ward managers, matrons and patient safety panel reviewed submitted incidents and grading of harm. Staff escalated serious incidents accordingly.
- Between October 2015 to September 2016, the trust reported 8,287 incidents of which 1,766 (21%) were generated from the medical division (excluding accident and emergency). Of incidents recorded across the division, 1,069 (62%) were no harm, 527 (31%) were recorded as low harm, 88 (5%) were rated moderate and less than 1% were classed as severe. The division reported two deaths.
- Ward managers, matrons and divisional leads all monitored incident trends and themes. The most

common incident type was the 'patient accident' category (32%). Of those incidents with moderate classification and above, these tended to relate to treatment, ongoing monitoring and review and patient accident.

- We reviewed four incident investigation reports/root cause analysis (RCA) documents. We found that the investigation reports provided a comprehensive summary of the investigation process, the background leading to the investigation, a checklist of critical concerns, a detailed timeline of events, organisational factors, care and service delivery issues, involvement of the patient or family, and areas of good practice. The reports detailed action plans, feedback mechanisms and processes in which lessons learnt could be embedded.
- In accordance with the Serious Incident Framework 2015, medical care services at the trust reported 45 serious incidents (SIs), 33% of the trust overall total. WCH reported 21 (47% of the total across the division) serious incidents (SIs) which met the reporting criteria, set by NHS England, between October 2015 and September 2016. The most common incident classification was 'pressure ulcer (PUs) meeting SI criteria' accounting for 58% of all reported.
- Staff confidently reported incidents and provided examples of incidents they would report. These primarily focussed on patient safety matters such as falls, pressure ulcers, near misses, medication errors and manpower/resource deficiencies.
- Between October 2015 and September 2016, WCH reported no incidents which were classified as Never Events for medical care. Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers (Strategic Executive Information System, STEIS).
- Staff reported all PUs irrespective of grade or classification and moisture lesions. The tissue viability team, comprising three tissue viability nurses working cross-site (TVNs) received all reported PU incidents. The TVNs completed a further assessment of the incident and graded according to severity. The TVNs aimed to respond to all PUs classified as category three or above within 24 hours and a review of others within 72 hours.
- Staff we spoke to knew of the Duty of Candour (DoC) requirements and of the trust being open policy. Junior staff understood that this involved being 'open and honest' with patients. Ward managers were aware of the Duty of Candour and some staff explained to us that they had been involved in investigating and responding to patients and families under this duty.
- The division shared learning from incidents and when things went wrong at all levels. Management discussed outcomes at divisional meetings, matrons and ward managers shared learning and cascaded key information to their staff at ward meetings, through the patient safety newsletter, on the intranet and with direct staff communications.
- The safety newsletter was re-launched in November 2016 and the division proposed holding safety summits on a monthly basis. The division had appointed a safety clinical director who led on programmes to improve clinical safety and learning methods.
- The division held monthly mortality and morbidity (M&M) review meetings and these were well attended, in particular by junior medical grades. The chair and attendees considered case summaries presented, reviewed outcomes and identified key lessons. The M&M template omitted the death classification column and did not always specify how the lessons learnt from this forum were disseminated to the appropriate persons and to wider audiences for shared learning. Ward managers informed us that outcomes from the M&M group (where relevant to their area) were discussed at ward meetings.

Safety thermometer

- Safety Thermometer is used to record the prevalence of patient harms at the frontline, and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.
- Data must be submitted within 10 days of suggested data collection date.
- Data from the Patient Safety Thermometer showed that the division reported 48 pressure ulcers, 53 falls with harm and 43 catheter urinary tract infections (CUTIs) between November 2015 and November 2016. The trend line for pressure ulcers and CUTIs shows the prevalence rate to be mixed with an upturn in reported PUs in the latter quarter and a decreasing picture for

CUTIs. The trend line for falls with harm shows the prevalence rate to be steady until September 2016, when there is a sharp increase; however the rate for October and November 2016 decreased and is showing signs of improving.

- From January to November 2016, the proportion of patients who received harm free care (all harms) averaged 91%; lower than national figures for the same period (NHS Safety Thermometer).
- Senior nursing staff considered PUs and falls reduction to be a key priority.
- Between October 2015 and September 2016, the division reported 210 PUs. Thirty-six (17%) of all recorded PUs during this period were hospital acquired. Compared to figures in the previous 12 months, the trust has seen a 36% reduction in the number hospital acquired PUs. During this period there were one category three and one category four PUs recorded across the division.
- Staff at WCH reported 14 hospital acquired PUs (39% of the divisional hospital acquired total) across all medical wards. None of those reported were in category three or four. The highest prevalence's were recorded against ward two and ward three; each reported four PUs.
- In the report to the Safety and Quality Committee In November 2016, the TVN team reported hospital acquired pressure ulcers continue to be a significant risk to patients. The trust had set a 50% reduction for year ending 2016/17 compared to 2015/16 data and at the time of the report (comparing Q1 and Q2 in the respective financial years), the trust projected to meet this target. The Tissue Viability Scrutiny Group worked with the North East and North Cumbria Pressure Ulcer Collaborative to embed best practices and to maintain the target trajectory.
- The division monitored falls prevalence and classified falls according to harm. The National Audit of Inpatient Falls (NAIF) 2015 showed that the number of falls per 1000 patient occupied bed days (OBDs) was higher than national average (8.02 against 6.63) and within the North West region, the trust reported the fifth highest prevalence out of 20 participants. The trust reported falls with moderate or severe harm to be 0.26 per 1000 OBDs, higher than the national average of 0.19 and regionally rated the highest out of 20 trusts.
- The NAIF also collected data on whether patients had been assessed for all the risk factors and whether there had been appropriate interventions implemented to prevent falls. They reported compliance using a 'red/amber/green' (RAG) rating. At the trust, NAIF auditors found three of the seven indicators to be compliant (mobility aid, continence care plan and call bell access), three to be in the amber domain and one in the red rating (blood pressure recordings).
- Between October 2015 and September 2016, the division reported 267 manager reviewed falls. 199 (75%) were reported as no harm, 60 (22%) reported as minor harm, six (2%) as moderate harm and two (less than 1%) categorised as causing major harm.
- Reported falls from WCH accounted for 32% (85 of 267) of the overall total within the division. The prevalence according to classification of harm was almost identical to the divisional figures overall with 78% reported as no harm, 21% as minor harm and less than 1% as moderate or major. The greatest incidences of falls were reported from EAU and ward four equally, with 31 each.
- The division were actively involved in the development of the trust action plan to reduce falls which was presented to the board in October 2016. The report highlighted falls to be a continuing problem with OBDs reported to be higher than national average throughout 2016 at WCH. The division had appointed a trust falls champion supported by Chief Matron to deliver improvements in this area. It was proposed to set up various task and finish groups, using a multi-disciplinary team approach, to look at multi-factorial variables contributing to falls.
- The division completed monthly venous thromboembolism (VTE) compliance audits. Auditors reviewed a minimum of five sets of patient records and recorded compliance against trust benchmark of 95% against five key indicators. Between September and November 2016, the division reported an average 97% of patients received VTE assessment on admission, 98% of patients received appropriate prophylaxis, 92% had the VTE plan clearly documented in the notes, 77% had documented the patient had been informed and 59% had a reassessment after 24 hours.
- We found safety thermometer information displayed clearly and consistently in an accessible and readable format on large whiteboards situated at the entrance of all wards.

Cleanliness, infection control and hygiene

- The division followed the trust infection control procedures.

Medical care (including older people's care)

- The trust healthcare associated infection (HCAI) prevention and control strategy was underpinned by national guidelines and infection prevention and control (IPC) policies to manage and monitor infection essential for patient and staff safety.
- IPC staff provided a seven day service with on-site presence and telephone advice.
- All wards we visited were visibly clean and tidy.
- The division were involved in the trust wide IPC monthly audits to monitor compliance against key IPC quality measures such as hand hygiene, cannula care, commode and mattress cleanliness, spray and glow, catheter care and standard precautions. Auditors rated compliance against indicators as a percentage.
- Between January and August 2016 all wards at WCH scored above 95% for hand hygiene compliance and spray and glow. The compliance data for commode and mattress cleanliness was inconsistently reported but overall was good. Compliance with standard precautions was also good. Cannula and catheter care showed the greatest variance in compliance across the wards at WCH ranging from 67% to 100% and 25% to 100% respectively. Ward managers confirmed that best practice was reinforced following IPC audits and, where findings were below standard, action plans were put in place to improve compliance in follow-up audits.
- All clinical and non-clinical areas had cleaning rotas and all equipment checked was visibly clean. All clean utility areas and treatment rooms were visibly clean and tidy. We observed clinical waste and sharps been disposed of appropriately.
- Wards we visited displayed the number of and date of last case of Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C. difficile).
- The division provided data and were involved in the 'Quarterly Reports on Clostridium Difficile Infections in Cumbria' published by Public Health England. IPC staff investigated all C. Difficile cases by way of root cause analysis using a pro forma agreed across the local health economy and with Public Health England. Staff uploaded findings onto the regional database where themes, trends and learning outcomes were disseminated. Staff reviewed confirmed cases at weekly HCAI meetings and the same were presented at IPC and Safety and Quality groups.
- Between August and October 2016, the trust reported eight C. Difficile cases of which six (75%) originated from the medical division. Only one case was attributed to WCH, where the patient had received care on CCU and ward four.
- The division had worked with IPC colleagues to complete periodic audits of MRSA screening compliance to develop IT support for better monitoring of cases. This project had extended to screen patients at risk of Carbapenemase-producing Enterobacteriaceae (CPE).
- The division reported no MRSA bacteraemia in the previous 12 months. The last case reported at WCH was over five years ago. The division had two apportioned Methicillin Sensitive Staphylococcus Aureus (MSSA) bacteraemia cases however neither was attributed to medical care at WCH.
- The division were involved in a number of ongoing IPC audits driven by the microbiology team. These included gonococcal and chlamydia testing, blood culture contamination audits, antimicrobial audits and HCAI data collection for national quality indicators.
- The wards displayed clear instructions and signage to encourage staff and visitors to wash their hands on entering the ward. The signage was repeated throughout the ward environments and there were numerous washbasins for handwashing. Wards provided wall mounted gel and soap for ease of use.
- We observed that personal protective equipment (PPE) such as disposable gloves and gowns were available to staff. Staff used PPE appropriately.
- Staff informed us of the procedure when caring for patients who required isolation for IPC measures. We observed the isolation procedure in force on one of the divisional wards at WCH. Staff used appropriate signage and reinforced best IPC practice to visitors to the ward.
- We observed staff carrying out hand washing prior to and after patient contact. Staff adhered to the "Bare below the Elbow" protocol.
- IPC training was mandatory within the trust and staff accessed IPC staff for advice and guidance when required. 70% of staff in the medical division had completed this training so far this year.
- The newly built endoscopy suite had disinfection facilities on site.
- The division were putting together a business case to appoint sepsis nurse specialists across both sites.

- The division contributed to the trust-wide monthly environmental audit. In September 2016, auditors reported cleaning audit scores at WCH as 97%.

Environment and equipment

- The divisional wards were situated in both the new and original building structure at WCH. There had been considerable investment to improve internal facilities which housed EAU, CCU and ambulatory care. There had also been some upgrade in furnishings and fittings on divisional wards in the old hospital block.
- All patients had designated bed space, which included a personal locker, table, call bell and access to gender specific toileting and bathing facilities.
- We checked the resuscitation trolleys on all the wards we visited and these contained correct stock. Staff checked the electrical equipment daily (defibrillator and portable suction/oxygen) and after use. Staff completed fuller weekly content checks of all stock including emergency drug expiry dates. We saw each resuscitation trolley had a log attached to it for staff to complete. We found all checks completed accordingly. Trolleys were fitted with a tamper proof tag.
- All equipment we checked had safety-testing stickers in date, which assured staff the equipment used was safe, and fit for purpose. Staff confirmed that, where equipment had not been routinely checked, they ceased to use it until they received medical engineering department approval.
- The CCU provided patients with bedside monitors and the unit provided telemetry monitoring for patients on EAU.
- The changes within the EAU layout had improved and streamlined access into other services such as A&E, CCU, radiology and scanning.
- The division provided weekday endoscopy services in the newly built unit at WCH. The unit had purchased new hardware and scoping equipment for the new facility. Staff were awaiting JAG assessment (Joint Advisory Group on GI Endoscopy providing formal recognition of competence to deliver services against recognised standards). Decontamination of the endoscopic equipment occurred in the suite.
- On the renal suite at WCH, the service had a designated renal technician from the medical engineering department to provide support to the care team whilst patients underwent dialysis. This involved pre-treatment machine checks and maintenance.
- Staff provided patients at risk of developing pressure sores with appropriate pressure relieving support surfaces such as mattresses and cushions in accordance with their assessed risk.
- Staff provided patients admitted into hospital with pressure sores or developed skin damaged whilst in hospital, higher specification mattresses. Staff obtained these through TVN or equipment stores.
- The division had purchased additional pressure relieving equipment to support patient comfort and skin integrity.
- The division contributed to the trust Patient-Led Assessments of the Care Environment (PLACE) 2016 audit. Performance improved in all four aspects of PLACE from 2015 to 2016. The greatest performance improvement in 2016 compared to 2015 was related to facilities which improved by 19%.

Medicines

- Divisional wards at WCH accessed a dedicated clinical pharmacy service and pharmacists were integrated into the multi-disciplinary team, attending handovers and ward meetings.
- Divisional wards at WCH received quarterly medicines safety data at ward level to identify individual ward actions to encourage learning and support improvement.
- These reports considered medicine safety results, reconciliation figures, allergy status compliance, medication omission rates, controlled drug audits, antibiotic audits, patient experience, education and training and discussed key incidents to share wider learning from other hospital areas.
- Overall, compliance figures were good however auditors found some areas for improvement in medicine related documentation such as the recording of indications for antibiotics and allergy status. Auditors also found a variance in omitted medicine doses and the division targeted an overall reduction in these figures to ensure patients received necessary medications at all times.
- Medicines on the divisional wards at WCH, including intravenous fluids, were appropriately stored and access was restricted to authorised staff. Staff managed controlled drugs appropriately and maintained accurate records in accordance with trust policy, including regular balance checks.

- Nursing staff were aware of local policy, professional standards for medicine management and for the storage and administration of controlled drugs.
- The division also took part in the controlled drug (CD) audit. In September 2016, the division's overall compliance was reported to be 94%. Auditors found medicines related documentation to be deficient in some areas, namely recording of time of administration and incorrectly amended errors in the register.
- Staff we spoke with knew how to report incidents involving medicines. There was an open culture to incident reporting and staff received support from ward managers to learn from incidents.
- Medicines requiring refrigeration were stored securely. Staff completed daily fridge temperatures checks to ensure these medicines were safe to administer. We found some omissions in daily checks on divisional wards. Staff informed us when a temperature reading was outside the upper or lower limit, they would immediately contact the pharmacy department for guidance.
- We reviewed nine medication charts and overall medicine related documentation was good. Medical and nursing staff completed the charts legibly with the names of the prescribed medication clearly written along with accompanying start and end dates where appropriate. On two charts reviewed we observed medication omissions however the reason for the omission was documented and both incidents were due to patient refusal. All prescription charts had patient allergies recorded however one chart omitted to record the indication for the antibiotic prescription. Overall, doctors prescribed antibiotics detailing the reason for the prescription, the duration and a review date specified in accordance with guidelines.
- On EAU, the division used the Omnicell system (providing individual patient medication at the bedside which then followed the patient throughout their period of hospitalisation) to improve medicines management and reconciliation. The ward pharmacist and pharmacy technician managed the system.
- The division reported findings following the British Thoracic Society Emergency Oxygen Audit 2015. Auditors found 9% of patients at WCH had oxygen signed for on the medication charts in the preceding 24 hours (compared to 28% nationally).
- Medicines management and calculations training across divisional wards at WCH ranged from 65% to 78%. Ward managers had actions plans in place to increase attendance on the course to improve staff knowledge and medicines safety.
- Non-medical prescribers (nurses and pharmacists) at WCH supported patient medication discharge processes.

Records

- The division recorded relevant clinical patient information in paper records and a number of core documents were completed on the electronic patient record (EPR).
- Where paper records were being used, these were collated consistently and in a good state of order. Staff stored these safely in portable locked cabinets or in areas manned by staff.
- The division had developed a number of care bundles and specialist care pathway documentation following best practice guidelines, such as the care and management of patients with chronic obstructive respiratory disease (COPD).
- We reviewed nine sets of nursing and medical records. Overall, the records were up-to-date with evidence of ongoing review, diagnosis and management plans and patient involvement. Staff documented multi-disciplinary team (MDT) involvement. There were two sets of records (22% of those inspected) in which care bundles and medical clerking documentation had not been completed in full, with minor omissions.
- We found safety bundle completion on EAU to be excellent with all patient risk assessments completed promptly, accurately and legibly.
- In November 2016, the renal team completed a records review against national clinical coding standards for nephrology patients. Auditors found coding was excellent for primary and secondary diagnosis along with secondary procedures however identified some primary renal admissions only had documentation in the renal notes which could not be accessed on the electronic record (PAS). The team are referring their findings to the Data Quality Group to ensure consistency in patient case notes for future review.
- The division completed annual case note audits to coincide with their requirements for the NHS Litigation Authority. Overall, the findings against the key clinical

content indicators were good however there were some poor administrative content shortfalls concerning legibility of entries, fully completed patient details on all pages and some date/time/signatory omissions.

Safeguarding

- The trust had an executive lead and designated team for safeguarding across the organisation.
- Senior divisional staff were involved in safeguarding board meetings.
- Staff were aware of safeguarding policy and accessed safeguarding information such as the annual plan and key documents on the intranet. Staff were confident in identifying concerns and escalating in and out-of-hours.
- The trust set a mandatory target of 95% for completion of mandatory safeguarding training by the end of March 2017. Compliance across the division at August 2016 showed adults and children (level 1 and level 2) training averaging 56% and level 2 training at 64% for medical staff. Nursing staff figures were better at 71% and 70% respectively. Level 3 compliance was reported as 71%. Ward managers confirmed all staff who had not attended their refresher had a date booked prior to the end of year.
- We observed safeguard policies and procedures on display in designated staff areas of wards. This information included process guidance, where to seek specialist advice and provided key contact details for escalation and further advice.

Mandatory training

- Generic mandatory training modules covered core subjects such as information governance, fire safety, equality and diversity, infection control, health and safety and basic life support.
- The division adhered to the trust mandatory training target of 95% by the end of March 2017. As of August 2016, compliance for medical staff ranged from 83% for equality and diversity and 50% for basic life support. Nursing staff compliance rates were better ranging from 97% for equality and diversity to 59% for fire safety.
- All wards displayed their own mandatory training figures and overall, these ranged from 70% to 100% at WCH.
- Ward managers also showed us mandatory training figures for their respective wards, which showed a slight variance from division figures. Generally, ward based capture of mandatory training was higher than reported.
- Ward managers kept an internal ward level list of key mandatory training dates.
- Many ward staff completed e-learning mandatory training modules at home to minimise time off the ward.
- Ward managers confirmed where identified shortfalls in mandatory training, staff were booked to attend the relevant session.

Assessing and responding to patient risk

- Staff used various tools to assess, monitor and respond to patient risk.
- All patients admitted to divisional wards at WCH had a core safety bundle and risk assessment documents completed in a timely manner. This included an assessment of falls, pressure ulcer, nutrition, sepsis and VTE. Staff reviewed all risk assessments at least a weekly basis or as patient circumstances dictated such as changes in mobility or if infection developed for example.
- Of nine records reviewed, we found staff completed the initial safety bundle and risk assessment completion in all cases (100%). We found all patients (100%) had a full pressure ulcer risk assessment completed within six hours of admission, all (100%) of patient records reviewed had a venous thromboembolism (VTE) assessment completed on admission, and, with the exception of one patient (so achieving 89%), a re-assessment within 24 hours. We also observed in all patients who required VTE treatment, staff prescribed the relevant prophylaxis.
- Staff completed an initial falls risk assessment in 100% of patient records reviewed. The falls bundle provided for a multifactorial risk assessment process where patient need required and risk indicated further intervention was required. Staff informed us patient risks were discussed at board rounds with MDT input.
- The division highlighted patient safety as a key concern within the trust and had increased resource to address particular areas of priority such as falls and pressure ulcer reduction. A senior divisional nurse was co-leading on falls reduction across the trust and the TVN team were strengthening education across the division with link nurse champions. All wards had purchased new equipment and there was greater engagement with the wider MDT, patient and carers to reduce potential patient harms.

Medical care (including older people's care)

- All patients had clinical observations (blood pressure, pulse, temperature, respirations) recorded regularly. We noted frequencies varied due to clinical need and on occasion due to delays in the observations being recorded.
- Staff told us they used National Early Warning System (NEWS), in which six observational parameters (respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse rate, and level of consciousness) are scored to identify a variance from the norm, to support escalation of care decisions.
- Auditors completed a very detailed review of NEWS compliance on a monthly basis across the division. Between October 2015 and September 2016, auditors found on average 60% of patients had evidence of full sets of observations recorded however 97% of patients had the correct NEWS score applied. Auditors also reported compliance with trigger levels and care escalation. Where NEWS triggers recommended referral to a junior doctor or nurse practitioner (scores of 5-6 or 3 in any one parameter) compliance was variable and ranged from 56% to 93%. Where NEWS triggers recommended escalation for senior medical review (scores of 7 or more), compliance ranged from 44% to 100%. Ward managers confirmed audit findings were cascaded to staff at ward meetings to reinforce the importance of adhering to NEWS triggers and to ensure any deviation from the recommendations were duly documented by an appropriate responder.
- We observed stickers adhered to medical and nursing notes where clinicians confirmed NEWS trigger deviation to meet individual patient need such as an elevated NEWS baseline.
- IN EAU, the 'real-time' patient admission system disallowed staff from formally admitting a patient if there was an omission or an attempt to bypass any patient risk assessment. Additionally, the system generated care and safety bundles aligned to patient need for example, sepsis, acute kidney injury (AKI), pneumonia and unexplained diarrhoea and vomiting.
- In the event of a patient deteriorating and requiring senior medical input, staff confirmed they could always get a consultant promptly in and out-of-hours. If a patient required level 2 or level 3 critical care (for example on an intensive care unit with full ventilator support), WCH had an intensive care unit (ICU) or the patient could be referred into CIC, for certain surgeries for example.
- Where a patient was admitted due to concerns around sepsis, the division followed the sepsis care bundle to screen and identify those vital high risk factors within an hour. The sepsis care pathway flowchart provided guidance in treating severe sepsis, management plan documentation, critical care considerations and observation monitoring.
- At the time of our inspection, stroke patients were thrombolysed in A&E and then transferred to CCU for initial monitoring. Additionally, CCU staff provided non-invasive ventilation (NIV) care on their unit and provided telemetry services to patients requiring cardiac monitoring on EAU. CCU had robust procedures in place for the management of patients who had suffered myocardial infarction (heart attack). For those patients diagnosed with ST-elevation myocardial infarction (STEMI), these patients were immediately transferred to CIC once stabilised. All Non-ST elevation myocardial infarction would be reviewed and remain at WCH for stabilisation.
- Specialist medical and nursing staff at WCH also carried a 'stroke bleep' which was activated when a patient suspected at having suffered a stroke was being brought into WCH A&E. This allowed the team to promptly respond and treat accordingly.
- In the newly built endoscopy unit at WCH all senior staff had been trained to deal with patients who may have suffered gastrointestinal bleeds. Due to insufficient endoscopy skilled medical staff on-site at WCH, all emergency gastrointestinal bleeds are transferred to CIC where a bleeding rota provides cover 24/7.
- In ambulatory care, where specialist nurses had clinical concerns regarding a patient's presentation, they accessed the 'consultant of the day' for immediate medical or surgical review.
- The division completed an audit of consultant review times in 50 patients in AMU during the spring of 2016. Auditors found 94% of patients had a documented consultant review within 14 hours of admission. Auditors considered the small shortfall was due to some consultant entries in the records not being timed and some inefficiencies in communications regarding admission times with A&E staff.
- Staff at WCH accessed the critical care outreach team (CCOT) when required and in particular when patients NEWS scores triggered escalation or clinical judgment warranted further urgent patient review. This service was provided 24/7 on site at WCH.

Medical care (including older people's care)

Nursing staffing

- Division managers confirmed the service had used the 'Shelford Model' (a Safer Nursing Care Tool - SNCT) to measure patient dependency and determine the number of staff required to care for those patients. The division also monitored acuity and staffing levels using the safe care system on a twice daily basis in order to respond to fluctuations in patient need and changes to anticipated staffing levels.
- The funded staffing establishments for all the general medical wards were based on this assessment, local knowledge and clinical experience. At WCH registered nurse (RNs) to patient ratios on wards during the day were established to be better than 1:8 (with the exception of the coronary care unit, which established ratios of 1:2.6 at all times) and between 1:7 and 1:10 overnight.
- The management team had identified nurse staffing as an issue within the medical division and this appeared on the services risk register. All wards visited (with the exception of ward three) confirmed they had registered nurse vacancies.
- The trust reported overall establishment nurse staffing figures at August 2016 to be 357.83 whole time equivalents (WTE) working across the division of which there were 302.3 in post. This equated to a shortfall of 55.53 WTE across the division.
- The registered nurse shortfall at WCH equated to approximately 15 WTE across all wards (with the exception of the oncology suite) ranging from 6.01 WTE on EAU to 0.41 WTE on ward two. All wards had appointed additional health care assistants (HCA) in excess of establishment to support registered nurse vacancies; on ward four for example, an additional 5.07 WTE and on ward three an additional 3.15 WTE.
- In September 2016, divisional registered nurse vacancy rates were reported at 7.7%, turnover rates at 7% and sickness rates at 5%.
- Ward 2 was a 27 bedded medical unit. The planned nursing establishment was four RNs and four healthcare assistants (HCAs) during the day with three RNs and three HCAs overnight. At the time of our inspection, the unit was one RN down during the day with an additional HCA working. This provided for a ratio of 1:9 RN to patients during the day. The ward manager reported three RN vacancies. Nurse staffing fill rates for October 2016 correlated with the day shift shortfall reported as 76% RN and 127% HCA and 96% RN with 120% HCA overnight. Historic rota reviews showed some shifts covered by staff from other areas or backfilled by HCAs.
- Ward 3 was a 15 bedded stroke unit. Planned nursing figures were two RNs during the day with support from three HCAs in the morning and two in the afternoon. The overnight figures were two RNs and one HCA. This provided for a ratio of 1:7.5. There were currently no vacancies on the ward following two recent appointments. The ward manager added that she also received support from the stroke nurse specialist and the matron when necessary. Fill rates for the ward in October 2016 reported 106% RN and 89% HCA during the day with 91% RN and 105% HCA overnight.
- Ward 4 was a 30-bedded older persons' care and rehabilitation unit. Planned nurse staffing was advertised as four RNs during the day and three at night, supported by four and two HCAs respectively. This provided for a ratio of 1:7.5 during the day and 1:10 at night. The ward manager confirmed that current vacancies of three RNs had a bearing on meeting established nurse staffing figures, and this correlated with fill rate figures and a review of historic nursing rotas. In October 2016, the unit reported 105% RNs and 96% HCAs during the day with 71% and 149% at night. The ward manager confirmed there had been interest in the vacant posts and hoped to appoint.
- EAU was a 29 bedded acute admissions suite. There was some confusion surrounding planned and actual nurse staffing figures. The ward manager confirmed planned to be six RNs and three HCAs during the day however advertised figures showed five and four respectively. Overnight figures were four RNs and two HCAs with an additional twilight shift to assist during the busier period. At the time of our visit, actual nurse staffing figures were in accordance with advertised planned providing a ratio of 1:6. The unit had three RN vacancies and two RNs currently working their notice period. There were also two HCA vacancies. This accorded with fill rates reported in October 2016 as 81% RN and 108% HCA during the day with 79% and 117% overnight. We reviewed historic nurse rotas which showed a number of RN shifts remained unfilled every week (averaging eight RN and four HCA). The ward manager confirmed she relinquished her coordinator role and managerial shifts to work clinically.

Medical care (including older people's care)

- CCU was an eight bedded unit providing care for cardiology, stroke and respiratory patients. Bed utilisation varied according to demand. The unit planned nursing figures were three RNs at all times, supported by a HCA during the day. The unit had one RN vacancy. The nurse staffing ratio was 1:2.5. The ward manager confirmed she sought additional RN support when patient acuity required and this was often provided by the advanced nurse practitioners and the outreach team. Fill rates reported 83% RN and 120% HCA cover during the day and 84% RN cover at nights.
- Ward managers confirmed they had difficulty in filling registered nurse shifts which they put down to a lack of nurses generally and the geographical location of the trust. Managers relied on the goodwill of their own nurses to work additional hours and flexibility in their working patterns. Ward managers confirmed their supervisory and management shifts were often converted into clinical shifts to support staffing levels.
- Where shifts could not be covered by existing staff, ward managers escalated concerns to their Matron. Escalation processes provided a number of options to help support wards where staffing remained depleted despite local ward based efforts. These included moving nursing resource from better staffed areas, sourcing bank staff, utilising nurse specialists, Matrons themselves attending the wards and backfilling with other grades of staff.
- Despite nurse staffing shortfalls, we obtained consistent evidence from all wards to confirm that there was a process in place for managing staffing levels and should there be a need to escalate due to a change in patient need. All staff confirmed patients were safe and not at risk.
- The trust provided us with data on the use of bank and agency nursing staff between April 2015 and March 2016. The use of bank and agency nurses across the division at WCH was reported to be 1.8%.

Medical staffing

- Medical staffing across the division had improved since the inspection in 2015.
- Recent medical recruitment processes had seen the appointment of physicians in respiratory care, cardiology, acute medicine, oncology and histology in the last 18 months. Divisional leads acknowledged this was an ongoing process with vacancies remaining in most specialisms across both divisional sites.
- In June 2016, the medical staffing skill mix showed the proportion of consultant staff reported to be working at the trust were lower than England average and the proportion of junior (foundation year 1 and 2) staff was higher.
- Where substantive posts remained vacant, the division had secured long term locum contracts to support stability within the service. The division had also appointed a Professor of Medicine who was involved in the take at WCH.
- The division had also partnered with colleagues at a neighbouring NHS trust to support haematology and cancer services. The division had also worked with primary care colleagues to utilise GP trainee clinicians and develop this workforce within the service.
- In September 2016, divisional managers submitted a 'Composite Workforce Business Case' to the Clinical Executive Group proposing the implementation of a new clinical workforce model in acute medicine at WCH. The proposal sought to pull together a clinical mix of medical staff to build on the model currently supported by advanced nurse practitioners at WCH. The aim is to end the reliance upon junior and middle grade locums, provide a more stable clinical workforce, address previously identified regulator concerns, provide a platform for consultant physician recruitment and achieve operational cost savings.
- The division provided information on medical cover at WCH. This was delivered by consultant presence until 10 pm with on-call thereafter, middle grade cover on site 24/7 with junior grade (foundation year 2 or equivalent) support 24/7. There was no deanery based trainees at WCH therefore no junior doctor cover at foundation year 1 level.
- Medical rota shortfalls were managed and reinforced by acute clinical practitioners on a 24/7 basis. The division had also implemented the 'hospital at night' programme to support clinical presence on site during night hours and WCH had a proactive critical care outreach team (CCOT) who worked 24/7. Broadly speaking, out-of-hours arrangements were two-fold at WCH – a team covering front of house (acute elements led by senior grades) and back of house (dealing with in-patient ward work managed by junior grades and the advanced clinical/nurse practitioners).
- Divisional wards at WCH (exception EAU and CCU) were managed by a substantive consultant and two long-term locum consultant grades.

Medical care (including older people's care)

- The EAU consultant was on-site until 6pm (and often later) during weekdays with the medical on-call rota taking over thereafter and at weekends.
- CCU held daily consultant ward rounds with middle grade cover on the unit at all times. At weekends, the cardiology consultant on-call at CIC completed a telephone ward round prior to the on-call team resuming responsibility.
- CIC based consultants rotated to WCH to provide support when required.
- Junior grades at WCH felt senior colleagues were supportive, available, approachable and willing to spend time with them when required.
- In September 2016, the trust reported medical staffing vacancy rates to be 26% across the division. Bank and locum usage mirrored the vacancy rate at 26%. Turnover rates were reported at 13% and sickness rates at less than 1%.
- Insufficient gastroenterology cover at WCH out-of-hours currently disallowed the endoscopy service to extend to a 24/7 facility.

Major incident awareness and training

- We saw that the trust had appropriate policies in place with regard to business continuity and major incident planning. These policies identified key persons within the service, the nature of the actions to be taken and key contact information to assist staff in dealing with a major incident.
- Staff we spoke knew how to access the major incident policies for guidance.
- Service managers and senior staff considered seasonal demands when planning medical beds within the trust.
- The trust Resilience Team carried out exercises to challenge emergency response procedures and communications from the team were shared with staff.

Are medical care services effective?

Good

We rated effective as 'good' because:

- The service was actively involved in local and national audit activity and followed recognised guidance which provided a strong evidence base for care and treatment. Staff reflected on audit outcomes and there was evidence of action plan development and changes in practice.
- There were very good patient outcomes recorded in the national stroke audit and the renal registry report. The division reported some improvements in national myocardial infarction and lung cancer audits showing improvements from the previous audit window.
- Patients informed us their pain was managed well and their nutritional and hydration needs met. Feedback from patients on the quality of the food was good and the division monitored food standards locally.
- Staff confirmed learning opportunities were variable across the division and this was mainly due to staffing pressures necessitating clinical work taking priority. The division made the most of ward based learning opportunities through the link nurse programme and clinical exposure.
- We found very good multi-disciplinary working (MDT) across the division. Ward rounds, board rounds and handovers were thorough, timely and considered key clinical content, care progression and risk elements. There was a real strength of working relationships between nurses and therapists.
- Staff had an awareness and understanding of the importance of considering consent, capacity and safeguarding issues in delivering healthcare under the Mental Capacity Act (MCA).

However:

- The service did not take part in the national heart failure audit.
- The division had not fully embedded seven day working across all areas however benchmarking against the NHS Services, Seven Days a Week Four Priority Clinical Standards was monitored by the division.

Evidence-based care and treatment

- Staff referred to a number National Institute for Health and Care Excellence (NICE) Guidelines/Quality Standards, Royal College, Society and best practice guidelines in support of their provision of care and treatment. Local policies, which were accessible on the ward and on the trust intranet site reflected up-to-date clinical guidelines.

- We reviewed a number of clinical guidelines on the intranet and all were current, identified author/owner and had review dates.
- The division was actively involved in local and national audit programmes collating evidence to monitor and improve care and treatment. The division compiled an Annual Clinical Audit Report of activity that specified a range of completed, planned and ongoing evidence-based reviews.
- In accordance with NICE Quality Standards, the division was involved in data collection activity for numerous national audits such as chronic obstructive pulmonary disease (COPD), cardiac rhythm management devices (CRM), diabetes, acute coronary syndromes and the falls and fragility fracture audit programme (including hip fractures).
- The division had developed a number of evidence based condition specific care pathways to standardise and improve patient care and service flow, for example ambulatory care and hot clinics.
- The division had reflected upon National Audit Report findings and developed action plans to support evidence-based care and treatment. Staff fed these into the respective business units and incorporated into local quality improvement projects.
- The division had adapted guidance for sepsis screening and management.
- All endoscopic procedures were carried out in accordance with recognised best practice and professional guidelines.
- The division had a designated audit lead and business units were active in the trust clinical audit group.

Pain relief

- We found all patients had access to prescribed analgesia. We found analgesia prescribed on a regular basis and on an as required basis.
- Staff considered the use of analgesia alongside the patient's clinical condition and particular need.
- Staff informed us they monitored pain and assessed effectiveness of pain relief using a number of techniques such as direct questioning, by observation, anticipatory ahead of procedures and with reference to observations and pain assessment tools such as the 0-3 pain scoring tool.
- Patients informed us staff asked them if they had any discomfort or if they required any pain relief.
- The division accessed the trust pain team if required.
- The division took part in the trust wide pain management audit. The audit considered four clinical indicators (pain assessment, care plan, analgesia administration and pain reassessment) with a benchmarking compliance of 95%. Between September and November 2016 the division reported overall compliance at 96%.

Nutrition and hydration

- The division recognised the importance of good nutrition, hydration and enjoyable meal times as an essential part of patient care.
- The division monitored nutritional documentation compliance by auditing nutritional screening, risk assessments and care plans.
- Of nine records reviewed during inspection, we observed all patients had had a malnutrition universal screening tool (MUST) risk assessment (equating to 100% compliance). Staff implemented care plans for those patients who required support and assistance with eating and drinking.
- Staff told us they accessed support from dietetics and speech and language therapy service (SALT) specifically allocated to their ward to support those patients who required additional input to maintain their nutritional status.
- Poor appetite menus available along with pictorial menus.
- We observed nutrition and hydration recorded on fluid and food charts which were kept by the patient bedside and summarised periodic intake during the course of the day. Overall, the completion and accuracy of these charts was good.
- Patients had protected meal times. Staff allowed family members to attend during meal times where patients required help or support in eating or drinking.
- We received positive comments from patients regarding food quality and menu choice. Of the ten patients we spoke to, all confirmed the food choice and quality to be good. There were no negative comments relating to presentation, temperature and timeliness of meals. There were various menu options for individual dietary requirement such as halal and vegetarian options.
- We observed staff of all levels (doctors, ward managers, staff nurses, care support workers, therapists,

volunteers, family members and support staff) assisting and supporting patients with eating and drinking. This included feeding, supporting with drinks and offering snack alternatives during the course of the day.

- The division contributed to the Patient Led Assessment of the Care Environment (PLACE) 2016 survey. In the food category, WCH recorded a 95% satisfaction rate, better than national average of 88%.
- The division was actively involved in the Nutritional Steering Group review of nutritional and hydration needs audit. The same was exceptionally detailed and considered three core areas. Auditors reported on all associated staff training directly and indirectly linked to the provision of food and hydration (such as Mental Capacity Act, food and nutrition and nasogastric tube training), along with clinical indicators (comprising 11 key indicators such as MUST completion, referrals, care planning, specific dietary requirements, access to drinks, preparation for mealtimes and monitoring of intravenous fluids) and patient satisfaction. Overall, against target of 80%, associated staff training was reported at 88%. Clinical indicator benchmarking compliance was 95% and, between April and September 2016, this averaged 93%, with the main deficit being around the full completion and review of MUST screening, which averaged a compliance score of 87%. Patient satisfaction across the 20 domains reviewed was good overall. At WCH, the overall satisfaction score averaged 77% with meal taste, food temperature and insufficient choice for religious beliefs or dietary requirements falling below the benchmark standard of 70%.
- The division reported similar results in the 'Meeting Nutritional Needs' project completed in October 2016 and an 'Assurance Audit of Food & Nutrition' in November 2016. In the former, auditors focussed on malnutrition screening and best practice guidelines provided by NICE (CG32). There were noted improvements from the 2014 audit and auditors recommended adding MUST to ward admission bundles, converting to a real-time MUST, and reviewing the provision of snacks on wards.

Patient outcomes

- Staff across the division were involved in large national audits and a number of local reviews to measure patient outcomes.
- WCH took part in the quarterly Sentinel Stroke National Audit Programme (SSNAP). On a scale of A-E, where A is best, the trust achieved grade B in latest audit, April 2016 and June 2016. Compared to the previous quarter, there were improvements in five of the domains plus the key indicator level for patient centred performance. Team centred and patient centred specialist assessments improved from a grade D in January to March to a grade B. Team centred performance saw improvement in three domains and decline in two.
- In June 2016, following SSNAP findings, the occupational therapy (OT) team completed an audit of patient and staff involvement in group work for patients receiving stroke care. The team identified the sessions met national standards however considered there to be more effective ways in which resource could be channelled to improve and develop group therapy sessions. New group therapy sessions were being considered and we were able to see the new dance group therapy session during our inspection at CIC.
- The trust did not take part in the 2015 Heart Failure Audit.
- WCH took part in the Myocardial Ischaemia National Audit Project (MINAP) 2013/14. WCH scored better than the England average for one of the three metrics and similar for the remaining two. The metric 'patients seen by a cardiologist or member of the team' improved when compared to the 2012/13 audit.
- WCH took part in the 2015 National Diabetes Inpatient Audit (NaDIA). They scored better than the England average in four metrics and worse than the England average in 13 metrics. The indicators regarding 'seen by MDFT within 24 hours', 'foot risk assessment during stay' and 'foot risk assessment within 24 hours' were the three lowest scoring metrics compared to the England average.
- In the National COPD Audit Programme 2014, WCH scored a total of 27 points across the five domains (less than the national median score of 33). The respiratory service received full recognition for non-invasive ventilation services and managing respiratory failure/ oxygen therapy. There were low scores against the senior review on admission and access to specialist care domains. In response to the results, the division compiled a very detailed and thorough action plan to address areas for improvement.
- The division reported findings following the British Thoracic Society Emergency Oxygen Audit 2015. The

summary showed 46.2% of patients at WCH had oxygen prescribed with target range against national average of 57.5%. The audit found 100% of patients were maintained within target range (compared to 63.5% nationally). The remainder of patients, 23% were maintained within 2% of their target ranged. 72% of patients at WCH had oxygen saturations recorded in accordance with documents frequency (against national average of 103.5%).

- The division participated in the 2015 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 90%, which was the same as the audit minimum standard of 90%. The 2014 figure was 97%. The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 25%, this is significantly better than the national level. The 2014 figure was 16%. The proportion of fit patients with advanced NSCLC receiving chemotherapy was 65%; this is not significantly different from the national level. The 2014 figure was 56%. The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 64%; this was not significantly different from the national level. The 2014 figure was 56%.
- The division provided evidence for the UK Renal Registry 18th Annual Report (published in 2016) to support benchmarking against quality of care standards. There were positive findings for the division with good mortality data, good proportion of patients on home therapies or who receive transplantation early and good practice identified with calcium, phosphate, bicarbonate and anaemia management. The report identified high incidence of tunnel neck lines (TNL) usage and the team are working with vascular colleagues to reduce the number of patients relying on this access.
- In June 2016, the dietetic team completed an audit against of inflammatory bowel disease standards (IBD). Eighty-eight patient records were selected over a two year period. Overall, whilst all areas were under the 100% target, there had been an improvement on 2014 measures (detailing medical history, current symptomatology, treatments, diet history, and food avoidances. The team identified areas for improvement in the recording of weight and height to inform body mass index (BMI) readings and action plans have been implemented to improve compliance in the next reporting period.
- The cardiology team completed an audit of cardiac rehabilitation services at WCH which involved a review of feedback from 99 patients. Patients rated the service positively however the team identified recommendations to enhance patient involvement. Actions to re-evaluate current education teaching sessions and improve patient information regarding specific conditions were ongoing at the time of our inspection.

Competent staff

- All staff employed by the trust and working in the division were required to meet their professional continual development obligations.
- The division provided a number of electronic on-line courses and specialist courses in house for staff to attend. The division also had strong links with network colleagues, higher education establishments, medical schools and universities.
- All newly qualified staff employed by the trust and working in the division were subject to a period of preceptorship and supervision, which varied according to the area worked in and was subject to competency sign-off.
- Ward managers discussed formal learning and training needs with individual staff members at 1:1 sessions and during appraisal. Informally staff identified their own areas of interest and proposed study for consideration at a local level.
- Junior medical staff maintained close links with the Deanery as part of their clinical placements and post rotations. The junior medical staff stated they division were extremely supportive with their learning, training and developmental needs. They added the clinical exposure they received fully underpinned the classroom and clinical skills training.
- Staff received formal engagement sessions with their ward supervisor or academic lead. These took the format of 1:1 meetings, clinical supervision sessions, attachment to specialist practitioners, mentoring and observation, reflective practice and revalidation.
- Nursing staff told us that they had received information and support from the trust about Nursing and Midwifery Council (NMC) revalidation.
- Divisional specialist nurses provided training sessions to all grades of staff and the link nurse programme was in force across divisional wards.

- A number of specialist clinicians were part of wider regional collaborative groups such as stroke and TVNs. A number of the divisional staff attended national conferences to support professional development and share learning on site.
- Appraisal rates reported by the division in March 2016 were reported at 55% for medical staff and 36% for nursing grades. These figures differed considerably and were significantly lower to those provided at ward level. All staff we spoke to confirmed they had received an annual appraisal in the previous 12 months. There was an improving and upward trend in appraisal completion rates from March 2016 and ward managers confirmed all staff to be appointed prior to year-end.
- Junior nursing and medical staff were supported by their senior colleagues who they described as approachable and willing to share. Many junior staff were involved in audit, improvement projects and invited to attend senior staff meetings.

Multidisciplinary working

- We observed well attended informal and structured multidisciplinary team meetings (MDT) throughout our visit. These meetings considered patient assessment, discharge planning and care delivery in hospital.
- The division had representation at the multi-agency steering group. The group were refreshing discharge procedures including adult social care colleagues.
- We observed physical therapies being provided by the MDT on the divisional wards at WCH. These included ward based activities, exercises and educational sessions.
- We also observed informal discussions between professional colleagues at safety huddles and ward meetings.
- Formal documented input from the MDT collective was recorded in the medical records. The entries highlighted involvement in care and treatment planning, discharge processes and social considerations. Although variable in terms of timeliness of the initial MDT review, all records reviewed had formal documented MDT screening within 72 hours from admission. There was evidence of patient and family involvement in the process.
- There were clear internal referral pathways to therapy and psychiatric services. Many wards had developed strong links with community colleagues when implementing discharge plans and care packages. This was particularly apparent on EAU and CCU with strong links to community specialist nurses and primary care colleagues.
- On EAU, the MDT meeting was well established and well attended. The meeting was led by the AMU consultant with input from the MDT. Other ward MDTs and board rounds were equally well attended.
- The stroke team was part of the North West Network multi-disciplinary collaboration model for stroke care.

Seven-day services

- The trust monitored its current working scheme against NHS Services, Seven Days a Week Clinical Standards.
- The division provided evidence to address the four priority clinical standards namely time to first consultant review, diagnostics, interventions and ongoing review.
- The division engaged in the trust seven day service standards (7DS) audit published in May 2016. The review audited 259 case notes, of which 155 were from WCH. The division contributed to 68% of the reviews at WCH.
- Auditors found there to be a lack of agreement between consultant job planning information and business unit advice to meet the consultant led ward rounds on every ward, every day. This impacted on the majority of wards across the division.
- Auditors found good compliance with patients being reviewed by a consultant within 14 hours of arrival at hospital. During weekdays at WCH, this was reported as 84% and at the weekend averaged 97%.
- Findings confirmed 83% of patients at WCH (and where appropriate family members) were made aware of diagnosis and management plan within 48 hours of admission during weekdays. This averaged 92% at weekends
- Auditors confirmed 67% of patients at WCH requiring computerised tomography (CT) and 100% of patients requiring microbiology diagnostics were able to access consultant directed diagnostic tests and completed reporting seven days a week within one hour for critical care needs. The trust identified gaps in accessing some diagnostics, namely pathology, magnetic resonance imaging (MRI), echocardiograms, ultrasound scanning, medical physics, and endoscopy.
- Auditors found patients had 24 hour access to consultant directed interventions 7DS either on site or by formal network arrangements in cardiac pacing, primary percutaneous coronary intervention (PCI),

thrombolysis, interventional endoscopy and renal replacement. It was identified there was no on-call interventional radiology service at WCH and urgent radiotherapy at weekends was provided by a neighbouring trust.

- On AMU at WCH, auditors found 54% of patients were reviewed by a consultant twice daily during weekdays and averaged 46% at weekends [CIC 26% and 17%]. For the acute stroke unit at WCH (beds provided on CCU), the figures reported 33% during weekdays and 100% at weekends.
- Once transferred from an acute area to a general ward, auditors found 75% of patients at WCH were reviewed as part of a consultant delivered war round (unless it is determined that this would not affect the patients care pathway) at least once every 24 hours, seven days a week during weekdays and 100% at weekends. Gaps in consultant weekend reviews of all patients were highlighted however where consults were required these were covered by other medical specialists on site.
- Endoscopy services in the newly built unit at WCH were restricted to weekday working (8am to 7pm) due to insufficiently skilled endoscopy medical staff on-site out-of-hours.
- The CCOT service was available to the division 24/7 at WCH.
- The trust audit team referred all findings of the 7DS review to relevant business unit heads for further consideration and to identify areas where investment, model changes and efficiency processes could be put in place to improve 7DS.

Access to information

- Staff we spoke with raised no concerns about being able to access patient information or investigation results in a timely manner.
- Staff informed us discharge-planning considerations commenced on admission with input from the discharge team.
- Staff informed GPs of patient discharge in writing and always made themselves available in the event of any GP telephone queries.
- Staff identified what community services or ongoing care needs would be required for the patient on discharge. Staff involved the patient, his or her family and the service providers in discharge planning.
- Staff on specialist units gave patients and their families discharge booklets which provided medical information, treatment details, contact information and signposting for further support and guidance.
- In the CQC In-Patient Survey 2015, patients rated various criteria around information sharing. Patients found information shared about continuity of care (6.8 out of 10), medications (8.1 out of 10), danger signals (5.3 out of 10) and details provided to family and friends (6.0 out of 10) to be in line with national average for similar trusts.

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

- We observed staff asking patients for their consent prior to care being delivered and procedures carried out.
- We saw that the trust had an appropriate policy informing staff about the consent process. This included reference to obtaining consent where patients may have capacity issues and included guidance on the Mental Capacity Act.
- All the staff that we spoke with were aware of the safeguarding policies and procedures and almost all had received training. Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was delivered as part of the mandatory training programme. Staff understood this was underpinned by legislature and the significance of failing to consider.
- We observed safeguarding and MCA guidance on all wards. Staff referred to the ward based documents and intranet site to show us the steps to follow to progress an application. Staff also referred to the trust intranet pages designated for safeguarding issues.
- Staff provided us with examples of DoLS, explaining steps taken to identify and support patients who may not have the capacity to consent. We saw evidence of mental capacity assessments completed in medical records.
- Of the nine records we reviewed, seven had the capacity section completed on EAU and two had the capacity assessment completed on the receiving ward. Staff on EAU stated they tended to complete all capacity assessments where there was a concern surrounding an individual's ability to understand and/or consent. Staff added on occasions, this may not be completed

immediately when a patient may require urgent care or if they only remain on the unit for a very short time. In any event, staff stated this would form part of the handover.
- Staff accessed the Safeguard Team if concerned about a patient and they confirmed responses were prompt.
- We found completion of MCA/DoLS documentation to be good overall.
- In August 2016, the trust reported that as at 31 August 2016, MCA training had been completed by 93% of staff across the division. DoLS training had been completed by 84% of divisional staff.
- The division had access to trust specialist nurses who had particular expertise in dealing with vulnerable groups such as learning disabilities and those living with dementia.

Are medical care services caring?

Good

We rated caring as 'good' because:

- Divisional staff considered the patients to be central to everything they did and there was a determination to ensure care delivered was of a high standard.
- Patient feedback was positive and this reflected in excellent response rates in the NHS Friends and Family Test and good recommendation rates for the service. The service also reported good outcomes from the National Cancer Experience Survey 2015.
- The division collated 'real-time' patient feedback to inform service delivery and care improvements. Patient ratings were good, in particular regarding 'care involvement' and 'privacy and dignity' domains.
- Patients (and their nominated family members or carers) were involved in their care to the extent they wanted to be. The expert patient programme and shared care initiative in the renal service emphasised real patient integration and care partnerships.
- Care was delivered in a compassionate, sensitive, thoughtful and individualised way taking into account personal preference, physical, emotional and social considerations. We observed clinical staff from all disciplines involved in providing care.
- Patients described staff as "smashing" and "marvellous", and the care they received as "excellent".

However:

- Patients considered staff were sometimes too busy delivering 'hands-on' care to spend time engaging in communication at the bedside.

Compassionate care

- The Friends and Family Test response rate for medical care at the trust averaged 35% which was better than the England average of 25% between November 2015 and October 2016.
- The response rate for WCH was 41% which was considerably better than the trust and England average. Response rates in some areas were reported at 80% with positive recommendations between 94%-98% in 11 of the 12 months during the reporting period.
- The division also engaged with the 'two minutes of your time' survey which was completed on a monthly basis across all wards at WCH. The survey covered six core questions relating to patient experience and quality of care such as 'were you treated with dignity and respect', 'were you involved in decisions about your care and treatment, 'did you receive timely information and 'were you treated with kindness and compassion'. Patients were asked to rate each question on a scale of 1 to 10 (with 10 being high). Additionally, patients were given the option to provide general comments about the care received as part of the survey or to underpin their scores. All wards at WCH reported positive results which reflected in patient ratings which were consistently above 9 out of 10.
- The division also took part in face-to-face and real time surveys where patients were asked to comment upon quality indicators overlapping and extending upon the 'two minutes of your time' survey such as pain control, medicines and noise at night. All wards at WCH reported consistently positive feedback and scores overall were in excess of 9.5 out of 10.
- Divisional wards advertised 'you said, we did' actions on noticeboards at ward entrances to report on changes made following patient feedback on care.
- The division took part in the National Cancer Patient Experience Survey (NCPES) 2015 receiving 362 responses. The trust was in the top 20% of trusts for three of the 34 questions, in the middle 60% for 23 questions and in the bottom 20% for eight questions. The trust performed in the top 20% for patient did not

think hospital staff deliberately misinformed them, patient never thought they were given conflicting information and all staff asked patient what name they preferred to be called by.
- We spent time observing care interactions between staff and patients. These were genuinely warm, compassionate and staff took time to listen to the patient.
- Patient described being safe on the wards and when they needed a member of staff, they responded promptly to the call bell.
- We noticed a number of patients wearing their own clothing and many had personal belongings in and around their personal bed area. Privacy and dignity was maintained and we observed staff information patients of any care delivery, seeking their consent, before proceeding.
- Staff confirmed when they assess patient needs they always take into account personal, cultural, social and religious needs. Staff considered this as important as the physical assessment.
- Staff showed an awareness of the 6 C's (care, compassion, courage, communication, commitment and competence - an indicator of values underpinning compassionate care in practice) and we noted wards had posters displaying the core values.
- The majority of the wards we visited had set visiting times to ensure meal times were protected. Staff authorised visiting outside these hours to assist in individual circumstances.
- Staff enjoyed telling us of positive feedback received from patients and family members and most wards we visited displayed 'thank you' cards.

Understanding and involvement of patients and those close to them

- Staff informed patients and their family members (where permission had been given to do so) of proposed treatment plans, the reasons for the treatment, the anticipated benefits and risks and the likely time to be spent in hospital.
- We observed patients being encouraged by therapy staff to engage in rehabilitative activities and the benefit of the same explained to them. Family members were actively encouraged to get involved in any aspect of care they felt able, willing and had patient permission to do so.
- Patients stated they were given time to speak with nurses and doctors about their care however commented how staff were very busy and did not always have time to spend at the bedside.
- Senior clinical staff availed themselves to answer any questions or concerns from patients and family members. Staff informed us relatives could book appointments to meet with medical and nursing staff at a time convenient to them.
- In the renal service, the team had embraced the 'expert patient programme' and 'shared care initiative' to promote patient empowerment and involvement in their care. This involved individual education packages, assessment of competence, support to carry out self-care procedures and integration with other patients.
- Staff assessed patients and used clinical judgment to identify those who may require additional support in understanding care and treatment plans. Staff gave examples of interpreters, specialist practitioners, the use of supporting documents, and support by way of family presence.

Emotional support

- We observed emotional support being provided by nurses and indirect care being provided by housekeeping and domestic staff.
- All patient care plans commented on individual patient social, emotional and spiritual needs and where relevant this was integrated into the care plan.
- Staff acknowledged hospitalisation was distressing and frightening to a number of patients, especially more vulnerable patient groups. Staff spent time understanding particular individual concerns and environmental triggers which could exacerbate emotional stability and wellbeing.
- Staff invited patients to make their bed area their own and to bring in non-valuable personal items and clothing.
- A patient described how she was always welcomed onto the unit by friendly staff, put at ease and supported throughout her treatments which she summarised as "caring for my body and my mind".

Medical care (including older people's care)

- Staff informed us patients received emotional support from chaplaincy and bereavement services, support groups, charity workers and volunteer staff.
- Staff offered patients and relatives private areas if they wanted time away from their bed area to discuss personal matters.
- A patient stated "they always have an eye on you and ask you how you are".
- In NCPES 2015, patients rated their overall care experience to be 8.4 out of 10 (national average being 8.7). 74% involved as much as they wanted to be (78% nationally), 79% knew of their Clinical Nurse Specialist (90% nationally), 89% found the nurse easy to contact (87% nationally), 85% stated they were always treat with privacy and dignity (87% nationally) and 89% were told who to contact if they were worried (94% nationally).

Are medical care services responsive?

Requires improvement

We rated responsive as 'requires improvement' because:

- Patient flow initiatives within the division at WCH were not fully embedded and required improved coordination, ward staff engagement and more timely discharge plans implemented. The ambulatory care suite was occasionally used as a patient holding area for those awaiting transfer or discharge.
- Medical outliers on the designated receiving ward accounted for a significant proportion of the in-patients beds with encroachment into surgical services. There remained a significant number of patient moves after 10 pm and repatriation onto boarding wards was not always actioned in a timely manner.
- Staff considered the efficiency of the new endoscopy suite at WCH was not fully meeting the needs of the local population due to changes in the booking and list preparation processes. Staff confirmed this had led to increasing 'did not attend' rates and patients being allocated to the wrong procedure list.
- The dementia strategy was not fully embedded across divisional wards at WCH however there were some positive reasonable adjustments made to support the care of this vulnerable patient cohort.

However:

- There was a clear and distinct difference in the quality of the estate between the new and old parts of the hospital where medical wards were situated. Overall, we found the facilities and the premises appropriate to meet patient need.
- The division worked with the trust management team and local partners to plan and deliver services at WCH.
- The division reported good results against 18-week standards across all specialisms.
- Divisional managers monitored access and flow through the division and were involved in a number of initiatives to identify problems within patient pathways leading to blockages in care progression, increasing unnecessary length of stay and discharge planning.
- There had been improvements in medical review for those patients the designated outlying wards.
- Ambulatory care services had developed to implement care pathways for specific medical conditions under strict criteria thus avoiding the need for hospitalisation and inpatient treatment. Rapid access clinics were also being increasing utilised to facilitate prompt access to consultant decision making.
- Complaint numbers were low on divisional wards at WCH and response times to complaint resolution were good.

Service planning and delivery to meet the needs of local people

- The division supported the trust in planning services to meet the needs of the people of Cumbria in conjunction with the local clinical commissioning group (CCG).
- Divisional management staff attended meetings with local CCG representatives in order to feed into the local health network and identify service improvements to meet the needs of local people.
- Divisional managers worked with partners involved in the 'Success Regime' established in the autumn of 2015 to review healthcare services across the region. These partners included Cumbria CCG, the West North and East Cumbria Success Regime, Cumbria Partnership NHS Foundation Trust, Cumbria County Council, North West Ambulance Service, NHS England and neighbouring NHS Foundation Trusts.
- It was acknowledged by the divisional management team that, by developing future services, it would be better positioned to respond to the demands upon it, namely the needs of its population, geography, local infrastructure, and recruitment issues. The evaluation of

any reconfigured services would need to involve a 'whole-system' model across multi-agencies. This was further emphasised in the regional sustainability and transformation plan (STP – an integrated health strategy for the region) looking at acute and emergency care services, specifically developing new partnerships and improving service design such as hyper-acute stroke services.

- The division had access to winter pressure escalation beds at WCH attached to an existing medical ward. When divisional managers opened the beds, these tended to be staffed by existing ward based staff from across the site. These were not in use at the time of our inspection.
- The division had appointed a number of specialist nurses and developed a number of specialist clinics.
- Patients at WCH had access to a nurse led ambulatory care service (with EAU consultant oversight). The service provided care to patients meeting 'referral criteria', (such as atrial fibrillation, cellulitis, low risk chest pain and pulmonary embolism) to avoid unnecessary admission where safe to do so. Additionally, the service hosted a number of specialist clinics such as transient ischaemic attack (TIA) and infusion treatments.
- The division had appointed a specialist stroke nurse at WCH. The role had been developed to improve stroke services cross-site, and in particular, to outreach into other clinical areas on site to capture patients requiring prompt access to specialist stroke care. Additionally, the stroke service was part of the North West Telemedicine Network which provided consultant review of patients out-of-hours.
- Staff in the newly built endoscopy suite at WCH identified a recent change in service planning had led to some service inefficiencies. Staff had observed an increased failure to attend rate (due to patient's not getting a choice on location for the procedure), some patients being referred onto wrong lists and receiving the incorrect preparation for the procedure. Staff considered this was due to the booking office being relocated to CIC.

Access and flow

- The medicine division at WCH accounted for approximately a third of the total admissions into the medicine service across the trust. The majority of these admissions (51%) were classified in the emergency category. The division provided care and treatment for patients in cardiology, renal, general medicine, oncology, respiratory, stroke medicine and older person's services across its 109 in-patient beds and day-case units.
- Between November 2015 and October 2016 the trust's referral to treatment time (RTT) for admitted pathways for Medical services had been better than the England overall performance. Additionally, the division showed no specialities below the England average for admitted RTT (percentage within 18 weeks) namely general medicine, rheumatology, thoracic medicine, geriatric medicine, gastroenterology, dermatology and cardiology.
- Between April 2015 and March 2016, patients at WCH had a lower than expected risk of readmission for non-elective admissions and a lower than expected risk for elective admissions. Elective Clinical Oncology and non-elective Gastroenterology had the highest relative risk of readmission and were higher than the England average.
- Between April 2015 and March 2016, the average length of stay for Medical elective patients at WCH was 3.5 days, which is lower than England average of 3.9 days. For Medical non-elective patients, the average length of stay was 6.2 days, which is lower than England average of 6.6 days. Non-elective Geriatric Medicine, elective General Medicine and elective Clinical Haematology all had a higher average length of stay than the England average.
- Divisional managers confirmed bed occupancy had a significant impact on flow through the service. Although trust bed occupancy figures reported an average of 85% usage (in line with England average), the division considered their occupancy to be higher at certain times requiring additional beds to be opened and leading to some medical patients being cared for on non-medical wards.
- At the time of our inspection, there were six medical patients being cared for on a designated non-medical ward ("outliers") at WCH. Patients identified as clinically suitable to be cared for on non-medical wards were generally those at the end of the care pathway or medically fit for discharge. Staff caring for the outlying patients confirmed however they often received patients who required longer periods of in-patient care than expected. They also added repatriation of this cohort of patients was difficult leading to a reduction in the number of beds available on the ward for non-medical patients. For ease of review and ongoing

management, medical outliers remained under the care of their admitting medical team and were reviewed by the team daily during the week and as required at weekends. Staff confirmed they had no difficulty in requesting review for the outliers when required. We reviewed two sets of medical records which showed frequent ongoing review by the medical team with consultant attendance at least on alternate days. Staff progressed medical discharges following the care plan and with support from the medical discharge team.

- Between August and November 2016, medical outliers on the designated outlier ward accounted for approximately 25% of the ward occupancy. During one week in October, staff reported there had been a day when there were 26 medical outliers on the ward; equating to approximately 75% of the total bed availability.
- The division accessed 15 escalation beds at WCH when required however these were not in use at the time of our inspection.
- The trust held local and cross-site bed meeting teleconferences during the day to address access and flow issues. Division senior nursing staff, matrons and business managers attended to record bed occupancy and availability, discharges and pending admissions. Here staff identified actual and potential bottlenecks to patient flow for that day and prioritised actions to remove obstacles for patient admissions and discharges.
- All wards held daily board rounds and staff worked with pharmacy colleagues to obtain patient medications to take home in a timely manner.
- The division had a discharge team based at WCH to support patients in the transition from hospital care into the community. Staff stated the local reasons for delays in discharging patients or moving patients to more suitable care facility was due to a lack of resource in the community and awaiting nursing home placements.
- Between August 2015 and July 2016, the main reasons for delayed transfer of care (DTOC) at the trust were waiting for further NHS non-acute care (35.9% compared to an England average of 18.3%), followed by awaiting care package in own home (19.5% compared to an England average of 17.8%).
- Divisional managers worked with partners to look at projects to improve patient flow standards, facilitate an improved transition to discharge and to reduce DTOC. The division had implemented the SAFER model (acronym for senior medical review, all patients having a discharge date, flow, early discharge and review). We identified this framework being referred to at the bed meeting however reference to the key model indicators were less apparent on ward and board rounds.
- Business units and the discharge steering group monitored the improvement plan. In the SAFER care bundle compliance audit data reported in September 2016, divisional wards at WCH were not meeting all targets. Auditors identified slow discharge planning and the consequences thereof to be the main issue, especially at WCH who found pre-midday discharges to be challenging. Auditors also commented upon the lack of clinical engagement and designated lead on site to drive the agenda and challenge lax practices.
- Due to the absence of the Home First and the lack of geriatrician capacity at WCH, the division has been unable to provide specialist frailty services and 'hot' frailty clinics on site. The division has engaged with a partner trust to support in-reach services into EAU for those patients who would benefit the frailty pathway.
- The division had developed a nurse led ambulatory care model at WCH. The service provided treatment to patients from a variety of specialisms and had standard operating procedures detailing referral criteria. These included patients requiring assessment and treatment for atrial fibrillation, cellulitis, low risk chest pain and pulmonary embolism. These pathways provided criteria to help staff identify patients whom could be safely cared for in ambulatory care setting without hospitalisation. The unit tend to see in the region of 200 patients a month (range from May to October 2016 was 182 to 226). The unit was sometimes inappropriately used as a holding area for patients awaiting discharge.
- The division had also developed a number of acute medicine clinics or rapid access clinics (hot clinics), for example to deal with suspected transient ischaemic attacks (TIAs). The hot clinic initiative avoided admission for many patients and ensured same day consultant review. Between May and October 2016, there were 112 new referrals into the clinics at WCH.
- Between September 2015 and August 2016, 54% did not move wards and 11% moved twice or more at WCH.
- From March to August 2016, there were a number of patients moving wards after 10pm at WCH. The total numbers were particularly high against EAU and CCU, these averaged 82 and 23 respectively. Ward managers confirmed moves at night were not helpful to staff and

could lead to distress to patients. Staff confirmed where such moves were necessary this was generally due to clinical need, demand on acute beds and late admissions from general practitioners or A&E.
- In the trust-wide Quality Improvement Plan (QIP) dated October 2015, the service detailed plans to improve patient flow throughout the hospital, minimising outliers, reducing bed moves and minimising night moves. This outcome remained 'open' and 'in progress' at the time of our inspection and actions were ongoing.
- There had been no mixed sex breached in the division in the previous 12 months.

Meeting people's individual needs

- The divisional managers confirmed when planning services, the needs of all patients, irrespective of age, disability, gender, race, religion or belief were taken into account.
- Staff confirmed that, when patients required additional support, for example, those with complex needs or who were vulnerable, the division took all reasonable steps to ensure the care that they received was uncompromised.
- The division had senior lead nurses for vulnerable patient groups such as those living with dementia. The trust had a dementia strategy with a vision to 'establish a programme of improvement to deliver best practice in dementia care consistently across the trust'. The strategic goals were to ensure the division met the dementia dozen standards, to ensure ward environments were dementia friendly and to ensure 100% compliance with trust dementia e-learning.
- During the course of our inspection at WCH, we observed various dementia initiatives in place to improve the care for the cohort of patients. These included dementia care bundles, John's campaign (a programme to reinforce corroboration and partnerships in care), Forget-me-not (an awareness project to reinforce the needs of people living with dementia) and the butterfly scheme (a recognisable visual identifier which alerts staff that an individual has particular needs as a result of a dementia related memory impairment).
- On ward visits we observed the butterfly symbol to be in use however we also noted it was missing for some patients who were identified as living with dementia.
- A number of wards had made environmental changes to reduce conflict and anxiety such as pictorial signage, furnishings, decorations and reminiscence triggers.
- The dementia working group had a detailed list of actions which had been in place since 2014. The same showed progression against key objectives and further activities under consideration. Current projects were looking to embed care partnerships with patients and their family, to improve dementia care bundles and to enhance staff knowledge and awareness.
- The division used the 'This is me' passports to support patients who had particular needs as a result of a learning disability. This booklet, owned by the patient, detailed personal preferences, likes/dislikes, anxiety triggers and interventions, which were helpful in supporting during difficult periods.
- Staff stated there were no particular additional adjustments or services made available to those persons with visual impairment or hearing difficulties. Staff indicated however they always considered visual or hearing problems as part of their assessment of the patient.
- Staff informed us they had ease of access/referral into psychiatric services for those patients requiring this care, in particular when needing MCA/DoLS guidance.
- All wards displayed information for patients and carers on a variety of topics such as trust information, quality standards, disease/condition specific information, ward/staff contact details, a who's who of staff on the ward and general useful signposting on where to get further information such as PALS, complaints and support groups.
- Staff explained that translation services were available however a number of staff had little experience of the service and could not detail the request process.
- The trust had chaplains who provided access to major faiths within their communities. Staff accommodated faith preferences in accordance with patient wishes and this was facilitated by the chaplaincy service or at the bedside.
- Staff we spoke with explained that they could access bariatric equipment via equipment storage when this was required. This included access to special beds, wheelchairs and chairs.

Learning from complaints and concerns

- The trust reported 291 complaints between September 2015 and August 2016. During this period, 21 (7%) complaints were attributed to the medical division (excluding accident and emergency). Only one

complaint was received at WCH. The majority of these (67%) related to treatment and care provided by a clinician or nurse and admission, discharge and transfer arrangements (14%).
- The division responded to complaints promptly averaging 21 working days at WCH to process.
- The wards that we visited displayed leaflets and posters outlining the complaints procedure, escalation processes, and how to access further support from Patient Advice and Liaison Services (PALS). We saw that the trust had a complaint policy and staff were aware of it.
- Staff discussed feedback from complaints and lessons learnt at ward meetings.

Are medical care services well-led?

Requires improvement

We rated well-led as 'requires improvement' because:

- The divisional risk register did not correlate with the top risks described by the divisional leads. There appeared to be some duplication of risks within the register and risk rating calculations were confusing. There was a lack of detail confirming action reviews and progress made.
- Divisional progress against the Quality Improvement Project objectives had been slow, many deadlines were not met and none of the targeted actions were completed in full.
- Staff considered the recent changes of leadership, the perceived temporary nature of the current management structure and multiple change management processes to be unsettling within the division.
- Staff morale was variable and staff did not always feel that their contributions were recognised and appreciated. Staff viewed the decision regarding the nurse bank and nurses being paid at a mid-point band 5, irrespective of their substantive grade negatively. Staff exampled the recent decision to assimilate additional hour payments for staff working on the nurse bank and beyond their contracted hours. We were assured that appropriate action plans were in place and being monitored.
- Staff were critical of some of the engagement opportunities made available to them by senior leaders. Staff felt the staff engagement agenda was management driven, lacking staff influence and representation.

However:

- The division had a strategy and vision which was aligned to organisational aims and wider healthcare economy goals. The division recognised the delivery of the strategy could not be achieved in isolation therefore engaged with internal and external partners to drive objectives.
- Divisional leads had an understanding of the pressures and risks the service faced. The service prioritised resource to address key considerations around quality and safety matters.
- Governance processes across the division were clinician driven with defined channels for feedback into trust board agenda. The division actively monitored quality outcomes by way of clinical local and national review. The division were also actively involved in the trust-wide quality improvement project targeting 17 key areas for action.
- There were defined leadership structures in place supporting the division. Staff knew their individual roles and accountability. .Staff affirmed there was a strong clinical leadership presence across the division.
- Staff confirmed the culture within the divisional team had improved over the last 18 months. Staff stated this was particular manifest in the strength of ward teams and staff working together to maintain service delivery. Staff recognised the pressures faced by the division and acknowledged management efforts to address these.
- The staff engagement agenda had seen increased activity in the last 18 months and a number of action plans had been drafted in response to staff feedback, in particular, around health and well-being. The division engaged with their public well and captured feedback on care delivery and future proposals for the service.
- The division were involved in a number of improvement projects targeting key themes to improve patient safety, patient experience and service efficiency.

Vision and strategy for this service

- The vision and strategic goals for the division mirrored the aims and objectives of the trust, "to provide person centred world class quality health care services."

Medical care (including older people's care)

- Divisional managers had developed a very detailed business plan which identified strategic priorities for the division aligned to trust principles and values.
- The divisional strategy had short, medium and long term projections corresponding with performance improvement, clinical strategy, partnership working and engagement. These included financial recovery plans, constitutional targets to meet patient outcomes, delivery of the trust quality improvement plan (QIP), close working with the 'Success Regime' (a 'whole-system' model of modernisation and sustainability by partner collaboration with multi-agencies - the Cumbria Clinical Commissioning Group (CCG), the West North and East Cumbria Success Regime, Cumbria Partnership NHS Foundation Trust, Cumbria County Council, North West Ambulance Service, NHS England and neighbouring NHS Foundation Trusts), exploring opportunities offered by the Five Year Forward View and improving staff engagement.
- Managers recognised the importance of each business unit's contribution to delivering the divisional strategy. The divisional business unit plan 2016/17 further detailed key strategic priorities relevant to all areas such as workforce planning and improving patient flow to specific objectives under relevant business specialisms such as stroke services, older persons services, cardiology, haemodialysis and ambulatory care.
- Divisional managers completed a service review in 2016 to analyse ongoing service delivery across key specialisms, namely renal, cardiology, respiratory, gastroenterology, older persons' services, stroke, and dermatology. This review looked at current service configuration, activity trend, quality and workforce issues, financial position, future clinical model proposals, sustainability issues and organisational options. Managers within the respective business units were currently considering recommendations.
- Staff were aware of the local divisional objectives however commented on the impact of the wider agenda in the region looking at the sustainability and transformation plans (STP). Staff had concerns about how this may impact on the provision of divisional services at WCH.

Governance, risk management and quality measurement

- The division had clear governance channels into the wider organisational management structure. The medical division governance was clinician driven with multi-specialism input.
- We reviewed monthly divisional governance, safety and quality board meeting minutes from April to September 2016. The agenda items covered relevant matters such as incidents, risk register, slips, trips and falls, clinical audit, medication issues and policy review. We reviewed the divisional governance dashboard compiled in part for review at the meeting. The same included necessary data and analysis of reported incidents, serious incidents, complaints, clinical audit, care bundles and risk registers to inform group discussions.
- We were provided with sight of the divisional risk register dated October 2016 and updated in December 2016. Divisional managers confirmed the risk register to be a live document with ongoing review, actions taken and progress. The registers contained a risk descriptor, risk controls, control assurances, risk grading and reviewed progress against each. The ongoing risks listed in the October 2016 risk register included a number of trust-wide matters. Of those risks which attracted a rating of 16 and above in the October register, these included nurse and medical staffing, failure to deliver cost improvement projects (CIP), patient flow issues and haemodialysis capacity.
- Of the 56 current risks listed across the division in the December 2016 register, there were three that attracted a rating of 16 and above namely a lack of consultant oncologist provision, demand of patient flow and capacity and medicine management training. Some of the inclusions in the risk register dated back to 2010 however the higher risk items referred to in October had current risk downgraded (medical staffing from 25 to 12, nurse staffing from 20 to 12, CIPs from 20 to 12 and haemodialysis capacity from 20 to 8).
- Whilst detailed in terms of risk description, the register appeared unreliable, duplicating a number of common themes and lacking detail in terms of actions taken and progress over the period of time since the risk was identified. The top three rated risks did not correlate with divisional managers top three concerns (stated to be nurse staffing, medical staffing and meeting the A&E 95% target) for the service and risk ratings appeared to play down a number of key areas such as staffing and patient safety.

- In September 2016, clinical audit activity confirmed 87 audits to fall within the 2016/17 plan. Of those reported, 17 (20%) had been completed, 28 (32%) were in progress, 37 (42%) were newly added or had not started and five (6%) had been abandoned. The divisional clinical audit reporting arrangements flow from the monthly dashboard into the Emergency Care and Medicine Operational Board (EMOB), to the Safety and Quality Committee before presentation at the Trust Board.
- The division actively contributed to the trust QIP which drew together organisational objectives and improvement plans. Of the 17 sub-areas under consideration to address areas previously highlighted for improvement and progress, none had been fully completed. Whilst all had been progressed or were partially completed, many had exceeded the proposed end date, such as outcomes for the deteriorating patient and sepsis management.
- There was internal clinical audit activity and monitoring of performance and quality within the division. Senior staff recorded local and national measures and outcomes which fed into divisional activity and drove the vision, strategy, and quality improvement projects. Some senior nursing staff considered local audit activity to be excessive. They suggested a more consolidated approach would provide more relevant and meaningful outcomes data.
- The division were involved in reviewing procedures caught within the National Safety Standards for Invasive Procedures (NatSSIPs) agenda, revised in September 2015. The team had identified local invasive practices by business unit based on core NatSSIPs and were reviewing procedures locally to standardise practice, referred to as LocSSIPs. Division leads were working with the NatSSIPSs Steering Group to prioritise specific procedures for development. This work was ongoing at the time of the inspection.

Leadership of service

- The medicine division (including emergency care) had a clear management structure defining lines of responsibility and accountability. The division was led by an associate medical director, an associate chief operating officer and a chief matron. The management team covered all sites.
- The division management structure was further underpinned by three general managers, business managers, a divisional human resources business partner, a governance facilitator and clinical directors for the service specialisms namely acute medicine, cardiology and respiratory, elderly care, rehabilitation and stroke, gastroenterology, renal, dermatology, oncology and allied health professionals.
- The divisional leads had an understanding of the current challenges and pressures impacting on service delivery and patient care.
- We reviewed divisional operational board (EMOB) monthly meeting minutes from June to August 2016. These meetings were very well attended by the divisional leadership across both sites and were networked by way of video conferencing facilities. The agenda covered strategic, operational, divisional and business unit items. The Chair updated action plans after the meeting and these were revisited as a standing agenda item at subsequent meetings.
- Divisional leadership recognised their cross-site responsibilities and encouraged staff to engage with colleagues on other trust sites to build team networks. Some roles provided staff with the opportunity to work cross-site and liaise with the wider divisional team.
- The divisional business unit leads also held regular leadership meetings to discuss particular issues within their area of expertise. These were fed into EMOB.
- Divisional managers and business unit leads acknowledged the work their team carried out and considered their workforce to be a real strength.
- Local clinical leads were committed and determined to ensure patient needs were prioritised and staff were supported to deliver care.
- Ward staff confirmed their clinical leaders locally to be visible, approachable and part of the team. Staff did not believe the senior team were as visible as they could be. Staff were of the view that frequent changes in the senior management structure, reconfigurations, and multiple change projects were unsettling. Staff accepted changes were necessary however felt some changes were hastily implemented without sufficient time for staff to reflect upon and embed new processes.
- Ward staff commented on the positive support they received from their matrons.
- Staff acknowledged the difficulties faced by their divisional managers and they told us, managers kept

them informed of such issues by way of bulletins and emails. Staff indicated there was often an over-reliance on email communications, which they often didn't have time to read, or they found messages to be repeated.
- Staff considered communications from the divisional leaders could be more comprehensive and succinct. This was supported in the NHS Staff Survey 20156, where 21% reported good communication between senior management and staff (versus 31% national average).

Culture within the service

- Staff at all levels spoke enthusiastically about their work, about the quality of care delivered across the division and of the improvements made over the last 18 months.
- Staff described how the organisational and divisional culture was evolving and becoming more open, honest and transparent although staff considered this to be work in progress.
- At listening events and focus groups prior to the inspection we heard divisional staff describe a real 'team' culture and resilience on the wards. Staff described strength of ward comradery and staff 'pulling together' to get the job done. We observed this on ward visits with staff from a variety of specialisms working together effectively.
- Staff morale was variable but improving and this did not detract from a determination to ensure patient's received the best care possible. Staff recognised the issues impacting on performance and morale but also considered there no quick fix for many challenges faced by the organisation. This was apparent in the NHS Staff Survey 20156 response which reported 85% of staff felt their role made a difference (lower than national average of 90%).
- Staff did not always feel their contribution was recognised and valued by senior leaders. Staff reinforced this by referring to a recent leadership decision to change remuneration payments for staff working additional hours to support the service.
- All staff we spoke with told us their immediate line managers and clinical leaders were professional, supportive and helpful.
- Junior nursing and medical staff described their senior peers to be supportive, approachable and willing to spend time with them when necessary.
- Matrons recognised that staff on wards were getting stressed and tired due to the constant pressures that they faced. Staff felt as though leaders were staring to listen to this and take on board staff feedback. Staff commented they had contributed to various surveys, in particular, looking at staff health and wellbeing. Staff hoped to see this become a greater priority in the future.
- Staff commented how they felt there was cultural acceptance around the publication of negative press for the organisation. Staff considered this had an impact on staff morale and wellbeing. Staff felt their committed efforts and positive divisional patient outcomes should be celebrated more widely by leaders to redress the balance.

Public engagement

- Divisional staff actively engaged with patients, family members and the local population to canvas their opinion and obtain feedback on current services and future proposals.
- Patients and their families provided views and feedback on their experiences of using the service in the Family and Friends Test, through the 'two minutes of your time' survey, 'face-to-face and real time surveys. Patients could also leave feedback on comment cards and via the trust website.
- Some wards provided designated appointment times for family members, at a time convenient to them, to discuss the care and treatment plans for their loved one.
- Wards displayed information for patients and their families on ways in which they could provide commentary about their experiences in a more confidential setting such as accessing PALS.
- The division had good links with numerous volunteer organisations, charities and national support groups.
- The division supported the organisation and wider health community agenda with the consultation surrounding the future of healthcare services across the region.

Staff engagement

- Staff commented how there had been an increased effort by divisional managers and the leadership team to engage with staff cross-site.
- The leadership team arranged staff forums and drop-in sessions. The trust Chief Executive held cross-site

roadshows with recent topics covering staff support, staff morale and generating cost savings. Some staff were critical of the format of these sessions as, more often than not, they were unable to attend due to ward clinical duties, and they also felt that the agenda appeared driven by leaders as opposed to being staff-led.

- Divisional leads in conjunction with the leadership team had progressed staff surveys looking at health and wellbeing and seeking opinion from staff on the Success Regime proposals. This had generated a number of action plans; in particular, organisational leaders were accessing physical activity schemes, physiotherapy services, and mental health initiatives, and had appointed a health and wellbeing coordinator.
- The division provided staff with information via the trust intranet, email, and cascades from senior staff meetings. The division supported the development of the 'glimpses of brilliance' (GOB) boards on wards where staff could share and celebrate positive outcomes, patient feedback and work related successes.
- Staff had developed good links with external professional colleagues, support organisations and volunteer groups.
- Staff said they felt supported when they had personal or family issues which impacted on their ability to work. Staff commented how their line managers and clinical support network showed understanding, empathy and kindness during the difficult time. Manager supported staff returning to work following a leave of absence.
- In the NHS Staff Survey 20156, the trust performed better than other trusts in nine questions, about the same as other trusts in 17 questions and worse than other trusts in six questions. The positive trends related to staff having opportunities to progress in the organisation and incident reporting. Staff engagement scores and staff contributing to work related improvements were lower than the national average.

Innovation, improvement and sustainability

- The trust provided us with detail of divisional innovations within the last 12 months. They reported a joint project with the University of Cumbria to develop and appoint allied nurse practitioners (occupational therapists) to support the nursing compliment across the division.
- The divisional physiotherapy team were leading on training for staff, caring for patients living with dementia to improve patient experience, activity levels and avoid decompensation by introducing 'dancing recall' (a project using dance to enhance the quality of life of those living with neurodegenerative conditions).
- The division had been involved in a task and finish group to improve opportunities for self-care and home haemodialysis to improve the quality of life of individuals living with renal conditions.
- The stroke team were part of the North West Network which provided telemedicine (telestroke) services across the region. This service provided rapid assessment of patients for consideration of thrombolysis.
- The division were working on a number of improvement projects focussing on reducing patient harms and improving care pathways.
- Staff in EAU and CCU had forged strong links with community respiratory colleagues to promote transitional care for this cohort of patients across the region.
- There were a number of quality improvement projects (QIPs) in the division which were focussed on key areas of risk such as reducing patient harm and optimising patient flow.

Surgery

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

Information about the service

West Cumberland Hospital provided surgical services for general surgery, head and neck, ENT, urology, rheumatology, orthopaedics, gynaecology and ophthalmology. There was one large ward, an operating suite, a day-case unit, and a recovery area. In total, the surgical division had 35 day case and 151 inpatient beds.

Across the surgical division the trust had 24,171 surgical admissions between April 2015 and March 2016. Emergency admissions accounted for 6,469 (26.8%), 13,210 (54.7%) were day operations, and the remaining 4,492 (18.6%) were elective.

During this inspection we visited the surgical ward 1 (32 bedded mixed surgical ward), and day surgery unit. We observed care being given and surgical procedures being undertaken in theatres and recovery areas.

We spoke with 17 patients and relatives and 25 members of staff. We observed care and treatment and looked at 14 care records.

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

Summary of findings

The overall surgery rating from the 2015 inspection was 'good'. Actions the trust were told that it must take were:

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

During the December 2016 inspection we rated surgical services as 'requires improvement' because:

- The surgical division reported 26 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England between October 2015 and September 2016 of these, the most common type of incident reported was Pressure ulcer (46.2%) followed by surgical/invasive procedure (30.8%). Nineteen SI's were reported from WCH.
- Between October 2015 and September 2016, the trust reported one incident which was classified as a Never Event for Surgery. The Never Event occurred at WCH in December 2015 and was regarding an incorrect component being implanted during a knee replacement procedure.
- The majority of surgical wards were below the nursing establishment levels. The data for WCH at the time of inspection showed that ward 1 required 20.86 whole time equivalent (WTE) but had 17.68 WTE nursing staffing in post. Similarly the day case unit had 7 WTE but required 8.93 WTE.

Surgery

- As of September 2016 the trust reported a nurse vacancy rate of 8.2% at WCH. WCH had the higher vacancy rate of the two sites. At WCH, General Theatres had the highest vacancy rate at 19.3%.
- There had been seven Never Events for Surgery between June 2015 and February 2016.
- We saw 26% (November 2016) of patients were re-assessed for venous thromboembolism (VTE) within 24 hours of admission. This is a decrease from October 2016 when 72% of patients were re-assessed with 24 hours of admission. September 2016 figures were 37%. The target is 95%.
- Surgical debrief as part of the five steps to safer surgery was undertaken 14% of the time. A trust audit recommended further work on encouraging the team debrief through business unit governance meetings and dissemination of learning by governance leads.
- We found that training levels for areas such as fire safety (58%), hygiene for clinical staff (67%), trust doctors patient safety programme (31%), and duty of candour (45%) were below the trust target.
- The proportion of patients having hip fracture surgery on the day or day after admission was 68.3%, which does not meet the national standard of 85%. The 2015 figure was 75.1%.
- A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice. For the period Q2 2014/15 to Q1 2016/17 the trust cancelled 1,410 elective surgeries. Of these, 12% were not treated within 28 days. The overall trend is that the trust has a much higher percentage of operations not treated within 28 days compared to the England average. Performance improved from Q1 2015/16 to Q3 2015/16 however performance deteriorated again from Q4 2015/16 and is showing signs of deteriorating further.
- Cancelled operations as a percentage of elective admissions includes all cancellations rather than just short notice cancellations. Cancelled operations as a percentage of elective admissions for the period Q2 2014/15 to Q1 2016/17 at the trust were consistently greater than the England average. The trust trend has followed a similar pattern to the England average, although the peaks and troughs are far more pronounced, particularly the increase in Q3 2015/16 although it should be noted that junior doctor strikes were planned during this period and may have contributed to the sharp rise.
- For the period November 2015 to November 2016 WCH cancelled 292 elective surgeries for non-clinical reasons.
- Four Surgical specialties were below the England average for admitted RTT (percentage within 18 weeks).
- An action on the quality improvement plan stated that the division aimed to achieve compliance with 18 week referral to treatment for the incomplete pathway standard by September 2016. The status of this action remained in progress as of December 2016.
- At trust level, general surgery had a longer average length of stay than the England average for both elective and non-elective admissions.
- At the time of inspection the perioperative improvement plan was in the early stages of implementation, impacting upon some areas but not yet fully embedded within the division.
- Staff morale was variable on the wards, theatres and recovery areas. Morale was affected by working in difficult circumstances during the last eighteen months to cover staff and skill shortages.
- We were advised of ongoing bulling allegations within the theatre departments.

However:

- The division held regular emergency surgery and elective care business unit meetings where serious incidents were discussed, investigations analysed and changes to practice identified.
- Senior nursing staff had daily responsibility for safe and effective nurse staffing levels. Staffing guidelines with clear escalation procedures were in place. Site cover was provided out-of-hours 24 hours per day, seven days per week by a team of senior nurses with access to an on-call manager. Numbers of staff on duty were displayed clearly at ward entrances.

Surgery

- A 'red flag' and safer staffing system had been introduced to identify when lower than optimal staff numbers may impact upon patient care and to initiate mitigation. Escalation processes were in place through the matron, service manager and chief matron. Capacity bed meetings were held twice daily to monitor bed availability, review planned discharges and assess bed availability throughout the trust.
- All wards participated in the NHS safety thermometer approach to display consistent data to assure people using the service that the ward was improving practice based on experience and information. This tool was used to measure, monitor, and analyse patient 'harm free' care.
- We looked at medical records across wards and saw they were appropriately completed, legible and organised consistently. All documentation checked was signed and dated, clearly stating details of the named nurse and clinician.
- Patients were treated in accordance with national guidance and enhanced recovery (fast track) pathways were used. Local policies were written in line with national guidelines. A range of standardised, documented pathways and agreed care plans were in place across surgery.
- During 2015/16, the surgical business unit participated in 12/14 national clinical audits covering a range of specialties, and completed 122 local audits. Outcomes from each audit were reported to Business Unit Governance Board (BUG Board).
- The perioperative surgical assessment rate was 92.4%, which does not meet the national standard of 100%. However, the 2015 figure was 62.4% showing considerable improvement.
- Patients admitted with a fractured neck of femur had their pain assessed immediately upon presentation at hospital and within 30 minutes of administering initial analgesia, hourly until settled on the ward and regularly as part of routine nursing observations throughout admission.
- A dedicated pain team was accessible to support with analgesia as required. The pain team visited patients when baseline pain relief was ineffective. Anaesthetists provided support with pain relief out-of-hours.
- Between March 2015 and April 2016, patients at WCH had a lower than expected risk of readmission for both elective and non-elective admissions.
- The Friends and Family Test response rate for surgery at the trust was 38% which was better than the England average of 29% between November 2015 and October 2016. Ward level recommendation rates were variable although recommendation rates were generally high, being between 70-100% for the overall period across all participating wards.
- We observed the treatment of patients to be compassionate, dignified, and respectful throughout our inspection. Ward managers and matrons were available on the wards so that relatives and patients could speak with them as necessary.
- The trust was actively working with commissioners to provide an appropriate level of service based on demand, complexity and commissioning requirements.
- The division had an escalation policy and procedure to deal with busy times and matrons and ward managers held capacity bed meetings to monitor bed availability.
- Complaints were handled in line with the trust policy, and discussed at all monthly staff meetings. Patients or relatives making an informal complaint were able to speak to individual members of staff or the ward manager. Wherever possible the patient Advice Liaison Service (PALS) would look to resolve at a local level.
- We met with senior trust and divisional managers who had a clear vision and strategy for the division and identified actions for addressing issues within the division. The divisional leadership team detailed their understanding of the challenges associated with providing good quality care and identified actions needed.
- The trust had developed a quality improvement plan (QIP) and had identified specific objectives to improve the management of the deteriorating patient, the recognition, and initiation of treatment for patients with sepsis and ongoing development of the Mortality and Morbidity Framework.
- The division had also developed a perioperative improvement Plan in response to recent issues identified within surgery. This aimed to enhance

governance through learning from events and incidents, develop the workforce through a positive learning environment, and initiate external assessment and compliance.
- There was a systematic programme of clinical and internal audit, which was used to monitor quality and systems to identify where action should be taken. Monthly audits were undertaken and audit outcomes were published quarterly.
- The division's risk register was updated following the safety and quality meetings with risks discussed, controls identified, with progress against mitigation, risk grading, assurance sources, and gaps in control documented.

Are surgery services safe?

Requires improvement

We rated safe as 'requires improvement' because:

- The surgical division reported 26 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England between October 2015 and September 2016 of these, the most common type of incident reported was Pressure ulcer (46.2%) followed by surgical/invasive procedure (30.8%). Nineteen SI's were reported from WCH.
- Between October 2015 and September 2016, the trust reported one incident which was classified as a Never Event for Surgery. The Never Event occurred at WCH in December 2015 and was regarding an incorrect component being implanted during a knee replacement procedure.
- The trust had reported its staffing numbers as of August 2016. These staffing numbers showed that the majority of surgical wards were below the nursing establishment levels. The data showed that ward 1 required 27.93 whole time equivalent (WTE) but had 23.21 WTE nursing staffing in post. Similarly, the day-case unit had 6.48 WTE but required 9.12 WTE.
- As of September 2016, the trust reported a nurse vacancy rate of 8.2% at WCH. WCH had the higher vacancy rate of the two sites. At WCH, General Theatres had the highest vacancy rate at 19.3%.
- We saw 26% (November 2016) of patients were re-assessed for venous thromboembolism (VTE) within 24 hours of admission. This is a decrease from October 2016 when 72% of patients were re-assessed with 24 hours of admission. September 2016 figures were 37%. The target is 95%.
- Surgical debrief as part of the five steps to safer surgery was undertaken 14% of the time. A trust audit recommended further work on encouraging the team debrief through business unit governance meetings and dissemination of learning by governance leads. A presentation provided by the trust highlighted that improvement work was underway.
- We found that training rates in areas such as fire safety (58%), hygiene for clinical staff (67%), trust doctors patient safety programme (31%), and duty of candour (45%) were below the trust target.

However:

- The division held regular emergency surgery and elective care business unit meetings where serious incidents were discussed, investigations analysed and changes to practice identified.
- Senior nursing staff had daily responsibility for safe and effective nurse staffing levels. Staffing guidelines with clear escalation procedures were in place. Site cover was provided out-of-hours 24 hours per day, seven days per week by a team of senior nurses with access to an on-call manager. Numbers of staff on duty were displayed clearly at ward entrances.
- A 'red flag' and safer staffing system had been introduced to identify when lower than optimal staff numbers may impact upon patient care and to initiate mitigation. Escalation processes were in place through the matron, service manager and chief matron. Capacity bed meetings were held twice daily to monitor bed availability, review planned discharges and assess bed availability throughout the trust.
- All wards participated in the NHS safety thermometer approach to display consistent data to assure people using the service that the ward was improving practice based on experience and information. This tool was used to measure, monitor, and analyse patient 'harm free' care.
- The trust carried out monthly audits of hand hygiene compliance, commode, cannulas, urinary catheters, personal protective equipment, ventilated patients, and we saw that the standard of environmental cleanliness was good across all wards inspected.
- We looked at medical records across wards and saw they were appropriately completed, legible and organised consistently. All documentation checked was signed and dated, clearly stating details of the named nurse and clinician.

Incidents

- Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Between October 2015 and September 2016, the trust reported one incident which was classified as a Never Event for Surgery. The Never Event occurred at WCH in December 2015 and was regarding an incorrect component being implanted during a knee replacement procedure.
- The incident had been subject to an early management report and had been fully investigated, root cause analyses undertaken and changes to practice made where appropriate.
- In accordance with the Serious Incident Framework 2015, the trust reported 26 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England between October 2015 and September 2016 of these, the most common type of incident reported was Pressure ulcer (46.2%) followed by surgical/invasive procedure (30.8%). Nineteen SI's were reported from WCH.
- The trust had commissioned an external review of Never Events by the Royal College of Surgeons (RCS) and been visited by the Clinical Commissioning Group (CCG). Actions were incorporated into the perioperative improvement plan and monitored by senior management.
- The division held regular emergency surgery and elective care business unit meetings where serious incidents were discussed, investigations analysed and changes to practice identified.
- Although learning from previous Never Events and changes to practice had been identified through these processes this was not displayed or easily identified through discussions with staff at WCH.
- Staff told us how they reported incidents through the electronic system and most said learning was shared through meetings, communication books, and team briefings. However, some staff said they received no feedback on reported incidents.
- Matrons had an overview of every incident, complaint, and concern and operated a system of response and feedback to patients and staff.
- The trust held regular mortality and morbidity case review meetings within all specialities to discuss case descriptions and summaries, classification, outcome, and key lessons. These were attended by multi-disciplinary teams and lessons learnt were identified and used to inform service development through audit (e.g. implant compliance, Warfarin reversal protocol, and wrong site surgery), safety huddles, ward meetings, newsletters and on a one to one basis as necessary.

Surgery

Safety thermometer

- Safety Thermometer is used to record the prevalence of patient harms at the frontline, and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. Data collection takes place one day each month with a suggested date for data collection is given but ward can change this. Data must be submitted within 10 days of suggested data collection date.
- This information was displayed in ward entrances and was easy to understand; staff had knowledge of the displayed information and ward performance.
- Audits showed 98% (November 2016, 100% in October 2016 and 100% in September 2016) of patients received an assessment of venous thromboembolism (VTE) in and bleeding risk using the clinical risk assessment criteria described in the national tool. We saw 26% (November 2016) of patients were re-assessed within 24 hours of admission. This is a decrease from October 2016 when 72% of patients were re-assessed with 24 hours of admission. September 2016 figures were 37%. The target is 95%.
- Quality of care boards were displayed on the ward and showed that the last ward had gone 39 days without a medication error.
- Patient safety was monitored through the completion of moving and handling assessments; falls risk assessments, the national early warning score (NEWS) and malnutrition (MUST) assessments and by following infection, prevention and control measures.

Cleanliness, infection control and hygiene

- The trust had an infection surveillance programme and an infection control matron in place. An annual infection prevention and control report was presented to the board and monthly reports to the safety and quality Committee.
- The trust had policies in place, amongst others, to cover aseptic techniques, patient transfers, hand hygiene, outbreaks, norovirus, and Methicillin Resistant Staphylococcus Aureus (MRSA). These were available as paper copies and on the trust intranet.
- The trust carried out monthly audits of hand hygiene compliance, commode, cannulas, urinary catheters, personal protective equipment, ventilated patients, ultra violet spray, and glow cleanliness.
- Each ward had daily, weekly, and monthly cleaning schedules for domestic staff, housekeepers and nursing staff. Cleaning and environmental audits were completed on a monthly basis and these showed all wards met the hygiene target between February 2016 and August 2016.
- Trust environmental cleanliness audits (January to August 2016) showed divisional compliance with hand hygiene techniques at 100% compliance. However, theatre recovery failed to submit seven months out of eight months audits.
- We saw that the standard of environmental cleanliness was good across all wards inspected. Infection control and hand hygiene signage was consistent and we observed clear signage for isolation of patients in single rooms.
- There were no cases of MRSA reported between September 2015 and August 2016.
- Quality of care boards were displayed on the ward. The rate of Clostridium Difficile (C. Diff) was zero between July 2016 and December 2016.
- All Trust C. diff cases underwent a root cause analysis (RCA) using a pro forma agreed across the local health economy and with Public Health England. These were then uploaded onto a database and reports generated themes. Each RCA was reviewed and a synopsis of each apportioned case was presented to the Infection Prevention Control Committee (IPCC) and safety and quality.
- A Healthcare Associated Infection Delivery Plan had been developed to ensure compliance with, for example, urinary catheter insertion techniques, hand hygiene, surgical scrub uniform policy, SSI national standards, cleaning standards and learning from SSI root cause analyses.
- We observed staff washing their hands and all patients we spoke with told us that this was done. Hand gel was available throughout the hospitals at the point of care and staff used personal protective equipment (PPE) compliant with policy.
- We observed clean equipment throughout surgical areas and staff completed cleaning records and domestic cleaning schedules.

- Clinical and domestic waste disposal and signage was good. Staff observed disposing of clinical waste appropriately. Linen storage, segregation of soiled linen in sluice rooms and the disposal of sharps followed Trust policy.
- Surgical Site Infection (SSI) group meetings were held to reduce the incidence of infections through for example, temperature monitoring, patient education, inter-operative practices, treatment rooms, pre-admission screening, SSI rates, and day zero practice.
- The trust report for April to June 2016 showed SSI rates of 1.73% for total hip replacements, 2.32% total knee replacements and 1.72% for repair of neck of femur and 2.85% revision of total knee replacements. No SSIs were recorded for revision of total hip replacements.

Environment and equipment

- All wards and surgical areas were uncluttered and in a good state of repair. Wards had a spacious design, large floor plan and storeroom capacity was available on all wards.
- We inspected resuscitation trolleys and suction equipment on wards and found all appropriately tested, clean, stocked, and checked weekly as determined by policy.
- All managers were responsible for ensuring risk assessments were completed to reduce the risk of slips, trips, and falls. Risk assessments included types of hazard and likelihood of occurrence, quality, and condition of flooring, maintenance and cleaning procedures.
- The arrangements for managing domestic and clinical waste kept people safe. All staff spoken to were aware of the clinical and domestic waste disposal procedures, the use of specific bags, and special ties to seal clinical waste.
- A Specific room and equipment had been designed for the use of bariatric patients to ensure safety for both staff and patients. Requests were made to the moving and handling team when further equipment was required.

Medicines

- In all wards and surgical areas, medicines were stored, prescribed, and administered in line with trust policy and procedures. We saw the trust had introduced an electronic dispensing system which staff had been trained to use.
- We checked records at random within theatres at WCH and found inconsistent practice in recording the prescription, administration, and destruction of medications. This was addressed during the inspection.
- Although pharmacists liaised with and supported ward teams regularly, we were told by staff that pharmacist input to theatres at WCH was less regular.
- Staff were required to attend mandatory updates on storage and recording of controlled drugs, and newly qualified staff were required to attend training and complete the e-learning safe medications training.
- Temperature checks were recorded for the safe storage of medication in refrigerated units on a daily basis.

Records

- We looked at 16 sets of medical records across wards at Cumberland Infirmary and saw they were appropriately completed, legible and organised consistently. All documentation checked was signed and dated, clearly stating the details of the named nurse and clinician.
- Daily entries of care and treatment plans were clearly documented and care plans and charts were reviewed regularly. Completed patient assessment, observation charts food and fluid balance sheets, consent forms with mental capacity assessments where necessary, and diabetes and wound care charts were implanted as applicable.
- Records included a pain score and allergies were documented.
- We reviewed handover sheets used by ward staff and the escalation documentation which was effective in communication and decision making for those patients at risk of deterioration.
- We saw good examples of complete preoperative checklists and consent documentation in the patient notes we checked.

Safeguarding

- The Trust had a clear safeguarding strategy and safeguarding board meetings. Minutes and action plans were clear and these meetings were well attended by

senior staff from across the Trust. Learning from serious case reviews was monitored and safeguarding showed good attendance and compliance of staff at safeguarding training.
- Safeguarding training plans and schedules were displayed in ward offices and held centrally by the training department.
- Divisional data (August 2016) showed 64% of medical staff had attended safeguarding adults - level one and 65% of the medical staff had attended safeguarding children - level two.
- Trust data (August 2016) showed 63% of nursing staff had attended safeguarding adults - level one and 77% had completed level 2. The percentage of nursing staff that had attended safeguarding children level two was 68% and 58% had completed level 3.
- The trust set a target of 95% for completion of safeguarding training by the end of March 2017.
- On each ward, staff understood their responsibilities and discussed safeguarding policies and procedures confidently and competently. Staff felt safeguarding processes were embedded throughout the trust.
- Information was available at ward level with guides, advice, and details of contact leads to support staff in safeguarding decision making.

Mandatory training

- The trust set a target of 95% for completion of mandatory training modules by the end of March 2017. Divisional audits showed 100% of staff attended the trust induction. Medical, nursing and healthcare assistants within surgery met the training targets for equality and diversity (89%), risk management (85%), VTE training (88%), moving and handling (83%), and advance life support (100%). All staff had met the training target for the 12 'essence of care' core modules set by the trust.
- We found that training such as medicines management level 2 / 3 (75%), dementia (77%), NEWS (76%), information governance compliance (61%), fire safety (58%), hygiene for clinical staff (67%), and the trust doctors patient safety programme (31%) were below the trust target.
- Duty of Candour requirements were explicitly stated within trust policies, the trust intranet, training and staff described to us how these procedures had been used following specific incidents. However, training levels were not meeting the trust target of 95% and were 45% in November 2016.
- The surgical division had an action plan in place to achieve compliance with mandatory training targets by March 2017 (95%) and attendance at mandatory training programmes for all staff was monitored locally and also by the education department.
- Staff told us they accessed mandatory training in a number of ways, such as online modules and eLearning, workbooks and key trainer delivered sessions. Staff said they were supported with professional development through education.
- Staff said they had a good induction and preceptorship programme when joining the trust and attended local sessions and those provided at a trust level.
- A clinical educator was in post and supported staff with training, their continued professional development and professional revalidation.

Assessing and responding to patient risk

- The trust used an early warning score risk assessment system. The strategy and processes for recognition and treatment of the deteriorating patient in surgery was embedded. Staff recorded observations, with trigger levels to generate alerts, which identified acutely unwell patients.
- We saw full completion of early warning score risk assessments and sepsis screening tools and staff were aware of escalation procedures.
- Comprehensive risk assessments were in place in surgical records and included the completion of cognitive assessment tools, falls risks, pressure ulcer risks, and bed rails assessments.
- Care planning based on patients assessed risk was good. We saw evidence of risk assessment for nutrition with the Malnutrition Universal Screening Tool (MUST) and this helped staff identify patient nutritional needs. Pain scores and diaries for patients were available.
- Staff knew how to highlight and escalate key risks that could affect patient safety, such as staffing and patient assessment and screening.
- A trust audit (May 2016) measured compliance with the 'Five Steps to Patient Safety' procedure. This showed 98% compliance with undertaking the team brief before surgery (previously 50%). The audit also showed 96% sign-in by the surgeon prior to anaesthesia at WCH.

- Time out was taken for all patients at the hospital with all members of the team listening and stopping and 100% responding as required.
- Debrief was undertaken 14% of the time. However, when debrief was undertaken all staff were present. The audit recommended further work on encouraging the team debrief through business unit governance meetings and dissemination of learning by governance leads. A presentation provided by the trust highlighted that improvement work was underway.
- We observed the checklist being applied in theatre and saw completed preoperative checklists and consent documentation in all patient notes seen where applicable at WCH.
- The procedure observed highlighted that on that occasion the initial time out was not undertaken at the appropriate time as the examination had already commenced.

Nursing staffing

- The National Institute for Health and Care Excellence (NICE) states that assessing the nursing needs of individual patients is paramount when making decisions about safe nursing staff requirements for adult inpatient wards in acute hospitals.
- A 'red flag' and safer staffing system had been introduced to identify when lower than optimal staff numbers may impact upon patient care and to initiate mitigation. Escalation processes were in place through the matron, service manager and chief matron. Monitoring of patient acuity, dependency and actual against planned staffing levels took place on a shift-by-shift basis.
- Senior nursing staff had daily responsibility for safe and effective nurse staffing levels. Staffing guidelines with clear escalation procedures were in place. Site cover was provided out-of-hours 24 hours per day, seven days per week by a team of senior nurses with access to an on-call manager. Matrons told us shortfalls in nursing cover were managed day to day through regular senior nurse team meetings and cross-site conference calls as a business unit working together to meet demands in ward activity.
- Numbers of staff on duty was displayed clearly at ward entrances. During the inspection all wards were staffed to the required levels.
- The trust had reported its staffing numbers as of August 2016. These staffing numbers showed that the majority of surgical wards were below the nursing establishment levels. The data shows that ward 1 required 27.93 whole time equivalent (WTE) but had 23.21 WTE nursing staffing in post. Similarly, the day-case unit had 6.48 WTE but required 9.12 WTE.
- As of September 2016 the trust reported a nurse vacancy rate of 8.2% at WCH. WCH had the higher vacancy rate of the two sites. At WCH, General Theatres had the highest vacancy rate, at 19.3%.
- Between April 2015 and March 2016 the trust reported a nursing turnover rate of 3.3% and a bank and agency usage rate of 3.5 % in surgical care.
- To address this the division had developed recruitment plans, sickness monitoring was reported quarterly to the Safety and Quality Board, and it used bank staff and overtime. Additionally, daily board rounds were undertaken to prioritise care, monitor rotas, and inform patients and families of actions taken.
- All wards within surgery cared for a number of 'outlier' medical patients. Staff told us these patients had different needs to surgical patients and increased their workload. Many staff expressed concern about the difference in skill required to care for medical patients. We saw no evidence to support an increase in incidents.

Surgical staffing

- Medical staffing skill mix across the hospital varied across grades compared to the England average at 39% consultant (national average 43%), 16% middle career (national average 10%), 26% Registrar group (national average 35%) and 20% junior doctors (national average 11%). As of June 2016, the proportion of consultant staff junior (foundation year 1-2) staff reported to be working at the trust was about the same as the England average.
- Between April 2015 and March 2016 the trust reported a bank and locum usage rate of -18% in surgical care. The trust told us that negative rates could occur due to the method that the finance department used to calculate the rate, as, occasionally, it could over-estimate, and this could result in negative spend in a future month when actual costs were known.
- The emergency surgical and elective care business unit risk register (September 2016) identified issues with staffing across the trust. The division had developed recruitment and retention policies to address these issues.
- Concerns had been raised about the quality of cover, changes to appointments and lack of continuity.

Surgery

- We saw that surgical handovers took place daily and were primarily consultant led and took place in private areas to maintain confidentiality.
- The trust gained in-house Royal College of Surgeons accredited START surgery course for foundation doctors in surgery.

Major incident awareness and training

- The trust major incident response plan was in place and available to staff on the trust intranet. This policy aimed to adopt a unified and cohesive approach to resilience, through business Continuity Planning and emergency Response.
- There were business continuity plans for surgery. These included the risks specific to the clinical areas and the actions and resources required to support recovery.
- A trust assurance process was in place to ensure compliance with NHS England core standards for emergency preparedness, resilience, and response.
- The trust's major incident plan provided guidance on actions to be undertaken by departments and staff, who may be called upon to provide an emergency response, additional service, or special assistance to meet the demands of a major incident or emergency.
- Training was provided by the Resilience Team which involved a "live" exercise every three years, a table-top exercise every year, a communications cascade test every 6 months and Executives and Senior Managers must complete media training every 3 years.

Are surgery services effective?

Good

We rated effective as 'good' because:

- Patients were treated in accordance with national guidance and enhanced recovery (fast track) pathways were used. Local policies were written in line with national guidelines. A range of standardised, documented pathways and agreed care plans were in place across surgery.
- During 2015/16, the surgical business unit participated in 12/14 national clinical audits covering a range of specialties, and completed 122 local audits. Outcomes from each audit were reported to business unit Governance Board (BUG Board). In addition, the audit activity and outcomes of different services was scrutinised via the Trust quality Panels and safety and quality Committee.
- The perioperative surgical assessment rate was 92.4%, which does not meet the national standard of 100%. However, the 2015 figure was 62.4% showing considerable improvement.
- In the Patient Reporting Outcomes Measures (PROMS) from April 2015 to March 2016, the Hip Replacement (EQ VAS) and Knee Replacement (Oxford Knee Score) indicators showed more patients' health improving and fewer patients' health worsening than the England averages. Groin Hernia (EQ-5D Index) showed fewer patients' health improving than the England average although slightly fewer patients' health worsened than the England average. The remainder of indicators were in line with the England averages.
- Between March 2015 and April 2016, patients at WCH had a lower than expected risk of readmission for both elective and non-elective admissions.
- Patients admitted with a fractured neck of femur had their pain assessed immediately upon presentation at hospital and within 30 minutes of administering initial analgesia, hourly until settled on the ward and regularly as part of routine nursing observations throughout admission.
- A dedicated pain team was accessible to support with analgesia as required. The pain team visited patients when baseline pain relief was ineffective. Anaesthetists provided support with pain relief out-of-hours.
- The trust reported that as at 31 August 2016 Mental Capacity Act (MCA) training had been completed by 89% of staff in within surgery for Level 1 and 72% for Level 2. Deprivation of Liberty training had been completed by 76% of staff within surgery.

However:

- In the 2016 Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 6.7% which falls within expectations. The 2015 figure was 6.2%. The proportion of patients having surgery on the day or day after admission was 68.3%, which does not meet the national standard of 85%. The 2015 figure was 75.1%.

Evidence-based care and treatment

- Patient treatment was in accordance with national guidance from the National Institute of Health and Care Excellence (NICE), the Association of Anaesthetists, and The Royal College of Surgeons.
- New systems and processes for the registration and monitoring of clinical audits were introduced corporately in the Clinical Audit Policy and continue to be developed, along with new processes for providing assurance around compliance to NICE guidance and Quality Standards. These require full implementation within the business unit during 2016/17.
- We saw that patients had their needs assessed and their care planned and delivered in line with evidence-based guidance, standards and best practice.
- During 2015/16, the surgical business unit participated in 12/14 national clinical audits covering a range of specialties, and completed 122 local audits. Outcomes from each audit were reported to business unit Governance Board (BUG Board). In addition, the audit activity and outcomes of different services was scrutinised via the Trust Quality Panels and Safety and Quality Committee.

Pain relief

- Patients were regularly asked about their pain levels, particularly immediately after surgery, and this was recorded on a pain scoring tool that was used to assess patients' pain levels. All patients reported their pain management needs had been met.
- There was a pain assessment scale within the NEWS chart used throughout the hospital. NEWS audits were in place and supported through feedback from the Friends and Family Test and directly from patients.
- A dedicated pain team was accessible to support with analgesia as required. The pain team visited patients when baseline pain relief was ineffective.
- Anaesthetists provided support with pain relief out-of-hours.
- Patients admitted with a fractured neck of femur had their pain assessed immediately upon presentation at hospital and within 30 minutes of administering initial analgesia, hourly until settled on the ward and regularly as part of routine nursing observations throughout admission.

Nutrition and hydration

- Priority was given to appropriate nutritional and hydration support for surgical patients on each ward. Staff identified patients at risk of malnutrition by working with patients and their families to complete a MUST score.
- Ward audits included checking whether patients received a nutritional risk assessment on admission and whether this risk assessment was reviewed within the required timescales.
- We observed appropriately completed fluid balance charts and dietary intake charts.
- The nutritional risk assessment identified the levels at which dietitian referral was recommended.
- Arrangements were in place for when enteral feeding was required out-of-hours as part of a protocol to ensure that patients did not have to wait for a dietitian to be on duty.
- We saw a range of food choice, meals, and snacks. Patients who required nutritional support were identified.
- Surgical pre-operative assessments performed by nursing staff, offered tailored nutrition and hydration guidance to patients, and provided all elective patients with fasting instructions to follow on the day of their surgery.
- Records showed patients were advised as to what time they would need to fast from. Fasting times varied depending on whether the surgery was in the morning or afternoon and recorded on the nursing notes.
- We reviewed 16 records and saw nurses completed food charts for patients who were vulnerable or require nutritional supplements and support was provided by the dietetic department.
- Meal charts were completed comprehensively and reviewed.

Patient outcomes

- Between March 2015 and April 2016, patients at the trust had a lower than expected risk of readmission for both elective and non-elective admissions. In elective admissions, Trauma and Orthopaedics had the largest relative risk of readmission of the specialities listed, although this was still only at the England average. In non-elective admission, vascular surgery had a markedly higher risk of readmission than any other speciality, although, as overall non-elective readmission rates were below the England average, it was likely that the activity in vascular surgery was low.

Surgery

- In the 2016 Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 6.7% which falls within expectations. The 2015 figure was 6.2%.
- The proportion of patients having surgery on the day of or day after admission was 68.3%, which does not meet the national standard of 85%. The 2015 figure was 75.1%.
- The perioperative surgical assessment rate was 92.4%, which does not meet the national standard of 100%. The 2015 figure was 62.4%.
- The proportion of patients not developing pressure ulcers was 94.7%, which falls in the middle 50% of trusts. The 2015 figure was 97.7%.
- The length of stay was 16.7 days, which falls in the middle 50% of trusts. The 2015 figure was 15.1 days.
- The trust showed marked improvement from 2015 for the perioperative medical assessment rate although all other measures have deteriorated on the 2015 audit results. Case ascertainment also dropped from 98.1% in 2015 to 92% in 2016, although the trust was higher than the England and Wales aggregate of 90.7%.
- In the 2015 Bowel Cancer Audit, 55% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was better than than the national aggregate. The 2014 figure was 52%.
- The risk-adjusted 90-day post-operative mortality rate was not submitted by the trust in the 2015 audit. The 2014 figure was 8.3%.
- The risk-adjusted 2-year post-operative mortality rate was 19.4% which falls within the expected range. The 2014 figure was 22.8%.
- The risk-adjusted 90-day unplanned readmission rate was not submitted by the trust in the 2015 audit. The 2014 figure was 24.2%.
- The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 34% which lower than expected. The 2014 figure was 37%.
- Case ascertainment was 87% in the 2015 audit, a slight improvement on the 2014 figure of 86%, and was good compared to other participating hospitals although was below the England and Wales aggregate of 94%.
- In the 2015 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 1.6% for Abdominal Aortic Aneurysms, indicating that the trust performed within expectations. The 2013 figure was 3%.
- Within Carotid Endarterectomy, the median time from symptom to surgery was 19 days, worse than than the national standard of 14 days. The 30-day risk-adjusted mortality and stroke rate was 1.9% and within the expected range. The 2013 figure was 0%.
- Case ascertainment for both Abdominal Aortic Aneurysms and Carotid Endarterectomy had markedly dropped from the 2013 figures (42% from 87% and 37% from 88% respectively) and were worse than the audit aspirational standard of 90%.
- In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), the age, and sex adjusted proportion of patients diagnosed after an emergency admission was 9.9%. This placed the trust within the middle 50% of all trusts for this measure.
- The 90-day post-operative mortality rate was not reported for this trust in the audit.
- The proportion of patients treated with curative intent in the Strategic Clinical Network was 34.2%, significantly lower than the national aggregate.
- This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres); the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results
- Case ascertainment was between 81-90% and was better than the national aggregate.
- In the Patient Reporting Outcomes Measures (PROMS) from April 2015 to March 2016, the Hip Replacement (EQ VAS) and Knee Replacement (Oxford Knee Score) indicators showed more patients' health improving and fewer patients' health worsening than the England averages. Groin Hernia (EQ-5D Index) showed fewer patients' health improving than the England average although slightly fewer patients' health worsened than the England average. The remainder of indicators were in line with the England averages.

Competent staff

- The percentage and numbers for medical appraisals within the surgical division was 95% (106 out of 115) completion rate at consultant levels and 91% (49 out of 51) for trust doctors across both locations up to December 2016.

- WCHs electronic recording system highlighted that appraisals for nurse staffing had improved months on month with completion rates at 33% in September, 40% in October and 81.5 % (44 out of 54) in December 2016.
- Most staff we spoke with felt able to discuss their training needs with their line manager. Many discussed opportunities to further their career and stated they were encouraged to undertake modules appropriate to their training needs. However, some members of staff stated that opportunities were hindered due to work pressures and the need to undertake training in their own time.
- Support was provided for nursing revalidation by identifying expectations and continued education required.

Multidisciplinary working

- Protocols had been developed for the effective multidisciplinary handover of patients when needed. These involved the identification of bed availability, NEWS assessment and both verbal, electronic and written transfer of information.
- Therapists worked closely with the nursing teams on the ward where appropriate. Ward staff told us they had good access to physiotherapists and occupational therapists.
- Staff explained to us the wards worked with local authority services as part of discharge planning and weekend discharges requiring support were identified at pre-assessment so that appropriate equipment and support could be arranged.
- We observed staff, including those in different teams and services, becomes involved in assessing, planning and delivering people's care and treatment.
- There were established multi-disciplinary team (MDT) meetings for care pathways and these included nurses, nurse specialists, surgeons, anaesthetists, and radiologists.
- Ward staff worked closely with the patient, their family, allied health professionals, and the local authority when planning discharge of complex patients to ensure the relevant care was in place and that discharge timings were appropriate.
- There was pharmacy input on the wards during weekdays. We observed pharmacist involvement with patient care.

Seven-day services

- Patients received daily consultant ward rounds, including weekends.
- Theatres had 24 hour shift cover plus an on call.
- There was a dedicated physiotherapist and occupational therapists for each ward available Monday to Friday.
- There was limited access to physiotherapists and occupational therapist at the weekend and patients were prioritised by level of need and orthopaedic plan of care and treatment.
- There was no speech and language support service at the weekends.
- There were pharmacist's onsite Monday to Friday, 9am to 5pm. Out-of-hours medication prescribing was nurse led by trained ward sisters.

Access to information

- Risk assessments, care plans, and test results were completed at appropriate times during the patient's care and treatment. Records were available to staff enabling effective care and treatment.
- There were appropriate and effective systems in place to ensure patient information was co-ordinated between systems and accessible to staff.
- Staff had access to policies, procedures, and guidelines on the trust intranet system. All staff felt confident in accessing the information they required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust reported that as at 31 August 2016 Mental Capacity Act (MCA) training has been completed by 92% of staff in within surgery for Level 1 and 79% for Level 2.
- Deprivation of Liberty training had been completed by 81% of staff within surgery.
- We looked at clinical records and observed that patients had consented to surgery in line with the trust policy and Department of Health guidelines.
- Mental capacity assessments were undertaken by the nurse or Consultant responsible for the patient's care and Deprivation of Liberty Safeguards (DoLS) were referred to the trust's safeguarding team.
- MCA and DoLS assessments were included in risk assessments.
- We found policy and procedures in place, ensured that capacity assessments and consent was obtained by middle grade level medical staff or above. Elective

patients were informed about consent as part of their pre-assessment process and were given information regarding risks and potential complications. However, some patients consented on the day of procedure.
- There was access to an independent mental capacity advocate (IMCA) when best interest decision meetings were required.
- Mental health liaison support was available at the WCH.

Are surgery services caring?

Good

We rated caring as 'good' because:

- The Friends and Family Test response rate for surgery at the trust was 38% which was better than the England average of 29% between November 2015 and October 2016. WCH had a better response rate than the England average. Ward level recommendation rates were variable across the two sites although recommendation rates were generally high, being between 70-100% for the overall period across all participating wards.
- The 'Two minutes of your time' survey was used to elicit patient feedback on how likely patients were to recommend the hospital to family and friends, respect and dignity, involvement in care and treatment, cleanliness, kindness and compassion received. These indicators, from April 2015 to September 2016 gave overall scores (maximum 10) of between 9.44 and 10.
- The trust took part in the Patient Led Assessment of the care Environment (PLACE, 2015). The results showed the surgical division scored 90.38% for providing privacy and dignity for patients and 70% for dementia care.
- We observed the treatment of patients to be compassionate, dignified, and respectful throughout our inspection. Ward managers and matrons were available on the wards so that relatives and patients could speak with them as necessary.
- Each patient felt their privacy and dignity had been respected and they were happy with the quality of care they had received.
- Patients we spoke to said, "received and excellent service and in very good hands", "Impressed with improvements", "staff explained everything", and "I felt looked after".

Compassionate care

- The Friends and Family Test response rate for surgery at the trust was 38% which was better than the England average of 29% between November 2015 and October 2016. WCH had a better response rate than the England average. Ward level recommendation rates were variable across the two sites although recommendation rates were generally high, being between 70-100% for the overall period across all participating wards.
- In the Cancer Patient Experience Survey 2015 the trust was in the top 20% of trusts for three of the 34 questions, in the middle 60% for 23 questions and in the bottom 20% for eight questions. The trust performed in the top 20% for: patient did not think hospital staff deliberately misinformed them; patient never thought they were given conflicting information; and all staff asked patient what name they preferred to be called by.
- The 'Two minutes of your time' survey was used to elicit patient feedback on how likely patients were to recommend the hospital to family and friends, respect and dignity, involvement in care and treatment, cleanliness, kindness and compassion received. These indicators showed July scored 9.91, August scored 9.85, and September scored 9.72 (out of 10).
- The trust took part in the Patient Led Assessment of the care Environment (PLACE, 2015). The results showed the surgical division scored 90.38% for providing privacy and dignity for patients and 70% for dementia care.
- 'You said we did' was used to identify patient views. Patients said walls were plain and uninviting, so staff put pictures on the walls, patients said there were no clocks, so staff provided a clock in each room.
- Patients we spoke to said, "received and excellent service and in very good hands", "impressed with improvements", "staff explained everything", and "I felt looked after".
- Each patient felt their privacy and dignity had been respected and they were happy with the quality of care they had received.
- During inspection we observed patients being spoken to in an appropriate manner, information being shared in a method that they understood, and staff taking time to reassure and comfort patients.

Understanding and involvement of patients and those close to them

Surgery

- All patients said they were made fully aware of their surgical procedure and that it had been explained to them thoroughly and clearly.
- Patients said they felt involved in their care and had been given the opportunity to speak with the consultant looking after them.
- Patients told us staff kept them well informed, explained why tests and scans were being carried out and did their best to keep patients reassured.
- We saw that ward managers and matrons were visible on the wards so that relatives and patients could speak with them.
- As part of the elective surgery pre-operative assessment process, patients had the opportunity to bring relatives or friends along to the consultation should they so wish.
- Patients felt they were well educated, supported, and prepared for their surgical procedures.
- The trust offered a forget me not passport of care for every inpatient admission. This was completed by the families and carers, telling the staff how to care for the person in their unique way, offering individual detail to give that personalised approach.
- There was a dementia lead nurse on each ward who undertook assessment, provided guidance, and support. There was access to psychiatric liaison team who supported with dementia, delirium, depression, and anxiety.

Emotional support

- Patients reported that staff spent time with them and staff recognised the importance of time to care and support patients emotional needs. Care plans highlighted the assessment of patients emotional, spiritual, and mental health needs.
- We were given information about support groups for patients. These included the local head and neck cancer support groups, and counselling clinics for the National Bowel Cancer Screening Programme take place on both main hospital sites.
- A chaplaincy service was available within the hospital to help patients, visitors, and staff to respond to their spiritual and emotional needs. This includes pastoral and spiritual care for people regardless of their religious connections. The Infirmary chapel and quiet room were available day and night, as places for quiet reflection and private prayer.
- Clinical psychology support services commissioned by the trust supported patients as necessary. For example support was routinely provided for amputee patients and those requiring stomas.
- Staff were aware of the impact that a person's care, treatment or condition may have on his/her wellbeing, both emotionally and socially.

Are surgery services responsive?

Requires improvement

We rated responsive as 'requires improvement' because:

- A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice. For the period Q2 2014/15 to Q1 2016/17 the trust cancelled 1,410 elective surgeries. Of these, 12% were not treated within 28 days. The overall trend is that the trust has a much higher percentage of operations not treated within 28 days compared to the England average. Performance improved from Q1 2015/16 to Q3 2015/16 however performance deteriorated again from Q4 2015/16 and is showing signs of deteriorating further.
- Cancelled operations as a percentage of elective admissions includes all cancellations rather than just short notice cancellations. Cancelled operations as a percentage of elective admissions for the period Q2 2014/15 to Q1 2016/17 at the trust were consistently greater than the England average. The trust trend has followed a similar pattern to the England average, although the peaks and troughs are far more pronounced, particularly the increase in Q3 2015/16.
- For the period November 2015 to November 2016 WCH cancelled 292 elective surgeries for non-clinical reasons.
- Four Surgical specialties were below the England average for admitted RTT (percentage within 18 weeks). Ophthalmology showed the poorest performance compared to the England average, with a marked

deterioration in June and July 2016 when the percentage within 18 weeks was 24.4%. This speciality improved in August to 29.6% but remains notably below the England average of 77.5%.
- An action on the quality improvement plan stated that the division aimed to achieve compliance with 18 week referral to treatment for the incomplete pathway standard by September 2016. The status of this action remained in progress as of December 2016.
- At trust level, general surgery had a longer average length of stay than the England average for both elective and non-elective admissions. Average length of stay for Trauma and Orthopaedics had contrasting performance, with elective admissions being shorter than the England average (2.9 days compared to 3.5) and non-elective being longer than the England average (9.3 compared to 8.8 days). Compared to the trust level, average length of stay at Cumberland Infirmary was longer for both elective non-elective admissions (at 2.5 and 5 days respectively).

However:

- The trust was actively working with commissioners to provide an appropriate level of service based on demand, complexity and commissioning requirements.
- The hospital had an escalation policy and procedure to deal with busy times and matrons and ward managers held capacity bed meetings to monitor bed availability.
- Complaints were handled in line with the trust policy, and discussed at all monthly staff meetings. This highlighted that training needs and learning was identified as appropriate.
- Patients or relatives making an informal complaint were able to speak to individual members of staff or the ward manager. Contact details for the Patient Advice Liaison Service and Complaints is clearly listed. Wherever possible the patient Advice Liaison Service (PALS) would look to resolve at a local level.

Service planning and delivery to meet the needs of local people

- The trust was actively working with Cumbria Clinical Commissioning Group (CCG) to provide an appropriate level of service based on demand, complexity, and commissioning requirements.
- The Patient Panel (an independent voluntary group) assists the trust in providing improved communication and information between patients, relatives, carers, staff, and the trust board to help improve service provision. Members review and make suggestions for ways and means of improving the quality and accessibility of services.
- North Cumbria University Hospitals maintain links with the Overview and Scrutiny Committee (OSC) which provides the checks and balances that ensure that decisions are made, which reflect the needs of the people of Cumbria, and is part of the county council's governance arrangements.
- The trust maintain links with Healthwatch Cumbria which is an independent organisation set up to champion the views of patients and social care users in Cumbria, with the goal of making services better and improving health and wellbeing.

Access and flow

- Between April 2015 and March 2016 the average length of stay for surgical elective patients at the trust was 2.3 days, compared to 3.3 days for the England average. For surgical non-elective patients, the average length of stay was 4.8 days, compared to 5.1 for the England average.
- At trust level, general surgery had a longer average length of stay than the England average for both elective and non-elective admissions. Average length of stay for Trauma and Orthopaedics had contrasting performance, with elective admissions being shorter than the England average (2.9 days compared to 3.5) and non-elective being longer than the England average (9.3 compared to 8.8 days)
- Compared to the trust level, average length of stay at WCH was longer for both elective non-elective admissions (at 2.5 and 5 days respectively). WCH was the reverse with shorter lengths of stay for both admission types than the trust level, although this site showed greater differences compared to the England average.
- The trust's referral to treatment time (RTT) for admitted pathways for surgery has been consistently worse than the England overall performance since September 2015. The latest figures for August 2016 showed that 59.4% of this group of patients were treated within 18 weeks versus the England average of 73.9%. Trust performance has been relatively steady over the time period, although there has been a slight decline in performance from May 2016.

Surgery

- Two surgical specialties were above the England average for admitted RTT (percentage within 18 weeks) these were ENT and general surgery.
- Four surgical specialties were below the England average for admitted RTT these were ophthalmology, oral surgery, trauma & orthopaedics, and urology. Ophthalmology showed the poorest performance compared to the England average, with a marked deterioration in June and July 2016 when the percentage within 18 weeks was 24.4% and 8.9%. This speciality has improved in August to 29.6% but remains notably below the England average of 77.5%).
- A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice. For the period Q2 2014/15 to Q1 2016/17 the trust cancelled 1,410 elective surgeries. Of these, 12% were not treated within 28 days. The overall trend is that the trust has a much higher percentage of operations not treated within 28 days compared to the England average. Performance improved from Q1 2015/16 to Q3 2015/16 however performance deteriorated again from Q4 2015/16 and is showing signs of deteriorating further.
- Cancelled operations as a percentage of elective admissions includes all cancellations rather than just short notice cancellations. Cancelled operations as a percentage of elective admissions for the period Q2 2014/15 to Q1 2016/17 at the trust were consistently greater than the England average. The trust trend has followed a similar pattern to the England average, although the peaks and troughs are far more pronounced, particularly the increase in Q3 2015/16.
- For the period November 2015 to November 2016 WCH cancelled 292 elective surgeries for non-clinical reasons.
- Capacity bed meetings were held twice daily to monitor bed availability, review planned discharges and assess bed availability throughout the trust.
- Theatre utilisation at WCH ranged from 17.5% to 81.8% during the period June 2016 to August 2016. Theatre 6 had the lowest average utilisation during the period at 22.9% while Theatre 4 (Ortho) had the highest (62.7%)
- Overall average utilisation rates trust-wide have decreased over the three month period, from 64.1% in June to 56.6% in August 2016.

Meeting people's individual needs

- Surgical teams' personalised patient care in line with patient preferences, individual and cultural needs.
- Ward information boards identified who was in charge of wards for any given shift and who to contact if there were any problems.
- Leaflets were available for patients regarding their surgical procedure, pain relief, and anaesthetic. Alternative languages and formats were available on request.
- There was good access to the wards. There were lifts available in each area and ample space for wheelchairs or walking aids.
- The surgical division applied the 'This is me' personal patient passport / health record to support patients with learning needs and dementia. Symbols on files identified special requirements such as dementia.
- The psychiatric liaison team were available for patients displaying confusion, delirium, and undiagnosed dementia as part of the National Commissioning for quality and Innovation(CQUIN), which also identified diagnosis of dementia using specific admission documentation. If confusion or forgetfulness was evident but there was no confirmed diagnosis of dementia a cognitive assessment was carried out by nurses on the surgical ward and appropriate referral is made for diagnosis.
- Support needs were identified through the Butterfly Scheme; it encouraged family and carers to be involved in providing important information about the patient.
- There were no mixed sex accommodation breaches over the last 12 months on any surgical ward at WCH.
- Specific equipment had been designed for the use of bariatric patients to ensure safety for both staff and patients. Requests were made when further equipment was required.
- The Patient Advice and Liaison Serviceassist with the provision of interpreters. Sign language interpreters can also be provided for patients with hearing or speech-impairment who require a qualified communicator 24 hours per day.

Learning from complaints and concerns

Surgery

- Between September 2015 and August 2016, there were 69 complaints related to surgical care across both the Cumberland Hospital and WCH. There was an average of six complaints per month and trend analysis shows that the number of monthly complaints remained consistent. The highest number of complaints for the Trauma & Orthopaedic department (32 complaints).
- The Trust had a 30 working day response timeframe with a 95% compliance requirement. The Trust has seen a systematic increase from April 2016 in response rates, achieving full 95% compliance in the first two months of Q2 2016/17.
- Ward meetings discussed complaints received as a standing agenda item.
- We reviewed complaints and compliments were discussed. We saw evidence of audit activity and learning from complaints and clinical risk management issues.
- All wards and departments had posters situated at the entrance clearly explaining what to do if anyone is unhappy with the care, services, or facilities we provide. Contact details for the Patient Advice Liaison Service and Complaints is clearly listed. Wherever possible the patient Advice Liaison Service (PALS) would look to resolve at a local level.
- Patients or relatives making an informal complaint were able to speak to individual members of staff or the ward manager. Themes of complaints were discussed with staff, who were encouraged to share learning to prevent recurrence.
- Ward staff were able to describe complaint escalation procedures, the role of PALS and the mechanisms for making a formal complaint.

Are surgery services well-led?

Good

We rated well-led as 'good' because:

- We met with senior trust and divisional managers who had a clear vision and strategy for the division and identified actions for addressing issues within the division. The divisional leadership team detailed their understanding of the challenges associated with providing good quality care and identified actions needed.
- The trust had developed a quality Improvement Plan (QIP) to ensure implementation of its Clinical Strategy, Nursing, Midwifery, and Allied Health Professionals (AHP) Strategy. Within the QIP the trust had identified specific objectives to improve the management of the deteriorating patient, the recognition, and initiation of treatment for patients with sepsis and ongoing development of the Mortality and Morbidity Framework.
- The division had also developed a Perioperative Quality Improvement Plan in response to recent issues identified within surgery. This aimed to enhance governance through learning from events and incidents, develop the workforce through a positive learning environment, and initiate external assessment and compliance.
- Regular divisional, emergency surgery and elective care business unit, safety and quality group and the clinical leads for National safety Standards for Invasive Procedures (NatSSIPS) meetings were held.
- There was a systematic programme of clinical and internal audit, which was used to monitor quality and systems to identify where action should be taken. Monthly audits were undertaken and audit outcomes were published quarterly.
- The division's risk register was updated following the safety and quality meetings with risks discussed, controls identified, with progress against mitigation, risk grading, assurance sources, and gaps in control documented.
- An integrated performance report which gave progress updates on the emergency surgery and elective care improvement plan was presented to the trust board at each meeting. An example of actions identified highlighted the implementation of additional clinical sessions to improve compliance against national standards for referral to treatment.

However:

- At the time of inspection the Perioperative Improvement Plan was in the early stages of implementation, impacting upon some areas but not yet fully embedded within the division. Although most staff were aware of the plan, they could not articulate specific outcomes.
- Staff morale was variable on the wards, theatres and recovery areas. Morale was affected by working in difficult circumstances during the last eighteen months to cover staff and skill shortages.

- We were advised of ongoing bulling allegations within the theatre departments.

Vision and strategy for this service

- We met with senior trust and divisional managers who had a clear vision and strategy for the division and identified actions for addressing issues within the division.
- The trust vision and strategy was displayed in wards and staff were able to articulate to us the trust's values and objectives across the surgical division.
- Staff demonstrated the values of the trust during the inspection, were clear about the trust vision, and understood their roles in contributing to achieving the trust-wide and directorate goals.
- The trust had developed a quality Improvement Plan (QIP) to ensure implementation of its Clinical Strategy, Nursing, Midwifery, and Allied Health Professionals (AHP) Strategy.
- Within the QIP the trust had identified specific objectives to improve the management of the deteriorating patient, the recognition, and initiation of treatment for patients with sepsis and ongoing development of the Mortality and Morbidity Framework.
- The division had also developed a Perioperative quality Improvement Plan in response to recent issues identified within surgery. This aimed to enhance governance through learning from events and incidents, develop the workforce through a positive learning environment, and initiate external assessment and compliance.
- The plan also identified initiatives for improvements in booking and scheduling, performance, information and reporting, reductions in sickness absence, patient, and public involvement and the implementation and monitoring of National safety Standards for Invasive Procedures (NatSSIPS).

Governance, risk management and quality measurement

- An Integrated performance report which gave progress updates on the emergency surgery and elective care improvement plan was presented to the trust board at each meeting. An example of actions identified was additional clinical sessions to improve compliance against national standards for referral to treatment.
- Regular divisional, emergency surgery and elective care business unit, safety and quality group and the Clinical Leads for National safety Standards for Invasive Procedures (NatSSIPS) meetings were held.
- We reviewed agendas and minutes and these showed that serious and clinical incidents, guidelines and standard operating procedures. We saw some evidence of audit activity and lessons learned.
- There was a systematic programme of clinical and internal audit, which was used to monitor quality and systems to identify where action should be taken. Monthly audits were undertaken and audit outcomes were published quarterly.
- The division's risk register was updated following these meetings and when needed. Risks were described, controls identified, with progress against mitigation, risk grading, assurance sources, gaps in control and assurance and dates of review documented.
- Risks identified included, for example, theatre overruns, staffing, compliance with national targets and guidelines; cost improvement plans and ward capacity. Action plans were monitored across the division and sub-groups were tasked with implementation.
- Additionally, the division had commissioned a programme of 'Human Factors' awareness training designed to increase awareness of the individual's role and impact in procedures. The programme was part completed at the time of inspection.

Leadership of service

- We held meetings with the divisional leadership team who detailed their understanding of the challenges associated with providing good quality care and identified actions needed.
- The team had identified specific strategies and initiatives to meet the challenges within the division and had developed the perioperative quality improvement plan to facilitate improvements.
- At the time of inspection the plan was in the early stages of implementation, impacting upon some areas but not yet fully embedded within the division. Although most staff were aware of the plan, they could not articulate specific outcomes from the plan. We saw improvement since the inspection in September 2016.
- Senior staff were motivated and enthusiastic about their roles, and they had clear direction with plans in relation to improving patient care. Senior managers and clinical leads showed knowledge, skills, and experience.

- Staff said service leads and managers were available, visible within the division, and approachable; staff we spoke with told us that leadership of the service was better but required further improvement. Clinical management meetings were held and involved service leads and speciality managers.
- Monthly speciality meetings were held and discussed financial and clinical performance, patient safety, and operational issues.
- The senior leadership team were fully aware that there were particular difficulties within the division and these were 'being tackled'. Specific issues identified that were on the risk register were:
  - the referral to treatment rate within 18 weeks for admitted patients
  - the percentage of patients whose operations were cancelled and not treated within 28 days
  - Inability to recruit permanent anaesthetic staff to maintain sustainable anaesthetic care model for clinical strategy
  - Theatre overruns with multiple theatres finishing late resulting in no theatre staff available for emergency theatres CIC.

Culture within the service

- We interviewed staff on an individual and group basis throughout wards, units, and theatres. They told us the division had improved leadership and most senior managers were visible and 'hands on'. This reflected the vision and values of the division and the trust.
- Staff spoke positively about the service they provided for patients and high quality compassionate care was a priority.
- Nursing staff stated that they were supported by their managers and they could access one-to-one meetings which were mostly informal, as well as more structured meetings and forums.
- Medical staff stated that they were supported by colleagues and confirmed they received feedback from governance and action planning meetings.
- There was an acknowledgement that the trust had plans in place to increase staffing levels and develop effective recruitment and retention plans. However, some staff told us they had been working in difficult circumstances during the last eighteen months to cover staff and skill shortages.
- The numbers of shifts not staffed to establishment across most surgical wards and areas, caring for medical 'outliers' and the high acuity and needs of patients supported the view expressed by staff that they were working under pressure within the division.
- Although staff were enthusiastic about their work, the service they provided, and, generally, the organisation they worked for, staff morale was variable and not always high on wards, in theatres, and in recovery areas. Staff explained that morale had been difficult to maintain despite recognised leadership support and effective team working. Ongoing pressures had left some staff feeling exhausted and consequently undervalued and not always listened to by senior staff.
- Most staff described good teamwork within the division and we saw staff worked well together. We saw examples of good team working on the wards between staff of different disciplines.
- We were advised of ongoing bulling allegations within the theatre department. Where we assured that appropriate action plans were in place and being monitored.

Public engagement

- People using the service were encouraged to give their opinion on the quality of service they received. Leaflets about the friends and family test, PALS and Two Minutes of Your Time, Tell us what you think questionnaires were available on all ward and reception area. Internet feedback was gathered along with complaint trends and outcomes.
- Ward managers were visible on the ward, which provided patients the opportunity to express their views and opinions.
- Discussions with patients and families regarding decision making was recorded in patient notes.
- All staff spoken to were clear about their roles and responsibilities, were patient focused, and worked well together.
- The Friends and Family Test response rate for surgery at the trust was 37% which was better than the England average of 29% between September 2015 and August 2016. The recommendation rate was between 70% - 100%.

- The 'Two minutes of your time' survey was used to elicit patient feedback on how likely patients are to recommend the hospital to family and friends, respect and dignity, involvement in care and treatment, cleanliness, kindness and compassion received.
- These results were supported through discussions with patients during our inspection. Patients were complimentary about the care and treatment that they received at the hospital and were very supportive of the services provided.

Staff engagement

- All staff were invited to attend regular forums with the chief executive, at which they were able to voice their opinions, listen to updates, and discuss any concerns. Several staff members stated these forums were difficult to attend due to staff shortage on the wards.
- We saw that senior managers communicated to staff through the trust intranet, e-bulletins, team briefs, and internal campaigns. Each ward held monthly staff meetings, which discussed key issues for continuous service development.
- All staff were invited to attend regular forums with the chief executive where they were able to voice their opinions, listen to updates and discuss any concerns. Several staff members stated these forums were difficult to attend due to staff shortage on the wards.

Innovation, improvement and sustainability

- National Patient safety awards finalist for better outcomes in orthopaedics.
- Trauma reorganisation was in progress across the hospital sites. Centring at CIC, with outpatient services built up at WCH.
- The trust had been a National Patient Safety Awards finalist for 'better outcomes'.
- The trust had the only surgeon between Leeds and Glasgow doing a meniscal augment in the knee.
- Honorary Professorship University of Cumbria received by a consultant for work on applying digital technologies in Health Care for elderly population in rural setting, a part of CACHET.
- Multinational multicentre prospective study in the use of intramedullary nail in varus malalignment of the knee. The trust had the largest international experience of this technology for this application.
- One stop general surgery clinic established (Pre-assessment and booking date for surgery at same visit)
- Joint/parallel clinics were set up with community surgeons in community hospital.
- Telephone advice clinics were in place for patients.
- The trust gained In-house Royal College of Surgeons accredited START surgery course for foundation doctors in surgery.
- Development of emergency ambulatory care in surgery.
- Equality and diversity surgery nurse raising awareness of the needs of transgender patients.

Critical care

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

Information about the service

The North Cumbria NHS Foundation Trust (NCFT) provides critical care services in the Cumberland Infirmary in Carlisle (CIC) and the WCH (WCH) in Whitehaven. For the purposes of governance the unit sits in the surgical and anaesthetic division. The unit is part of, and works closely with, the North of England and Cumbria Critical Care Network (NoECCCN).

The trust has a total of 15 adult critical care beds and the Intensive Care National Audit and Research Centre (ICNARC) data indicates that there are around 1150 admissions a year, with 300 at the WCH site. Across two sites there are eleven 'intensive care' (ITU) beds, for complex level 3 patients, who require advanced respiratory support or at least support for two organ systems; and four 'high dependency' (HDU) beds, for level 2 patients who require very close observation, pre-operative optimisation, extended post-operative care or single organ support and this includes care for those 'stepping down' from level 3 care. Beds are used flexibly with the resources to increase and decrease the numbers of either ITU or HDU admissions.

The focus of this report is the critical care unit at WCH, which can flexibly admit four level 3 and two level 2 patients into six single rooms. The service provides intensive and high dependency care for patients, predominantly admitted from the medical speciality since the reconfiguration of major elective surgical services and all emergency surgery was moved to Carlisle. The unit did admit small numbers of paediatric admissions, who had short stay for stabilisation prior to transfer to specialist hospitals outside of the trust.

During inspection our team spoke with 12 members of staff. We spoke with three patients and four relatives. We observed care, reviewed policy and documentation and checked equipment. We were able to review a range of performance data during the inspection.

Critical care

Summary of findings

During our last inspection of critical care services at WCH, in July 2015 we rated good overall, We have rated the service as 'good' overall after a comprehensive announced and unannounced inspection visit in December 2016, with evidence of ongoing improvement in the unit:

- There was ongoing progress towards a harm free culture. Staff we spoke with understood the incident reporting system and improvement in reporting culture had been noted by the critical care team. There was a proactive approach to the assessment and management of patient - centred risks and staff had a good understanding of the trust position related to learning from incidents, serious incidents and Never Events. The number of pressure sores recorded in the incident reporting system had shown significant improvement since our last inspection and staff reporting of pressure ulcer grading and level of harm was good.
- There had been zero Never Events in critical care and zero reportable serious incidents at the WCH site. There had been ten NRLS reported incidents and themes were monitored closely by grade and seriousness of harm.
- A 24/7 Critical Care Outreach Team (CCOR) was well established. We observed good practice for recognition and treatment of the deteriorating patient. One hundred percent of patients received follow up once discharged from the unit. Practice was in line with GPICS (2015), NICE CG50 and against the seven core elements of Comprehensive Critical Care Outreach, (C3O 2011) 'PREPARE'; 1. Patients track and trigger, 2. Rapid response, 3. Education and Training, 4. Patient safety and governance, 5. Audit and evaluation (monitoring patient outcome), 6. Rehabilitation after critical illness and 7. Enhancing service delivery.
- Medical staff we spoke with discussed good anaesthetic staffing levels and continuity for rotas and out-of-hours cover. Use of locum consultant staff at WCH for anaesthetic cover was lower than CIC (35%) at 9.4% for 2015/16. The demands of the service were very different since the move of major surgery to CIC and this was reported as having an impact on recruiting new anaesthetic staff to the unit.
- The policy and activity around critical care patient transfer to other hospitals when required were good. The arrangements for the small numbers (seven in 2015/16) of paediatric admission for stabilisation for hours prior to transfer were also good, to include levels of staff training and competence and storage and checking of essential equipment. The unit were part of the 'North East Children's Transport and Retrieval' (NECTAR) new transport service.
- The emergency resuscitation equipment and patient transfer bags for both adults and children were checked daily with a good system in place as per trust policy. There was good provision of equipment in critical care, good storage and robust systems for medical device training.
- The unit was visibly clean, spacious and met Department of Health Building Note HBN-04.02 standards for new build units; standards of infection prevention and control were in line with trust policy. All patient rooms were large single isolation rooms as the unit was modern in design and opened in September 2015 as part of the new hospital build plan since our last inspection.
- The team in the unit had invested in, and implemented an electronic patient record and prescription system specific to intensive care which we observed to be comprehensive and well understood by staff. All records checked in the system were complete and risk assessment, patient review and prompt systems and processes were good.
- Patients were at the centre of decisions about care and treatment. We reviewed consistent positive survey feedback and comments which gave evidence of a caring and compassionate team. There was also evidence of well-attended nurse led support groups for patients in the local community. Staff whom we observed and spoke with were positive, motivated, and delivered care that was kind, promoted dignity,

and focused on the individual needs of people. The improvements made towards the rehabilitation of patients after critical illness since our last inspection were comprehensive.

- The team in critical care services spoke highly of their local leadership and felt supported by matrons, consultants and senior matrons. A culture of listening, learning and improvement was evident amongst staff we spoke with in the unit. Staff whom we spoke with across the team were positive about their roles. Governance arrangements were clear to the staff especially in view of reporting frequent changes in the senior team over the past five years. Staff expressed that they wanted a period of stability in the senior and executive team.
- We found that ICNARC data showed that patient outcomes were comparable or better than expected when compared with other units nationally, this included unit mortality. ICNARC data had been collected and submitted consistently at WCH. The data was available to the team and, during inspection, we were able to review consistent annual reports; however we reported to the critical care team that, although data had been published on the ICNARC website, it related to only one unit. Staff we spoke with were not aware of this, and they could not explain why data was not published for both units.
- Plans were in place to provide multidisciplinary follow up clinics across both units for rehabilitation of patients after critical illness, as recommended by NICE CG83 and GPICS (2015). These were for those patients who had experienced a stay in critical care of longer than four days. A small dedicated team was being led by the matron and senior physiotherapist and a health care assistant was recruited to deliver this standard and progress was good. Support groups had been well attended in the local community with staff organising a range of supportive and educational opportunities. The use of patient diaries had been embedded in practice.
- Patients received timely access to critical care treatment and consultant led care was delivered 24/7. Readmissions to the unit were monitored closely by the Consultant and CCOR team and were below National average. There was good evidence of analysis of reasons for readmission and we reviewed a summary of cases with no significant trends. Minimum numbers of patients were not transferred out of the unit for non-clinical reasons. We found that patients were not cared for outside of the critical care unit when Level 2 or 3 care was required, and we did not see examples of critical care outliers in theatre recovery or ward areas.
- Patients in the critical care unit were discharged to wards within 8 hours once a decision to discharge was made as per GPICS (2015). ICNARC data indicated a position that comparable with the national performance against this target. There was good performance for patients discharged within 4 hours of the patient being ready for discharge. There were no incidents of single sex breaches.
- We spoke with senior staff about concerns with nurse staffing levels and the actual and potential impact on safety and staff morale created by the increase in long term sickness levels. Senior staff responded to our concerns with evidence of plans to ensure safe staffing levels and escalated recruitment plans for Band 6 and band 5 nurses. This included temporary bed closure and close monitoring of activity. Escalation policies were reissued to staff. This gave assurance that the senior team were supportive and managing the escalation of this short term staffing pressure.

However:

- During our inspection we found that it was difficult to maintain nurse staffing levels in the unit due to a recent significant increase in long term sickness levels in the unit. We observed that there had been occasions were there had not been sufficient numbers of staff to provide 1:1 nursing for Level 3 patients, in line with intensive care standards. We escalated concern to senior staff during the inspection around this issue, and in addition: the impact of staff sickness and increased risk to patient safety, by the lack of supernumerary coordinator, in line with GPICS (2015), and the reduced visibility by nursing staff to/from each single room. A comprehensive action plan was produced by the trust after an unannounced visit which provided

Critical care

further assurance that these issues were being closely monitored and managed. Nurse staffing had been good prior to September 2016 with sufficient staffing levels for provision of critical care standards.

- The CCOR team had been moved frequently to support shortfalls in staffing in other wards and departments. We spoke with staff who felt that this presented a risk to patient safety across the trust when they were unable to provide a CCOR service. It had affected the morale of team however we did not see evidence or incident at the time of inspection that patient care or safety had been compromised i.e.; increased readmission rates or late admissions to critical care. Staff we spoke with told us that more recently senior support had changed and improved. Protection of the CCOR cover had been prioritised since September 2015 and since the unit restructure under the Surgical and Anaesthetic directorate.
- There was no supernumerary clinical educator in the unit, in line with GPICS (2015). Staff provided support for training however it was recognised that the sickness in the senior, experienced team may impact on the team's ability to provide training and support to junior staff.
- The critical care pharmacist provision was well below GPICS (2015) standards. We spoke with staff in the unit who did not report any issues with management of medicines and pharmacy support, however pharmacists were not able to fulfil the critical care role, join ward rounds or deliver improvements in practice with only 0.2 WTE dedicated hours.
- Discharges out-of-hours, between 22.00 hrs and 06.59 hrs have been proven to have a negative effect on patient outcome and recovery. Critical care discharges out-of-hours were reported as 2.8% in 2015/16, against a national average of 2.0% as reported by ICNARC for 2015/16.

Are critical care services safe?

Good

We rated safe as 'good' because :

- There was ongoing progress towards a harm free culture. Incident reporting was understood by the staff we spoke with and improvement in reporting culture had been noted by the critical care team. There were low numbers of incidents in critical care and evidence of good reporting culture. The number of pressure sores recorded in the incident reporting system had shown significant improvement since our last inspection and staff reporting of pressure ulcer grading and level of harm was good.
- There was a proactive approach to the assessment and management of patient-centred risks and staff had a good understanding of the trust position related to learning from serious incidents and Never Events. Staff we spoke with took responsibility for driving improvement to reduce risk of patient harm or acute deterioration. We observed examples of good practice around patient nasogastric tube insertion and feeding as a result of learning from incidents.
- A CCOR team was well established and covered 24/7. We observed good practice for recognition and treatment of the deteriorating patient. One hundred percent of patients received follow up once discharged from the unit. Practice was in line with GPICS (2015), NICE CG50 and against the seven core elements of Comprehensive Critical Care Outreach, (C3O 2011) 'PREPARE'; 1. Patients track and trigger, 2. Rapid response, 3. Education and Training, 4. Patient safety and governance, 5. Audit and evaluation (monitoring patient outcome), 6. Rehabilitation after critical illness and 7. Enhancing service delivery.
- The approach to transfer of the critically ill patient was very good and monitored closely with training provided for staff. The arrangements for stabilisation and transfer of seven paediatric patients in the unit in 2015/16 were also comprehensive and consistent across both units.
- Consultants were all experienced in critical care and there was a consultant clinical lead. Medical staffing rotas offered continuity for patient care and we observed good multidisciplinary (MDT) handovers and consultant led ward rounds. Consultant to patient ratios

were in line with GPICS (2015). Staff we spoke with were positive about working in the unit. There were good processes in place for multidisciplinary mortality and morbidity review and cardiac arrest audit as part of the surgical and anaesthetic directorate and trust governance structure.

- The unit was visibly clean and equipment and stores were very well organised. We observed staff adhering to infection prevention and control policy without exception. There were good processes in place for decontamination of equipment, equipment training and provision of domestic services.
- During inspection we observed that medicines management was good and controlled drugs and medicines were stored securely in the unit. All clinical fridges had the correct recording of temperatures as per policy and national standards for pharmacy. Medicines and antimicrobial audits and monitoring of incidents were performed by the pharmacy team, microbiologist and senior nursing staff.
- Critical care had developed an electronic patient record. We reviewed five care records in the electronic patient record system. The team was familiar with the system, and staff we spoke with were positive about using it. Good processes were in place to be able to transfer patient information to paper for discharges and transfers. Entries in the records were complete and in line GPICS (2015) and professional General Medical Council (GMC) and Nursing and Midwifery Council (NMC) standards. All patients' notes that we observed had received a daily review, and treatment plans were documented.
- Mandatory training provision was organised and staff attendance was good overall with 88% and a plan to achieve the trust targets of 80% attendance in most areas across 2016/17. This included achievement of the target of 95% for safeguarding training to protect vulnerable adults and children and staff had good understanding of safeguarding for both adults and children. There was an increased priority given to level two and three child safeguarding training and paediatric resuscitation training in view of the paediatric admissions to the unit.

However:

- During our inspection we found that the team were finding it difficult to maintain nurse staffing levels in the unit due to a recent significant increase in long term sickness levels in the unit. We observed that there had been occasions were there had not been sufficient numbers of staff to provide 1:1 nursing for a long-term level 3 patient in line with intensive care standards. We escalated concern to senior staff during the inspection around the impact of a recent spike of 12% in staff sickness, which increased potential risk to patient safety. WE also highlighted the lack of a supernumerary coordinator in line with GPICS (2015) and the limitations and pressure on nursing staff who were observing patients in single rooms. A comprehensive action plan was produced by the trust after an unannounced visit which provided further assurance that these issues were being closely monitored and managed. Nurse staffing had been good prior to September 2016 with sufficient staffing levels for provision of critical care standards.
- The CCOR team had been moved frequently to support shortfalls in staffing in other wards and departments. We spoke with staff who felt that this had presented a risk to patient safety across the trust when they were unable to provide a CCOR service. It had affected the morale of team however we did not see evidence or incident at the time of inspection that patient care or safety had been compromised i.e. increased readmission rates or late admissions to critical care. Staff we spoke with told us that more recently senior support had changed and improved. Protection of the CCOR cover had been prioritised since September 2016 and since the unit restructure under the Surgical and Anaesthetic directorate.

Incidents

- Staff we spoke with had a good understanding of the incident reporting system and trust policy. Learning from incidents was shared across the team in meetings and daily safety communications. There was good understanding of duty of candour amongst all staff we spoke with, however zero incidents that had triggered the duty in 2015/16 in WCH. The duty of candour is a legal duty on healthcare providers that sets out specific requirements on the principle of being open with patients when things go wrong.
- Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and

should have been implemented by all healthcare providers. Between October 2015 and September 2016, the trust reported no incidents which were classified as Never Events for critical care services.

- In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SI) in critical care services (WCH) which met the reporting criteria, (pressure ulcer) set by NHS England between October 2015 and September 2016.
- We reviewed the National Reporting and Learning System (NRLS) incidents between May 2016 and August 2016. There were 86 incidents attributed to critical care across both hospital sites, with 27 at the WCH unit. All incidents were reported in the following categories; negligible (n7), minor (n10), moderate (n8), major (n2). There were no specific trends to reported incidents but we did note good reporting detail and information about staffing issues.
- We observed that incidents were discussed in multi-professional meetings and in a team communication log, to share learning as needed and document actions. This demonstrated a commitment to developing an open and transparent safety culture in critical care and across the trust.
- Mortality and morbidity review took place as part of the surgical and anaesthetic directorate governance meeting agenda. Staff we spoke with told us that meetings took place regularly for review of all deaths and alternate monthly themes were discussed in the directorate audit meeting. We saw evidence of Cardiac Arrest audit findings being reviewed as part of the meeting. Grading of cases adhered to National Confidential Enquiry into Patient Outcome and Death (NCEPOD) guidance. The meeting was open to the MDT.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harm-free care. This focuses on four avoidable harms: pressure ulcers, falls, catheter associated urinary tract infections (CAUTI) and blood clots or venous thromboembolism (VTE).
- Avoidable patient harm incidents were reported as follows in 2015/16; two falls, one CAUTI, zero VTE and three pressure ulcers in WCH critical care across all four reportable areas.
- The unit displayed performance information on the 'Quality Board' at the entrance to the unit. The display included a range of information and all the measures of harm, including associated audit activity.
- The number of pressure sores recorded in the incident reporting system had shown significant improvement since our last inspection and staff reporting of pressure ulcer grading and level of harm was good.
- We observed good practice in critical care for completion of VTE risk assessments on admission and prescription of prophylaxis. There were zero reported incidents for 2015/16 in critical care.

Cleanliness, infection control and hygiene

- According to the data published by the Intensive Care National Audit and Research Centre (ICNARC) the unit performance (0.0) was better than similar units (1.0) for unit-acquired infections in the blood. Unit acquired methicillin-resistant staphylococcus aureus (MRSA) and clostridium difficile infection rates were zero. There was ongoing monitoring of sepsis admission activity to the unit which was also submitted to ICNARC.
- The clinical environment was visibly clean, equipment and stock was stored appropriately. The six bed spaces were all single room with one isolation room in the unit with appropriate design and positive and negative air exchange for infection prevention and control.
- Staff had access to trust infection prevention and control policies. We observed good compliance with hand hygiene by all nursing staff, with good access to sinks in the unit. We observed staff using alcohol hand gels. Uniform and 'bare below the elbows' policy was observed to be good and staff use of personal protective equipment (PPE), whilst caring for patients was also good.
- Standards of infection prevention and control practice were monitored by senior staff. Hand hygiene, environmental cleanliness, mattress audit, cannula commode cleaning and infection data showed consistently good standards in critical care, with 100% compliance in most areas, this information was displayed on 'Quality Boards' and discussed with staff in team meetings.
- The consultant microbiologist attended the unit daily and reviewed patients as part of the consultant led ward round. Microbiology also performed relevant audit.

Environment and equipment

- The unit had six single rooms and was modern and spacious in design. It had opened in September 2015 as part of the new hospital build plan since our last inspection. There was a central nurse's station and some restrictions to visibility from that point of the door to each room and through windows but only at times when it was possible to have curtains and doors open. We observed that it was difficult to observe patients in the bed spaces due to the single room design. Staff we spoke with said this was challenging, especially in view of the current staffing issues.
- The unit was accessed securely from a corridor with good display of information for patients and staff on noticeboards. There was access to a spacious visitors' room and facilities.
- We checked 32 pieces of adult and paediatric equipment and found all to be clean with appropriate labelling and safety checks. We checked blood gas monitoring and point of care equipment and found all to be clean, with good maintenance systems in place.
- Patient bed spaces were noted to be the recommended 25.5 m2 (Department of Health, Health Building Note - HBN 04-02, 2013) for a new build intensive care unit. The bed space size we observed, gave sufficient clear floor space to allow room for visitors, staff and equipment brought to the bedside. We observed patients with the larger purpose design chairs, and equipment for their specific use at the bedside without any compromise to space and safety.
- The emergency resuscitation equipment and patient transfer bags and trolleys were checked daily with a good system in place as per trust policy. The equipment was central and easy to access. There was also good provision of emergency paediatric equipment which was also checked regularly to ensure it was ready for use.
- There was very good provision of equipment required for level 3 and level 2 critical care for both adults and children. We observed a thorough record and a robust reporting system of medical device training for all staff. Staff we spoke with told us that the links with the medical engineering team were good.
- We did note that the dirty utility room was shared with the adjoining coronary care unit. It was small for the size of both units and consequently cluttered with equipment and dirty linen storage. The shared arrangements were described by staff as more of a challenge to ensure cleaning, storage and infection control standards were met.

Medicines

- We observed good storage and security associated with the management of medicines in the unit. We observed good practice and checking systems for use and storage of controlled drugs by nursing and pharmacy staff. There were two incidents in 2015/16 with no themes.
- The Guidelines for the Provision of Intensive Care Services (GPICS, 2015) state that there should be at least 0.1 whole time equivalent (WTE) Band 8a specialist clinical pharmacist for each level 3 bed and for every two level 2 beds. Pharmacy provision at the WCH site did not meet the guidelines for the size of the unit, with only 0.2 WTE pharmacist cover.
- Staff we spoke with told us that the pharmacist attended the unit every day and this included daily review of prescribing Monday to Friday. There was no available dedicated pharmacist at weekends.
- There was a low number (two) of drug related incidents in the unit in 2015/16 and the process for reporting and investigation was good. We noted that an open and transparent approach was taken to sharing lessons learnt with the team and patients and this was supported by the senior nursing and consultant staff in the absence of a pharmacist.
- We observed five electronic prescription charts and allergies were clearly documented in all cases. The microbiologist took responsibility for antimicrobial stewardship for critical care.
- The unit was not included in the trust medicines safety audit, however the EPR system provided assurance as prompted staff to check antimicrobial prescribing and missed doses were not reported as an issue in the unit.

Records

- The team in the unit had invested in and implemented an electronic patient record (EPR) and prescription system specific to intensive care which we observed to be comprehensive and well understood by staff.
- We reviewed five EPR and five ITU care charts. Entries in the EPR were complete and in line GPICS (2015) and professional General Medical Council (GMC) and Nursing

and Midwifery Council (NMC) standards. Patients received a daily review and treatment plans. Staff across sites could view the EPR which improve communication about patient care and treatment.
- Notes were stored securely and electronic versions were accessed on computers on trolleys with appropriate password protection as per trust policy. There had been no incidence of confidentiality breach in the unit. Staff did not report any issues with the electronic record.

Safeguarding

- The trust safeguarding policy and resources were available to staff and the unit had an organised approach to provision and staff attendance of safeguarding training to protect vulnerable adults and children, with good planning by senior staff to ensure staff were up to date. ITU at WCH had staff attendance compliance of 100% for level one safeguarding training for adults and children, and 100% for level two. Sisters and senior nurses attended level 3 for children to ensure each shift had a nurse on duty with training.
- Staff we spoke with told us that they understood the safeguarding processes and could identify staff to contact to escalate any concerns for vulnerable adults and children.

Mandatory training

- The trust had a mandatory training compliance target of 80% for staff attendance and senior nursing staff we spoke with had an organised approach to achieving the targets for unit staff across the year.
- Senior clinical leads we spoke with reported overall % achievement at the time of inspection against all areas. Fire safety and Basic Life Support had the worst attendance at 68% and 62%; staff we spoke with were aware of the shortfall and had a plan in place for these sessions.
- The trust provided core elements in mandatory training to include, fire, equality and diversity, basic life support, infection prevention and control, information governance, health and safety, safeguarding adults and children, and manual handling.
- Training provision for infection prevention and control was good with 88% of staff having attended hand hygiene and infection prevention and control mandatory training.
- Staff attendance of information governance training as part of mandatory training, was below 80% target at 68%. Senior staff we spoke with had a plan to achieve target. Staff could access mandatory training in a number of ways, online eLearning modules and face to face sessions delivered by key trainers.

Assessing and responding to patient risk

- There was a designated Critical Care Outreach Team (CCOR) at the trust who covered the service 24/7. This included 100% patient follow-up after discharge to wards within 36 hours. The team also had oversight for the compliance and training for staff using National Early Warning Score (NEWS) observations across the trust. There was good evidence of escalation policy being implemented on wards and critical care. There was an eLearning package for NEWS training.
- The EPR included a range of risk assessments completed on patient admission to critical care. We observed good compliance with completion for Malnutrition Universal Screening Tool (MUST) assessment, moving and handling, tissue viability, VTE, delirium, infection control and falls risk. If a patient was identified as having an elevated risk the action required to reduce it was evident in the care plan and practice.
- We observed good use of 'quality check lists' which prompted staff to check equipment, processes, referrals, incidents, stock levels, documentation, infection issues and reviews.
- NEWS and patient escalation audit was performed across the trust with mixed performance. Critical care compliance with NEWS was comparably good across both sites with 85% to 100% compliance.
- CCOR staff were responsible for delivering training across the trust for the ALERT course, which was being replaced by the AIMS course in 2016.
- Patients with tracheostomy were cared for on designated ward areas to manage the increased risks associated with their care. Training was provided to staff by CCOR and the team took the lead on a tracheostomy group across the trust to support best practice.
- Staff we spoke with told us that transfer of adult and paediatric patients was well managed. A trust and network policy was in place. There were no incidents to report as part of critical care transfers.
- Follow up clinics were being planned for critical care patients and a dedicated team was in the progress of being recruited to support the rehabilitation of patients after critical illness. At the time of inspection clinics were not in place.

Critical care

Nursing staffing

- During the inspection visit we found that nurse staffing levels were good as senior staff were on duty providing additional support, however due to a recent significant increase in long term sickness levels in the unit it was challenging to cover shifts. We observed on rotas and evidence provided that there had been occasions were there had not been sufficient numbers of staff to provide 1:1 nursing for Level 3 patients, in line with intensive care standards GPICS (2015).
- We escalated concern to senior staff during the inspection visits around this issue and the risk of not having consistent levels of nursing support for patients in the critical care environment; the impact of staff sickness; the lack of supernumerary coordinator, in line with GPICS (2015), and in addition our judgement that staff had limited visibility to each single room when no additional support staff were on duty. A comprehensive action plan was produced by the trust after an unannounced visit which then provided further assurance that these issues were being closely monitored and managed. Nurse staffing levels had been good on rotas we reviewed prior to the increase in staff sickness in September 2016 and staff told us and gave evidence that they would be working hard to support the team during this period affected by staffing sickness issues.
- The CCOR team had been moved frequently to support shortfalls in staffing in other wards and departments. We spoke with staff who felt that this presented a risk to patient safety across the trust when they were unable to provide a CCOR service. It had affected the morale of team however we did not see evidence or incident at the time of inspection that patient care or safety had been compromised i.e. increased readmission rates or late admissions to critical care. Staff we spoke with told us that more recently senior support had changed and improved. Protection of the CCOR cover had been prioritised since September 2016 and since the unit restructure under the Surgical and Anaesthetic directorate.
- Staff we spoke with gave mixed feedback about visibility and support from trust site managers who would call the unit or visit when they needed to request staffing support from critical care to ward areas. This did not include the critical care senior team and clinical leaders, who were reported as supportive to the needs of critical care however staff expressed concerns around decisions made by some non-clinical and trust-wide managers about acuity and staffing movement and the risk posed to patient safety when the CCOR service was compromised to staff ward areas.
- The unit did not have funding to support a supernumerary unit coordinator across a seven day week and 12 hour day shift pattern in line with GPICS (2015) standards for six bedded units. A supernumerary clinical educator was also not in post at this site.
- A 'red flag' and safer staffing system had been introduced to identify when lower than optimal staff numbers may impact upon patient care and to initiate mitigation. Escalation processes were in place through the matron, service manager and chief matron. Monitoring of patient acuity, dependency and actual against planned staffing levels took place on a shift-by-shift basis.
- Nursing staff sickness was worse than the trust target of 3.5% at 7.03% in the 2015/16 reporting period. At the time of inspection it was reported as greater than 12% with most of the unavailable staff being experienced. The use of agency staff was minimal, despite the overall sickness. The unit relied on established bank staff to cover any shortfalls in critical care as could not draw on staff across the trust due to the competency requirements. There were no vacant nursing posts at the time of inspection and turnover was low at the WCH unit at 6%.
- A comprehensive six week local induction was in place for any staff new to the department with support from the senior staff.
- Nurse handovers were well organised and effective, and the multidisciplinary team worked well together with daily performance of safety huddles and meetings. CCOR staff attended the team and medical handover.
- There had been the development of advanced critical care practitioner (ACCP's) nursing posts in the unit and in CCOR across both sites and the roles were well established.
- Staff addressed risks on a daily basis and proactively as part of an efficient approach to managing the unit. Clinical leads attended trust bed management meetings.

- Nursing staff we spoke with were positive and professional, Morale was affected by the staffing issues with staff expressing some concern, however the team were working hard towards improvement and staff supported one another.

Medical staffing

- Care was led by a consultant in intensive care medicine; the lead consultant was based at Carlisle but did weekly sessions on the unit at WCH. Rotas had been developed across a five day block system to support competent medical cover and patient continuity. The unit at WCH were working to a 3 day system and attention was given to continuity of patient care as a priority.
- Consultant staff to patient ratios were in line with GPICS (2015). Handover arrangements were good at various points of the day for different levels of staff and the MDT.
- Staff we spoke with told us that staffing levels were satisfactory for the rota with cover from consultant, experienced middle grade, acting as a first on call and additional consultant and middle grade staff acting as third on call from home. This cover provided support in times of increased demand. In addition the consultant anaesthetist on call at CIC would also be able to support the consultant anaesthetist at the WCH.
- WCH reported consultant cover over Monday to Friday 08:00 – 18:00. A resident 24 hour non-consultant grade who was first on-call covered maternity and the unit. Consultant out of routine hours 24/7 covers anaesthesia including maternity and ICU as well as airway emergencies backing up the first call. A third call consultant or non-consultant grade covered eventualities if a transfer occurs.
- Anaesthetic staff we spoke with reported no issues with the cover and rota management as a result of the changes in admission type to the unit. Staff we spoke with did report that recruitment in the future would be challenging as a result of the major surgery being moved to CIC. It was a concern that the unit would not be attractive workplace to junior anaesthetic staff and this was a significant risk identified on the risk register.
- There were less staff vacancies (5%) and low sickness reported (1.3%) in anaesthetic cover in WCH critical care and recruitment was discussed as challenging. There was a low rate of 9.4% use of locum staff overall.
- There were consultant led unit ward rounds and patient review twice daily, as documented in the EPR by medical staff and advanced critical care practitioners (ACCP). These were attended by the Multidisciplinary Team (MDT) and relationships were described as very good by the consultant team.
- The team had developed and established advanced critical care practitioner (ACCP) and CCOR roles in response to some of the historical recruitment and middle tier medical cover challenges, especially at the WCH site. The roles were embedded and working well across site providing cover for daytime sessions in addition to the trainees both during the week and at weekends across both sites. The CCOR team were described by anaesthetic staff as excellent and very supportive.
- We spoke with all grades of doctors who gave us positive feedback about working and support in critical care from consultant and senior colleagues. We were told of examples of consultants being in
- We spoke with junior medical staff who expressed that middle grade doctors needed to rotate to CIC in order to maintain skill levels of care and treatment for all critical care patient demographics. The admission criteria at the WCH unit limited some experiences for doctors.
- We spoke with medical and nursing staff, who provided corroboration and evidence that a paediatrician was present at all children's admissions to the unit, along with a consultant anaesthetist and support from children's ward as required.

Major incident awareness and training

- Major incident and business continuity plans were in place and policy was clear and available to staff on the intranet and in paper copy.
- Staff had attended training to test the plans and escalation processes in critical care as part of the surgical and anaesthetic directorate.
- Staff we spoke with told us that there had been no test of the policy in practice.

Are critical care services effective?

Good

We rated effective as 'good' because:

Critical care

- During this inspection and in our 2015 inspection we found patient care was planned and delivered by staff who were knowledgeable and aware of implementing current, evidence-based guidance and standards. There was a programme of clinical audit in place.
- There was consistent data collection and submission of ICNARC data, with a dedicated member of staff in post to support. Patient outcomes were comparable or better than national and local critical care unit performance for April 2016 to March 2016. Unit mortality had improved since our last inspection and was better in comparison to other units as reported to ICNARC. The patient unplanned readmission rate within 48 hours of discharge from the unit (0.6%) was also monitored and better than the national average (1.2%) for the same time period.
- The critical care service continued to be part of the North of England Critical Care Network (NoECCN), working with other stakeholders (acute trusts and clinical commissioning groups) to commit to sharing and promoting best practice.
- Commitment to education and training was good, with six week supernumerary induction for new nursing staff and a sustained performance in ensuring 50% or more of nursing staff had a post-registration award in critical care, or were working towards achievement at local universities. Across both sites 84% of nursing staff had achieved the course. Continued commitment to nurse appraisal was evident with 100% staff performance. Staff were knowledgeable and committed to critical care education. There was good evidence of transfers for adults and children being managed safely and effectively, with monitored activity, training priorities and assurances around competence and equipment management.
- We observed good multidisciplinary handovers, led by consultants with critical care team involvement in ward rounds and safety huddles.
- Patient's pain was well managed; we noted good evidence of delirium scoring in the EPR. Individual patient nutrition and hydration needs were met, and we observed a person centred approach to assessment and planning of individualised care.
- There was a good culture of discussion, documentation of decisions around Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards DoLS. The EPR had a prompt system for staff. Consultants were knowledgeable and engaged with the process. The matron for critical care had been the MCA / DoLS lead and had extended knowledge of best interest assessment, which supported the team education and practice in critical care. Arrangements were improved since the 2015 inspection.

However:

- There was no provision for a supernumerary practice educator at WCH in line with GPICS (2015).
- The critical care pharmacist provision was well below GPICS (2015) standards. We spoke with staff in the unit who did not report any issues with management of medicines and pharmacy support, however pharmacists were not able to fulfil the critical care role, join ward rounds or deliver improvements in practice with only 0.2 WTE dedicated hours.

Evidence-based care and treatment

- We reviewed policies and guidelines in the unit, on the intranet and in paper copies and found all to have review dates. The unit used a combination of national guidelines and policy to determine the care and treatment they provided. These included guidance from National Institute for Health and Care Excellence (NICE), Intensive Care Society, the Faculty of Intensive Care Medicine and the NOECCCN. There was a continued commitment to clinical audit and evaluation amongst all levels of staff.
- We found that ICNARC data showed that patient outcomes were comparable or better than expected when compared with other units nationally, this included unit mortality. ICNARC data had been collected and submitted consistently at WCH. The data was available to the team and, during inspection, we were able to review consistent annual data; however we reported to the critical care team that data was not published on the ICNARC website for both units. Staff we spoke with were not aware of this and could not explain why only one unit's data had been published.
- During this inspection we saw evidence of progress towards meeting the NICE CG83 pathway for rehabilitation after critical care, which was supported and had a lead for rehabilitation. Collection of data to measure if assessment and rehabilitation prescriptions were documented within the first 24 hours of admission and pre-discharge showed good performance for patient admission. The matron and senior physiotherapist had taken the lead for achieving this

standard. A larger audit was being carried out for a sample of 200 patients to provide evidence that comprehensive rehabilitation interventions were effective. 100 patients had been surveyed in 3 months.

- Patients at risk of VTE were risk assessed and prescribed prophylaxis in accordance with NICE QS3 quality statement and pathway. Staff we spoke with told us that audit and monitoring was carried out to ensure compliance targets were maintained in critical care and across the directorate.
- Recognised care bundles to reduce the risk of ventilator – acquired pneumonia (VAP), sepsis, falls and nutrition were embedded in practice and audit work was ongoing to monitor compliance. The unit had adopted a delirium scoring system since our 2015 inspection.

Pain relief

- We reviewed five care records and observed that pain was assessed and pain and delirium scores recorded in the unit. All patients we spoke with told us that staff paid attention to their pain and comfort needs.
- The trust had an acute pain management team and staff would access the specialist advice as required, with some post-operative patients receiving follow up routinely. We observed pain scores and patient assessments being discussed in the ward round by the MDT and conversations were led by the consultant. The EPR prompted assessment.

Nutrition and hydration

- Patients admitted to critical care had a malnutrition universal screening tool (MUST) assessment. Patients who are malnourished, at risk of malnutrition or obese were identified using this tool. In all five EPR's scores were documented.
- A dietitian was allocated to support patients in the unit and had expertise in critical care. Patients were commenced on feeding regimes as soon as possible. We observed patients receiving total parenteral nutrition (TPN) and nasogastric (NG) feeding. Training was being embedded across the trust by the critical care clinical educator and dietitians around safe insertion and care of NG tubes.
- We saw excellent fluid management and hourly documentation of fluid balance. There was good training provision for fluid balance management for staff in the unit.
- We observed nursing staff taking time to assist patients with oral nutrition and when they required support at mealtimes. Patients whose condition had improved were offered drinks by staff and assisted as needed. Nutritional intake was documented. There was good choice of suitable foods for patients.

Patient outcomes

- The unit could demonstrate continuous patient data contributions to the Intensive Care National Audit and Research Centre (ICNARC). Dedicated staff were in post to support ICNARC data collection and reporting.
- ICNARC supports critically ill patients by providing information and feedback data on specific quality indicators as part of its case mix programme (CMP). Critical care units can benchmark their practice and services against 90% of other units. This was in line with the recommendations of the Faculty of Intensive Care Medicine Core Standards (FICM).
- Low levels of harm around infections and sepsis was noted, and admission rates for sepsis were monitored closely through ICNARC. We noted a comparable or better than national mortality rate, indicating a good approach to patient care.
- There was good evidence of transfers for adults and children being managed safely and effectively, with monitored activity, training priorities and assurances around competence and equipment management. Both adult and paediatric patients were transferred to tertiary centres for specialist care and treatment from WCH. There were nine cases of adult patients being transferred and escalated to CIC ITU and nine cases to nearby tertiary centres. Two patients were repatriated to wards in the trust.
- Since our 2015 inspection risk adjusted hospital mortality ratio had improved and was comparable with national reporting at 1.0 across both units, and 0.97 at WCH. Risk adjusted mortality ratio for patients with a predicted risk of death of less than 20% was 0.39 at WCH. Mortality was reported as a percentage of all discharges, deaths and transfers out of the unit. It was reported that mortality was comparable or lower than expected range within the ICNARC CMP.
- Unplanned patient readmission to ITU within 48 hours after discharge was worse than other units (1.2%) in the reporting period April to September 2016 at 2.8%, and better overall than other units in ICNARC annual report across 2015-2016 at 0.6%.

- We also noted that against regional units the 'post unit in hospital survivorship' was better than the network and national average.

Competent staff

- Staff we spoke with told us that they received trust induction and we noted that 100% had attended. Appraisals had been carried out for 100% of nursing staff at the time of inspection.
- GPICS (2015) outlines that critical care units should have a supernumerary educational coordinator. The post holder for critical care overall was 0.8 WTE which did not allow for effective working across both sites. She was also delivering key objectives across the trust for training staff in care of NG tubes as a response to serious incidents and Never Events. It was not possible for the post holder to fulfil the requirements of the GPICS (2015) standard for the unit at WCH.
- New nursing staff to the unit were given a local induction and six weeks supernumerary period whilst they achieved critical care competencies essential for safe practice. Junior staff were supported by more experienced nurses through mentorship programmes. Fifty percent of staff should hold a post registration award in critical care nursing, in line with GPICS. At the time of reporting this standard had been exceeded for nursing staff on ITU across both sites (71 of 85 staff) had achieved this target. There was good access locally to the course and staff were supported to attend.
- There was also a commitment to the Critical Care Steps programme for staff with good levels of achievement.
- We observed examples of the nursing and medical staff teaching junior members of the team at the bedside and during handovers and ward rounds.
- Nurses we spoke with told us the trust had a supportive strategy in place for revalidation. We saw nursing staff sharing the processes for revalidation in the unit.

Multidisciplinary (MDT) working

- We observed good working relationships and commitment to critical care between members of the MDT. Members of the team attended ward rounds and safety huddles in the unit, including the CCOR team.
- Physiotherapy staff were supporting critical care patients in essential care, respiratory assessment, review and rehabilitation from critical care and provided treatment for patients requiring passive movements to prevent muscle contracture during periods of restricted mobility. GPICS (2015) supported a minimum rehabilitation standard of 45 minute sessions, admission and discharge prescriptions and staff were able to consistently deliver this during weekdays.
- Physiotherapy staff were integral to and enthusiastic about driving the improvements made for patient rehabilitation after critical illness since our last inspection, working closely with the matron.
- We spoke with the dietitian and speech and language therapy (SaLT) staff during the inspection. The dietitian had a daily visit to the unit and took referrals on unit attendance or by telephone. They did not attend ward rounds. SaLT had a referral system and attended to patients as required.
- The units had dedicated administrative ICNARC support to ensure consistent data collection and reporting.
- The critical care pharmacist provision was well below GPICS (2015) standards. We spoke with staff in the unit who did not report any issues with management of medicines and pharmacy support, however pharmacists were not able to fulfil the critical care role, join ward rounds or deliver improvements in practice with only 0.2 WTE dedicated hours.

Seven-day services

- Daily consultant ward rounds were embedded with documented daily reviews. The critical care unit provided services 24/7.
- Seven day working had been extended with the addition of advanced critical care nurse practitioners (ACCP's) working at middle tier grade and consultant working across the service.
- There was an on call physiotherapy and pharmacy service out-of-hours and at weekends.
- Admissions to critical care of emergency and unplanned patients can be at any time of day or night, in the case of critical emergencies consultants directed diagnostic tests and reporting of results.

Access to information

- Information could be accessed in electronic and paper systems. We did not see any problems with the transfer of information from the critical care EPR to paper handover.

- Staff involved in the critically ill patients care pathway at every stage could access the information that they needed in a timely manner. We saw good evidence of access to transfer and discharge summaries in paper and electronic versions
- We observed safe transfer and handover processes and had assurances for staff we spoke with that practice was consistent.

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

- We spoke with consultants in critical care and staff told us they would seek independent mental capacity advocate (IMCA) advice when required. There was a good culture of discussion, documentation of decisions and challenge from medical and nursing staff around MCA and DoLS. Consultants were engaged with the process and policy and would contact the safeguarding team based at CIC. The matron for critical care had been the MCA and DoLs lead and had extended knowledge of best interest assessment, which supported the team education and practice in critical care.
- Staff had attended training with an 80% attendance rate against the trust target. Junior staff could explain experiences of application in practice in the critical care environment. Senior staff were more knowledgeable, however all staff we spoke with knew how to seek advice and could access guidance in paper and intranet resources.
- We observed good assessment of consciousness, delirium and confusion with use of Glasgow Coma Scale (GCS) and the Confusion Assessment Method, CAM-ICU, all recorded on the daily observation chart and care plan. These validated measures supported assessment of patient confusion, delirium and subsequent level of mental capacity in the unit.

Are critical care services caring?

Good

We rated caring as 'good' because:

- As in our previous inspections we observed care, evaluated data and had conversations with families, patients and staff and judged the critical care unit at the WCH to be delivered by dedicated, caring and compassionate staff. We observed a visible person centred culture. Staff were positive, motivated, and delivered care that was kind and promoted dignity.
- Nursing staff managed support groups and held them in the local community as part of the ITU national support programme.
- The bereavement support in the unit was very good.
- The model for rehabilitation after critical illness was making good progress and support for patients was evident after discharge from critical care. Physiotherapy staff had organised additional sessions for patients in the hospital gym to encourage them to continue with their rehabilitation exercises. The physiotherapy team used communication boards for patients with learning disabilities to support communication.
- There was continued commitment to organ donation and a dedicated specialist nurse for organ donation (SNOD) was appointed to manage the sensitive issues relating to approaching families to discuss the possibility of organ donation.
- We saw sustained and good use of individual patient diaries to support care planning, rehabilitation and recovery in critical care.
- Survey responses from service users were consistently positive in the Family and Friends Test (FFT) and two minutes of your time responses. During previous inspections we found that the unit were not gathering patient experience information consistently and the team have worked to achieve significant improvement. They had introduced a 'talk to us' email box through social media.

Compassionate care

- We observed staff to be caring and compassionate with patients and their relatives without exception during the inspection. We observed episodes of care that promoted patient dignity and respect.
- We observed letters and cards of thanks from patients and relatives on display. Senior staff shared positive messages from patients in team meetings, on quality noticeboards in staff and public areas and during one to one opportunities with staff.
- Staff would escort patients who were ventilated as part of rehabilitation outside of the unit to the coffee shop. One patient had been supported to visit a local distillery

organised trip with his family. A family pet dog had been allowed to visit the unit after liaison with infection control to support the patient after a long admission period in the single room.

- The NHS Family and Friends Test (FFT) data was collected in critical care and there was a commitment to continuous improvement to response rates with 86% - 100% responses (for around 6-8 patients). Display was consistent with the trust approach in a format that is easy to understand by staff and visitors. We saw positive results and comments, with 100% of patients highly recommending the unit to family and friends.
- The following quote represents the themes in many of the comments and compliments we observed: "They have been absolutely brilliant in here. The lady on shift last night sat with me for three hours to reassure me that I would be OK; she sat with me until I feel asleep. The staff can't do enough for me; they have all been great; I even got a cuppa through the night. They have answered all my questions as I have had a lot because I am quite nosey and I ask them a lot. When I have been panicking the staff have talked me through things and really helped me. They have let me be in control of the pain; I just press a button when I feel like I need pain relief. None of the staff will walk past the room without speaking and checking that I am OK. I can't wait to get out and tell everyone how fabulous it has been on here."

Understanding and involvement of patients and those close to them

- We observed staff communicate with patients and their families and friends in approaches that supported their understanding of care and treatment in critical care. We observed good examples of documented discussions in the EPR between medical staff and patients and families in care records. The EPR prompted medical staff to discuss care and treatment with patients daily.
- We saw evidence of consistent use of patient diaries in critical care. This supported the patient in better understanding of their experience, which supported recovery and rehabilitation.
- Staff we spoke with told us that they could access specialist advice for a range of support services in the trust or externally. This included specialist nurses and teams for organ donation and language interpretation services at the trust.
- Relatives we spoke with all complained about parking at the hospital.

Emotional support

- The spiritual needs of patient's takes priority in critical care and the trust had good access and provision of spiritual, religious and pastoral support. We saw evidence of information about services in the visitors' room. We observed individual needs of patients recorded as part of assessments and reviews in the EPR.
- We observed the additional support given to longer term patients in the unit. Singe room environments were made more personal with family photographs, cards and items from home.
- The bereavement support in the unit was very good.
- Additional psychological support was assessed on an individual basis. In-patient and General Practitioner (G.P) referrals to a psychologist would be made by Consultants staff. There was work ongoing to introduce follow up clinics, this had not been implemented at the time of inspection, but plans were positive.
- The unit operated a flexible approach to visiting times for family and friends to promote the emotional support of patients. We observed nursing, medical, and support workers, and members of the MDT talking to relatives and patients and it was evident that they had established positive, supportive relationships. We saw a long term ventilated patient who was mobile in a wheelchair be able to sit with staff at the nurses station and the team were very attentive in supporting his emotional needs.

Are critical care services responsive?

Good

We rated responsive as 'good' because:

- The unit had sustained its performance since the previous inspection in 2015, supporting patients discharge within four hours of the decision being made by a consultant. Occasions were the patient discharge was delayed beyond eight hours were better than National units and this was managed closely by the senior team against a CQUIN target for delays of greater than 24 hours. We also noted zero mixed sex breaches in 2015/16 in line with Department of Health guidance (November 2010). When we reviewed ICNARC data we

found that the unit was much better (1.4%) than other national units (5.0%) for eight hour discharge targets. Length of stay in the unit was 2.2 days which was comparable with national averages of 2.2 days.

- There was also a commitment to providing patients rehabilitation needs after critical illness and this was being led by the matron and senior physiotherapist. Patients were assessed within 24 hours of admission to the unit. There was a plan to introduce and develop MDT follow up clinics, in line with GPICS (2015) however at the time of inspection they were not in place at the WCH, but recruitment of dedicated staff was underway. Staff we spoke with recognised that this would give the opportunity for patients to gain further explanation of events, access screening for critical care complications, including psychological, physiotherapy or pharmacological support as required.
- There was one formal complaint in critical care at WCH. When people did complain at a unit level staff knew how to respond. The policy and processes for managing complaints was good and understood by all staff we spoke with.
- Patients received timely access to critical care treatment, when decision to admit had been made. Patients were rarely transferred out of the unit for non-clinical reasons and readmission rates were worse (2.8%) against similar units (1.6%), Staff had monitored reasons for the readmission with actions around patients developing pneumonia post discharge.
- Bed occupancy in critical care was 65% in WCH with the total number of admissions being stable with no increase in activity since 2014. There had been 132 admissions in the WCH unit in the six month period from April to September 2016, which indicated no significant increase.
- We have previously reported concerns with the admission of critical care patients (also known as outliers) to theatre recovery in critical care units. We spoke with theatre and critical care staff and reviewed the data and found minimal 'rare' occasions when critical care patients were reported as outliers. This was corroborated when speaking with the CCOR team.

However:

- Discharges out-of-hours, between 22.00hrs and 06.59hrs have been proven to have a negative effect on patient outcome and recovery. Critical care discharges out-of-hours were reported as 2.8% in 2015/16, against a national average of 2.0% as reported by ICNARC for 2015/16.

Service planning and delivery to meet the needs of local people

- Critical care service planning and delivery was managed as part of the Surgical and Anaesthetic Directorate in the trust. There was evidence of consistent and collaborative cross site working during our inspection and in the review of minutes of senior governance meetings. Senior staff were committed to the cross site working model and recognised the challenges of delivering critical care services across two units separated geographically in a rural community.
- The trusts and critical care strategy for the provision of services across the two sites appeared to still be under review since our last inspection in 2015. A number of proposals were reviewed and discussed but no agreement had been reached. .
- Structured bed management meetings took place throughout the day with representation from all specialities.
- There was involvement in the critical care network and good practice and learning was shared across the region.
- There was evidence of support groups in the local community which were well attended by patients and relatives who had experienced critical care illness and admission to the unit.

Meeting people's individual needs

- The critical care team were skilled in managing patients with complex needs and we saw evidence of individual care planning and treatment. We saw good examples of individual care and management of patients requiring one to one support.
- We observed staff to be supportive of families who needed an overnight stay and a kitchen facility was available in the visitors' room. We spoke with relatives who told us that every opportunity was supported to stay overnight during the stressful admission experience.
- A range of information leaflets and specific guides were on display in the unit for visitors. The team were able to

meet the cultural needs of patients in terms of religious beliefs and specialist support or dietary requirements. There was an easy to access number displayed for staff to arrange bariatric equipment for patients.
- We observed excellent leaflet information to support paediatric patients and their relatives. In view of the low number of child admissions to the unit (seven in 2015/16) it was very positive to see how the needs of children had been prioritised.
- The information available to patients about physical and psychological aspects after critical illness was specific to the needs of patients and relatives in the unit.
- Specialist rehabilitation chairs had been purchased to enhance patient recovery in critical care.
- The trust had a good system for access to translation services through switchboard as either an on-call or pre-booked service.

Access and flow

- The unit had written operational policy for admission and discharge.
- GPICS (2015) states admission to critical care should be timely and within four hours from the decision to admit for emergency patients, to improve their outcomes. The decision to admit was made by the critical care consultant, or middle grade doctor/CCOR/ACCP, together with the consultant caring for the patient. Reviews were performed within 12 hours of admission in line with GPICS (2015)
- Information provided to ICNARC presented a picture of bed occupancy at WCH which was lower than the national average, at 65%. Length of stay in the unit was 2.2 days which compared with national averages of 2.2 days.
- The unit had sustained its performance since the previous inspection in 2015, supporting patient discharge within four hours of the decision being made by a consultant. There were minimal occasions were the patient discharge was delayed beyond eight hours (2.2% against a National 4.9%, ICNARC) and this was managed closely by the senior team against a CQUIN target for delays of greater than 24 hours. We also noted zero mixed sex breaches in 2015/16 in line with Department of Health guidance (November 2010), which had been simpler to manage in a single room unit since the move to the new unit.
- Discharges out-of-hours, between 22.00hrs and 06.59hrs have been proven to have a negative effect on patient outcome and recovery. Critical care discharges out-of-hours were reported as 2.8% in 2015/16, against a national average of 2.0% as reported by ICNARC for 2015/16.
- There were four transfers to other units for non-clinical reasons in 2015/16 reported by the unit.
- We have reported concerns with the admission of critical care patients (also known as outliers) to theatre recovery in critical care units. We spoke with theatre and critical care staff and reviewed the data and found minimal 'rare' occasions when critical care patients were reported as outliers. This was corroborated when speaking with the CCOR team.

Learning from complaints and concerns

- We reviewed one complaint reported at WCH, across the trust for 2015/16. We spoke with senior managers who told us that concerns were resolved promptly at trust level with issues having included aspects of clinical treatment and provision of timely information.
- The trust had a Patient Advice and Liaison Service (PALS) and we observed patient information leaflets in the relative room areas, including poster display.
- The surgical and anaesthetic directorate had good processes for the management of complaints. Staff we spoke with were aware of the complaints policy and process and complaints were discussed in unit meetings

Are critical care services well-led?

Good

We rated well-led as 'good' because:

- Staff we spoke with at all levels had a good understanding of the governance framework in critical care. The management structure had changed since the inspection in 2015 and critical care now sat in the surgical and anaesthetic directorate. Staff spoke positively about this change and felt that support was improved. We noted good leadership in the unit. The clinical leads represented the unit at an executive level and communicated vision and strategy across the team.

- Staff felt valued by the clinical leads in critical care, specifically the clinical sisters, matron, senior matron and Consultant leads. It was evident from conversations we had with staff that patient centred; quality of care was the priority.
- During inspection of critical care we found a positive, open culture with knowledgeable staff at all levels. Staff were encouraged by the leads in critical care to share concerns or comments they had about patient care, colleagues, or the service. We did not hear of any complaints or conflict amongst staff in the critical care unit. The team communicated very well with one another and with partners across the network.
- The team in critical care services spoke highly of their local leadership and felt supported by unit matrons, consultants and senior matrons. A culture of listening, learning and improvement was evident amongst all staff we spoke with at unit level. Staff we spoke with across the team were positive about their roles. Trust governance arrangements were clear to the staff we spoke with, despite staff reporting frequent changes in the senior team over the past five years. Staff expressed that they wanted a period of stability in the senior and executive team.
- There was strategy and vision for the trust that had been updated and cascaded to staff. The team had been given opportunity to attend listening sessions with the chief executive and had found them to be positive. Proposals for longer term vision of the unit at WCH had been made but decisions were under review at trust level and had not progressed since our last inspection.
- We spoke with senior staff about concerns with nurse staffing levels and the actual and potential impact on safety and staff morale created by the long term sickness levels. Senior staff responded to our concerns with evidence of plans to ensure safe staffing levels and escalated recruitment plans for Band 6 and band 5 nurses. This included temporary bed closure and close monitoring of activity. Escalation policies were reissued to staff. This gave assurance that the senior team were supportive and managing the escalation of this short term staffing pressure.

However:

- CCOR staff reported concerns about past behaviours of senior staff across the trust when staffing moves were being managed and expressed that they had felt unsupported by some members of the senior team. This issue had been reported in 2015 but it was clear that recent changes to senior team management structure had improved the support in the unit and it was reported that the executive team had a better understanding of the impact of moving staff out of the CCOR team.

Vision and strategy for this service

- All senior staff we spoke with in critical care were knowledgeable about the trust vision, values and strategy, and junior staff told us that patient safety and quality of care was a priority. They had a good understanding of the challenges facing staff across the units.
- Critical care priorities were given proportionate and appropriate attention as part of the surgical and anaesthetic directorate. There had not been an update of the network critical care capacity review in 2014 that we note during our last inspection as being a key driver for planning services.
- The advanced critical care nurse practitioner roles were embedded across both sites and working well since inspection in 2015.

Governance, risk management and quality measurement

- Governance arrangements were clear. Critical care was represented at board and trust level and information was shared across the service. We reviewed minutes of staff meetings and reviewed performance and dashboard reports that presented that staff monitored and reviewed quality, incidents and risk across critical care.
- Although trust governance arrangements were clear to the staff we spoke with, they also reported that frequent changes in the senior team over the past five years had a negative effect on the team. Staff expressed that they wanted a period of stability in the senior and executive team.
- Guidelines and policy were consistent across both sites and units.
- Dedicated data administrators produced a detailed critical care ICNARC submission, by working closely with the consultants and clinical team. There was consistent submission of information to the ICNARC CMP.
- The risk register for critical care was detailed with progress and ownership being documented as part of

the surgical and anaesthetic directorates overall risk register. We saw reviews and action plans associated to specific critical care risk and felt that the items on the register reflected what we observed and discussed with staff during inspection as their concerns.
- Matrons and senior staff shared information in a variety of ways to reinforce the quality agenda with good effect. Staff discussed key issues in daily safety huddles.

Leadership of service

- The senior team structure in critical care was established and understood by staff we spoke with on both sites. Changes at an executive level and as part of a restructure were seen as positive by the staff we spoke with, however the need for stability was requested by all staff we spoke with. There was a commitment by senior staff to be visible on both units. There was good leadership support and clear line management, with an emphasis on 'cross site working' and support.
- There was a designated consultant clinical lead, experienced senior matron and matron across site. The unit had an experienced nursing team at band six and seven level, however there had been an impact on the numbers of senior staff with the recent increase in staff long term sickness, The senior team recognised the challenges faced by the changes and had developed a detailed action plan to support the unit team and patient care and safety.
- We interviewed the senior individuals responsible for critical care units at both sites and they consistently reported that they felt supported by the executive team. There was a clinical director in intensive care, and experienced senior nurses, with low turnover of staff.
- Staff felt valued by the clinical leads in critical care, specifically the clinical sisters, matron, senior matron and consultant leads. It was evident from conversations we had with staff that patient centred; quality of care was the priority. Staff we spoke with told us that a culture of listening, learning and improvement was developing across the trust. Staff we spoke with across the critical care team were positive about local leadership.
- The unit could not provide the consistent support of a supernumerary clinical coordinator, the role was not included in the establishment figures for WCH and due to staffing pressures across the trust it was also difficult to provide any additional support to the unit when it was busier with increased dependence and acuity of patients.

Culture within the service

- During inspection of critical care we found a positive, open culture with knowledgeable staff at all levels. Staff were encouraged by the leads in critical care to share concerns or comments they had about patient care, colleagues, or the service. We did not hear of any complaints or conflict amongst staff in the critical care unit. The team communicated very well with one another, the unit at CIC and with partners across the network.
- Morale was generally good amongst the staff we spoke with, who we found to be very dedicated, positive and professional. Staff we spoke with told us that it was difficult sometimes to work in a trust in special measures and that they had to defend that position with patients and relatives on occasion. Staff expressed concern around 'bad press' in the media and the impact on patients using the service.
- It was recognised that staff were concerned about the staffing shortfalls due to a peak in sickness. Morale was fair amongst nursing staff at the time of inspection. CCOR staff were concerned about the impact of being moved frequently to cover ward areas that had staffing shortfalls. Across the trust the nurse recruitment and staffing issues would mean that this had been a regular occurrence until very recently. Staff wanted to provide safe care for patients in the unit and ward areas but felt removing the CCOR service was a risk and patient safety could be compromised. Staff spoke of how the differences in working in critical care and working in ward areas had been overlooked by some senior, non-clinical trust management staff, but said that unit senior staff were supportive.
- Doctors reported that "Consultants are active and very supportive on the ICU; they like teaching and are approachable." And "The morale of the staff is good and there is a strong culture of team support in the unit."
- Staff we spoke with had mixed opinions about the culture and future of the unit. It was considered a good place to work in the trust amongst junior and senior

staff and in contrast to many ward areas experienced by junior staff. There was uncertainty about the plans for the future of the service. Overall staff expressed positive opinions about working in critical care.
- There was an open and transparent culture. Staff were encouraged to share concerns or comments they had about patient care, colleagues, or the service. We did not hear of any complaints or conflict amongst staff in the critical care unit.
- Collaboration was good within the surgical and anaesthetic directorate, the wider trust team and across the region in the critical care network.

Public engagement

- We observed how experiences of patients influenced staff to improve care and develop new services, for example development of the local organ donation team. We observed the proposals for development of follow up clinics and the ongoing commitment to supporting rehabilitation of people in the community who had experienced critical care. Staff were engaged with seeking patient feedback and acting on results. The unit was engaged with the wider critical care network.
- We observed good examples of critical care staff engaging with the public to share lessons around care, treatment and prevention. The CCOR team had spent time talking to visitors in the atrium of the hospital about key messages around sepsis.

Staff engagement

- Critical care senior staff recognised that ongoing work was required to continue improvement in employee engagement. The results from the NHS staff survey 2015 showed that improvements had been made overall, but responses (3.60) were less than the national average (3.79). Further independent staff survey responses showed an improvement in key issues around prioritising the care of patients, incident reporting and acting on concerns. These responses aligned to the positive discussions we had with staff during inspection.
- Senior staff communicated key information through the trust internet, team briefings, encouraging daily safety huddles and on one to one or meetings as required. There was a good structure for team meetings with regular agenda items and detailed minutes with staff responsibility made clear against actions.
- There was investment in training and education of staff in critical care. We spoke with members of the team who felt valued and had opportunity to develop professionally.
- The team had been given opportunity to attend listening sessions with the chief executive and had found them to be positive.

Innovation, improvement and sustainability

- Critical care had introduced patient diaries to allow patients to process the impact of critical illness, improve memory recall and support staff to respond more holistically to patient's needs. Staff had also developed support groups for patients in the community who had experienced critical care admission.
- Specialist rehabilitation chairs had been purchased to enhance patient recovery in critical care.
- The unit was an active member of the North of England and Cumbria Critical Care Network. Membership of the network enabled the unit to work collaboratively with commissioners, providers and users of critical care to focus on making improvements.
- The development of the electronic patient record in the unit had been embedded and was working well. EPR was not yet established across the trust and the system we reviewed in the unit was easy to use and understand and had been tested across other units in the United Kingdom. The team had driven this improvement at a local level with trust support.
- The arrangements for the small numbers (seven in 2015/16) paediatric admission for stabilisation for hours prior to transfer were also good, to include levels of staff training and competence and storage and checking of essential equipment. The unit were part of the 'North East Children's Transport and Retrieval' (NECTAR) new transport service.

Maternity and gynaecology

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

Information about the service

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

There were 13 maternity beds located across three wards for antenatal and postnatal care. The gynaecology ward had 8 inpatient beds.

Between April 2015 and March 2016, there were 1,274 births at WCH. Across the trust, the percentage of births to mothers aged 20-34 and percentage of births to mothers aged 20 and under was slightly higher than the England average.

During our inspection, we visited the antenatal clinic, antenatal and postnatal ward, labour ward and gynaecology ward. We spoke with three women and their partners and 30 staff, which included: midwives ward sisters, matrons, doctors, consultants, senior managers and support staff. We observed care and treatment and looked at six care records. We also reviewed the trust's performance data.

Summary of findings

During the last inspection in April 2015 the service was rated as 'requires improvement' for being safe, effective and well-led. This was because of a lack of dedicated medical staff cover, no dedicated second theatre, mandatory training levels not being met, ineffective medicines management, insufficient governance and audit processes, staff not following guidelines and lack of cohesive working across hospital sites.

At this inspection although some improvements had been made the service remained as 'requires improvement' for being safe and well-led because:

- Some of the risks identified were still in place and sufficient actions to mitigate the risks had not yet been implemented particularly the lack of senior paediatric medical cover out-of-hours to manage advanced neonatal resuscitation and lack of surgical out-of-hours cover. Although there was no evidence of adverse outcomes this still presented a risk to patients.
- Due to the public consultation taking place at the time of our inspection, it was noted that a preferred option and decision was yet to be taken by Cumbria Clinical Commissioning Group on the future of maternity and children and young people's services.

  Although there was some improvement in cross site working the cohesiveness of the two hospital sites for maternity services was not fully embedded. Certain

Maternity and gynaecology

elements of the obstetric team remained dysfunctional with a lack of clinical engagement and support. It was not clear what action was being taken to resolve this.
- There was some improvement in strengthening of governance processes but there were no indicators to ensure performance and understanding of risk or governance roles. There continued to be gaps in how outcomes and actions from audit of clinical practice were used to monitor quality and systems to identify when action should be taken.
- Not all staff in the service felt engaged in the reconfiguration of maternity services and felt that their opinions were not listened to.

However:

- Staff understood their responsibilities to raise concerns, to record safety incidents and near misses.
- Nursing and midwifery staffing levels were similar to the national recommendations for the number of babies delivered on the unit each year. Additional medical staff had been recruited to cover the obstetric rota.
- Care outcomes were meeting expectations in most areas, and where improvements were required the service had identified action.
- There were systems to ensure the safe management of medicines. Infection, prevention and control measures were in place.
- Most women were positive about their treatment by clinical staff and the standard of care they had received. They were treated with dignity and respect.
- Services were planned, delivered and co-ordinated to take account of women with complex needs, there was access to specialist support and expertise.
- Midwifery and medical staff worked together ensuring women received care which met their needs.

Are maternity and gynaecology services safe?

Requires improvement

We rated safe as 'requires improvement' because:

- There remained concerns about the lack of senior paediatric provision for advanced neonatal resuscitation out-of-hours; the current situation was that the lead midwife on shift on delivery suite was the first line for basic neonatal resuscitation. There were no midwives trained in advanced life support. There was discussion that additional funding was being sourced to train midwives in advanced neonatal resuscitation however this was not yet implemented.
- The Consultant Surgeon on call provided surgical cover after 6pm for the Trust, based at the Cumberland Infirmary who is available for advice on individual case management and transfers of care if required. A standard operating procedure is in place to formalise this process. The Trust recognised that it did not fully meet the Royal College of Obstetricians and Gynaecologists guidelines. There had been no adverse incidents reported and patients had been safely transferred to CIC for their surgery. A formal risk assessment was in place and this was reflected in the risk registers for the service.

  There was no supernumerary delivery suite co-ordinator within the staffing establishment; this was not in line with national guidelines.
- Although staff awareness of which incidents to report had improved further work was required to ensure that staff received sufficient information about themes and trends. Not all staff understood the duty of candour principles. Perinatal mortality and morbidity meetings were not held jointly across hospital sites which meant that sharing of lessons and feedback was only carried out locally.
- Safeguarding champions were in place but due to the high demands of the service safeguarding supervision was not well established and fell short of national recommendations.

- Medical midwifery and nursing staff in maternity services were not meeting trust targets for mandatory training or training in safeguarding adults and children; this was particularly low for medical staff.

However:

- Staff awareness of what incidents to report had improved. There were systems to share learning from incidents across maternity and gynaecology services.
- Nursing and midwifery staffing levels were similar to the national recommendations for the number of babies delivered on the unit each year. Additional medical staff had been recruited to cover the obstetric rota.
- Clinical risks to patients were identified and actions to reduce them were put in place. The maternity and gynaecology units were clean and staff adhered to infection control policies. There were processes for the safe management of medicines.
- There were appropriate safeguarding procedures and systems which were understood by staff.
- Required records were kept correctly. There were some records where the foetal heart monitoring review sticker was not being consistently used, the new guideline was only introduced in December 2016 and was not yet fully embedded.

Incidents

- Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Between October 2015 and September 2016, the trust reported one incident, which was classified as a Never Event for Maternity and Gynaecology. The Never Event occurred in theatre but was not directly related to maternity services. The incident was under the category Surgical / invasive procedure incident meeting SI criteria. To reduce risk the maternity service had a standard operating procedure (SOP) in relation to swab and instrument counts. Accountability for this was reflected in maternity documentation including mandatory fields in the electronic reporting system.
- In accordance with the Serious Incident Framework 2015, the trust reported 12 serious incidents (SIs) in Maternity and Gynaecology, which met the reporting criteria, set by NHS England between October 2015 and September 2016. Of these, the most common type of incident reported was maternity / obstetrics incident meeting SI criteria: mother only. Three of the 12 incidents were reported for WCH.
- There were 790 incidents reported for maternity and gynaecology across all hospital sites between October 2015 and September 2016. The majority of incidents were reported as low or no harm, 51 (6.5%) were moderate, three severe (0.4%) and one death (0.1%).
- The main category of incident was treatment /procedure (41.5%), infrastructure including staffing (23.3%) and access, admission, transfer discharge (13.5%).
- Staff completed incident reports using an electronic system. The initial incident review was by the risk team to agree severity of harm. The risk midwife said this could take up to a week to complete. The trust risk team notified the maternity team of any serious harm incidents. Risk midwives and clinicians did not review incidents they had been involved in, which ensured independence during the investigation. The consultant labour ward lead undertook incident reviews.
- The risk midwives produced a monthly incident report, which was presented at the maternity directorate meetings. The quality of the report needed improvement to include more information about themes and trends.
- There were monthly perinatal mortality and morbidity meetings. All serious cases, including stillbirths and neonatal deaths, were reviewed by a multi-disciplinary peer group which included obstetricians, paediatricians, junior doctors and medical students. There was limited attendance by midwives. The meetings were not held jointly across hospital sites.
- We looked at four root cause analysis investigation reports following incidents, which showed that duty of candour regulations, were followed. There was evidence to show women and families were involved in the investigation process, and informed of the outcomes. However, not all staff were able to describe duty of candour.

Safety thermometer

- The maternity services used the national maternity safety thermometer. This allowed the maternity team to check on harm and record the care.
- Some of the data for the maternity safety thermometer was incomplete so the data could not be interpreted

accurately however the median average for the last 18 months showed 87% of women did not express concern over their perception of safety and 73% of women or babies did not experience any of the combined harms at this trust.
- The maternity dashboard and external measures showed that outcomes for obstetrics and gynaecology were either similar to or were meeting national and local targets.

Cleanliness, infection control and hygiene

- There were no cases of hospital-acquired Methicillin-Resistant Staphylococcus Aureus (MRSA) or Clostridium difficile (C. difficile) in 2016/17.
- Observations during the inspection confirmed that all staff wore appropriate, personal protective equipment when required, and they adhered to 'bare below the elbow' guidance in line with national good hygiene practice. All clinical areas were clean.
- Hand hygiene audits showed 100% compliance for the labour and maternity ward.
- Training records showed that 58% of medical and 79% of nursing and midwifery staff in maternity and gynaecology had completed Infection Prevention and Control training against a trust target of 95% completion by the end of March 2017.
- The CQC Survey of Women's Experience of Maternity Services (2015) showed that the service scored 'about the same' as other trusts for cleanliness, infection control and hygiene.

Environment and equipment

- Adult and neonate resuscitation equipment was checked, stocked and maintained. Records showed that checks were carried out daily.
- There was adequate equipment on the wards to ensure safe care, specifically cardiotocograph (CTG) and resuscitation equipment. Staff confirmed they had sufficient equipment to meet women's needs.
- The post-partum haemorrhage (PPH) trolley was stocked correctly however there was no pro-forma on the trolley but staff told us that a pro-forma was completed following a major PPH (> 2 litres).
- Oxygen cylinders in the antenatal clinic were checked daily but the checks were not recorded. Staff said they felt this was not required because they checked the equipment each day.
- There were no sluice facilities in antenatal clinic. Urine was tested and disposed of in the patient's toilet. Managers were aware of the lack of sluice facilities. The infection control team had advised on disposal of waste.
- Internal signage in the antenatal clinic had improved in response to an incident.
- There was some negative feedback from women about the old environment on Honister Ward. Any changes to the environment were part of the future plans for maternity services.
- There were some concerns at the last inspection about privacy on the gynaecology ward. All rooms used by gynaecology patients were now single en-suite rooms.
- The service had made appropriate adjustments to ensure women with a disability had access to suitable facilities. Specialist equipment for women with a high body mass index (BMI) was available when required.
- All community midwives had emergency equipment bags. These were standardised across areas with checklists so that staff could access the correct equipment for home births.
- The neonatal unit was close to the delivery suite. Staff said that paediatric staff could attend emergencies quickly.
- There was a birthing pool. There was appropriate evacuation equipment, which was tested. All equipment was serviced and maintained to the relevant safety standards.

Medicines

- Medicines and IV fluids were stored securely in locked cupboards. The emergency and anaphylactic drug box was stocked and in date. Fridge temperatures were checked weekly not daily but were in range.
- The controlled drug register showed that stock levels were recorded correctly and daily checks completed.
- We looked at six medicine charts, all recorded allergy status, start date and no omitted or delayed medication was recorded which showed medicines were given as prescribed.
- The Quality of Care Board showed 423 days since the last medication error.
- Take home medicine packs were available for women on discharge, which prevented delays.

Records

- The service used the standardised maternity notes developed by the Perinatal Institute. We reviewed six records, which were completed to a good standard. Each record contained a pathway of care that described what women should expect at each stage of labour. There was evidence of senior review. Staff signatures were legible and staff designation recorded in most cases.
- A venous-thromboembolism risk assessment was completed at booking with obstetric referral as indicated. Foetal growth charts were in use and had been completed.
- We looked at three CTG recordings which were annotated with patient name, DOB and hospital number, all were dated, timed and stored in separate brown paper wallets. The service had introduced the use of hourly systematic CTG review using a sticker. We found stickers were available in the notes but were not being consistently used. Staff informed us that the new guideline was only introduced in December 2016 and was not yet fully embedded.
- An audit of the management of maternity records (November 2016) showed 81% of antenatal summaries were completed, 71% pregnancy notes and 74% birth notes. Documentation on foetal heat monitoring records was 89%. The target for minimum overall % compliance for each process was 75%. However, where compliance fell below 100%, actions had been included in the action plan to ensure increased compliance at the next audit.
- Trust data showed 75% of medical staff and 60% of midwifery and nursing staff in maternity and gynaecology had completed information governance training against a trust target of 95% completion rate by the end of March 2017.

Safeguarding

- There was a named midwife for professional safeguarding issues who worked two days a week and was due to retire. A full-time post was being recommended at a Grade 8(as recommended by the Inter Collegiate Document 2014). Maternity safeguarding was managed clinically by the Associate Director and Head of Midwifery.
- Safeguarding champions were in place but due to the high demands of the service safeguarding supervision was not well established and fell short of national recommendations. The named Midwife did provide group supervision when there were specific cases to discuss. Twelve episodes of supervision were held between April 2015 and March 2016
- There was good liaison with other specialist midwives such as teenage pregnancy, mental health and substance misuse.
- The lead midwife for safeguarding was the lead for female genital mutilation (FGM). There was FGM guidance for staff. Staff had received training on child sexual exploitation.
- Midwifery manager and safeguarding lead meetings were held monthly. Any risks were reported as an incident and discussed at weekly ward meetings on both sites alternating on all three maternity sites and at governance monthly meetings.
- All teenage pregnancies were risk assessed for safeguarding issues at booking and early help assessment was started. The teenage pregnancy pathway was embedded in midwifery practice.
- Staff had access to an independent domestic and sexual violence advisor. There was a lead midwife for domestic abuse.
- The trust set a target of 95% for completion of safeguarding training by the end of March 2017. The trust had not yet achieved its target for any safeguarding training course**.** Training figures for medical staff showed 58% had received training at level 1 for safeguarding vulnerable adults 50% had completed training for safeguarding children level 2; and 60% level 3. For midwifery and nursing staff 66% level 1; 85% level 2 and 75% level 3. The plan was to offer training every month to all staff and to achieve 95% target within 18 months.
- Infant security was in place using a baby tagging system and CCTV including secure access to the ward. A desk top abduction practice drill was completed.
- Women were asked about abuse at booking and when they were alone. Midwives tried to see women alone at least three times in their pregnancy.

Mandatory training

- Mandatory training was provided using e-learning or study days and included health and safety, infection control, equality and diversity, information governance, first safety and basic life support. The trust's target compliance rate was 95%.

- Trust data for 31 August 2016 showed that no targets had been met by medical staff, equality and diversity training was 92%. All other training compliance was between 42-75%. For the same period for nursing and health care assistants, training compliance was at 55-79% with the exception of equality and diversity training which was 100%. There were plans to ensure that staff achieved the trust target of 95% by the end of March 2017.

Assessing and responding to patient risk

- The service used an early warning assessment tool known as the 'Maternity Early Obstetric Warning System' (MEOWS) to assess the health and wellbeing of women who were identified as being at risk. This assessment tool enabled staff to identify and respond with additional medical support. We looked at six records, four showed that a set of observations were recorded on admission to the unit and an early warning score was calculated in line with trust guidelines, recording of observations were increased when MEOWS increased. In two cases the MEOWS scores were not fully completed.
- A MEOWS audit of 123 entries showed 100% were completed correctly between January and September 2016.
- There was a lack of senior paediatric provision for advanced neonatal resuscitation out-of-hours due to a lack of paediatric middle grade and resident paediatric consultant cover. Currently this provision was available approximately 60% of the time. Middle grade tier, 12 nights out of 28 there was no middle grade or resident consultant cover. In addition four evenings per month between 5pm and 9.30pm there was no senior cover. The lead midwife on shift on delivery suite was the first line for neonatal resuscitation (NLS trained) There were no midwives trained in advanced NLS. This was identified on the maternity risk register. Some incidents were reported with no adverse outcomes (this included occasions when paediatrics had been asked to attend an anticipated problem and then asked to stand down as not required). This was not in line with Safer Childbirth (2007) paragraph 4.4 (Paediatric staffing levels).
- The Consultant Surgeon on call provided surgical cover after 6pm for the Trust, based at the Cumberland Infirmary who is available for advice on individual case management and transfers of care if required. A standard operating procedure is in place to formalise this process. The Trust recognised that it did not fully meet the Royal College of Obstetricians and Gynaecologists guidelines. There had been no adverse incidents reported and patients had been safely transferred to CIC for their surgery. A formal risk assessment was in place and this was reflected in the risk registers for the service.

  Staff undertook training that enabled them to identify and act in the instance of a critically ill woman. Trust data showed attendance figures at PROMPT (Practical Obstetric Multi-Professional Training) for maternity staff; August 2016 was 77% of midwives on delivery suite, 100% of medical staff and 94% of community midwives had completed this training against a trust target of 80%.
- The 'five steps to safer surgery' procedures (World Health Organisation safety checklist (WHO)) were completed consistently. A retrospective audit of the checklist between June and December 2016 showed 100% compliance with the exception of surgeon 'sign in' which was 95%.
- There was currently no second dedicated theatre for obstetrics which was identified on the trust risk register. There was a standard operating procedure in place identifying how a team should be released at short notice from main theatres if required. In the new build the dedicated delivery suite theatre was in close proximity to the centralised operating theatre. Handovers on the labour ward identified any high risk women and plans made for the use of the theatre.
- There were clear processes in the event of maternal transfer by ambulance, transfer from homebirth to hospital and transfers postnatally to another unit.
- Women who had a body mass index of 60 or above were referred to Newcastle for their care.
- There were guidelines for the risk assessment of venous thromboembolism and staff were aware of their responsibilities to assess and reduce this risk.
- The unit used the 'fresh eyes' approach, a system which required two members of staff to review foetal heart tracings (CTG). There were no serious incidents in 2015 concerning CTG misinterpretation and no clinical incidents reported in 2016. The trust has had an ongoing contract with K2, an e-learning programme for all midwives and doctor on CTG interpretation to complete each year. In October 2016, 107 midwives (63%) and 21 (70%) of doctors have completed K2 training in the last

12 months. K2 data was reported twice a year with the next formal report due in January 2017, the service was confident that remaining staff will have completed the required e-learning.
- Risk assessments were completed for higher risk women wishing to have a home birth. This involved a Supervisor of Midwives and the consultant.

Midwifery staffing

- The service met the national benchmark for midwifery staffing set out in the Royal College of Obstetricians and Gynaecologists (RCOG/RCM) guidance 'Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour' with a ratio of 1 midwife to 26 births, which was better than the RCOG recommendation of 1 midwife to 28 births.
- Current staffing levels were reviewed using a model to measure acuity. This was calculated in care hours per patient day and resources were managed accordingly. The recommended staffing levels for West Cumbria were identified as 24 births to 1 midwife.
- Issues with maternity staffing were reported each month. There was an escalation plan which was implemented to provide the necessary staff cover. Community midwifery team leaders reviewed workloads and moved staff to cover activity during hours. There was a process to review workloads out-of-hours with the lead midwife in the hospital making the decision to bring the on-call community midwives into help. There were no cancelled homebirths due to staff shortages between September and December 2016. However, on 24 November 2016 homebirth on call was cancelled due to staff shortages, although no women were booked or phoned in for a home birth.
- Between July and September 2016 qualified and unqualified nursing and midwifery staffing fill rates were above 80%.
- There was no supernumerary delivery suite co-ordinator within the staffing establishment on either hospital site. This was not in line with RCOG guidelines which stated that 'to ensure 24-hour managerial cover, each labour ward must have a rota of experienced senior midwives as labour ward shift coordinators, supernumerary to the staffing numbers required for one-to-one care'. This gap was identified on the maternity risk register since 2014.
- As at 30 September 2016, the trust reported a vacancy rate of 0% in maternity and gynaecology services.
- Between April 2015 and March 2016, the trust reported a bank and agency usage rate of 1.7% and a turnover rate of 8% in maternity and gynaecology services.
- The unit used a recognised communication tool: Situation, Background, Assessment and Recommendation (SBAR). Staff reported the details of any patient they had provided care for during their shift, including any risks which may be present.

Medical staffing

- Between 1 June 2016 and 30 June 2016, the proportion of consultant staff reported to be working at the trust were lower (worse) than the England average. The proportion of junior (foundation year 1-2) staff reported to be working at the trust were higher (better) than the England average.
- Between March 2015 and August 2016 West Cumberland hospital had an average of 40 hours consultant cover on the labour ward. This met the RCOG recommendations.
- There was consultant cover from 8am to 6pm performing elective procedures and ward round cover of women in the postoperative phase (Monday-Friday).
- There was consultant obstetrician physical presence on the labour ward from 8:30 am to 5pm, consultant obstetrician on-call 5pm to 8:30am. Middle grade cover 8:30am – 10pm, SHO cover was available up to 10pm; overnight cover was provided by advanced nurse practitioners. Trained operating theatre nurses were the second surgical assistant at night.
- The service had recruited three speciality doctors. A GP with a specialist interest also worked three days in the community and two days at the hospital; at a senior SHO level with direct support from the consultant. There were two gaps in the middle grade rota which was being covered by long term locums.
- There was a non-consultant grade anaesthetist resident 24 hours a day seven days a week. Out-of-hours duties included both obstetric anaesthesia and critical care. There were two morning consultant anaesthetist sessions per week in obstetric anaesthesia (effectively an elective caesarean section list.) Cover during all other weekday daytime sessions was the same as out-of-hours cover. There was a consultant on-call covering all out-of-hours times. This was non-resident. Duties included obstetric anaesthesia and critical care. There was a 3rd on call out-of-hours. This was no-resident and was either consultant or non-consultant grade. Duties included both obstetric

anaesthesia and critical care. This rota was intended for the rare situation when both the resident and consultant on call were busy. There was also a consultant clinical service lead with job planned supported professional activities (SPA) time.
- Staff we spoke with said they had experienced no delays in getting hold of middle grade staff, consultants or an anaesthetist.
- Between April 2015 and March 2016, the trust reported a turnover rate of 37% in maternity and gynaecology.
- Between April 2015 and March 2016, the trust reported a bank and locum usage rate of 26%.

Major incident awareness and training

- There were escalation processes to activate plans during a major incident or internal critical incident such as shortfalls in staffing levels or bed shortages.
- Medical staff and midwives undertook training in obstetric and neonatal emergencies at least annually.

Are maternity and gynaecology services effective?

Good

We rated effective as 'good' because:

- Women's care and treatment was delivered in line with evidence based practice. Where policies or procedures did not meet guidance, or posed a risk these were on the risk register and staff were aware of them.
- Care outcomes were meeting expectations in most areas, and where improvements were required the service had taken action.
- A formal preceptorship programme was in place for newly qualified midwives. This ensured appropriate support while developing skills and competencies and was a positive step in developing an integrated workforce. The majority of staff had received an appraisal.
- There were support systems for new mothers in feeding their baby. The service had achieved stage 1 of the United Nations Children's Fund (UNICEF) Baby Friendly Initiative (BFI) Accreditation Scheme.
- Women were provided with options for pain relief. Anaesthetist response times within 30 minutes for epidural analgesia were 100%.
- Midwifery and medical staff worked together ensuring women received care which met their needs.
- Staff had received training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Consent processes were effective and followed legislation and guidance.

However:

- There was a maternity audit schedule for 2016 however there was currently no effective process to ensure that cyclical improvement was established and ongoing. This was identified in an external review of Governance: Maternity Services report.
- Although junior doctors we spoke with said they were satisfied with the training and support they received, the General Medical Council National Training Scheme 2016 showed some outliers for maternity relating to a supportive environment**,** clinical supervision and adequate experience. There was an action plan and monitoring to ensure improvement.
- There was no practice development midwife due to retirement of the previous post holder. The clinical lead for obstetrics said the service was working towards appointing to the post.

Evidence-based care and treatment

- From our observations, records and through discussion with staff we found that policies were in line with the National Institute for Health and Care Excellence (NICE).
- Records showed women received care in line with NICE Quality Standard 22, covering antenatal care of pregnant women up to 42 weeks of pregnancy, in all settings that provided routine antenatal care, including primary, community and hospital based care.
- For women who planned for or needed a caesarean section, this was managed using NICE Quality Standard 32.
- Care of women was in line with Royal College of Obstetricians and Gynaecologists (RCOG) guidelines (including 'safe childbirth: minimum standards for the organisation and delivery of care in labour') with the exception of safe childbirth 4.4 (Paediatric Staffing Levels) that 'on-site' clinicians must have access to senior colleagues who have advanced skills for immediate advice and urgent attendance (within 10 minutes) when required. This was identified on the risk register.

- There was a maternity audit schedule for 2016 however there was currently no effective process to ensure that cyclical improvement was established and ongoing. This was identified in the review of Governance: Maternity Services report (Fleming, 2016).
- Where policies or procedures did not meet guidance, or posed a risk these were on the risk register and staff were aware of them. An example was the standard procedure developed due to the lack of a dedicated second theatre for obstetrics.
- There was a guideline development group. Staff confirmed they were consulted on guidelines. Guidelines were approved by the divisional governance group. We looked at 26 policies and guidelines relevant to maternity and gynaecology and found four were under review and three were out of date. The guidelines followed evidence based practice.
- The service was part of the Saving Babies in North England (SaBine) project. Currently, NCUH detection of SGA babies compared favourably with national statistics, (with a detection rate of 40.5% against 39.1% nationally. There was an ongoing audit in relation to missed small for gestational age (SGA) babies. The audit currently produced individual patient classification which was actioned at a local level. The service was working towards providing a more meaningful report with action and learning using the new Perinatal Institute audit template.
- The NHS screening programme sets key performance indicators (KPI) for antenatal and new-born screening programmes. The service had a number of areas identified for improvement following a quality assurance visit. The screening midwife said most of the actions were completed with one outstanding action relating to cohort data not being robust in all antenatal programmes. This would be resolved with the introduction of a new patient administration system next year.

Pain relief

- Women were provided with information to make them aware of the pain relief options available to them. Most women we spoke with said they had received sufficient pain relief.
- Women were offered pain relief options which included oral, injectable, medical gasses and epidural.
- An audit of anaesthetist response times within 30 minutes for epidural analgesia for the last six months at WCH was 100%.

Nutrition and hydration

- Breastfeeding initiation rates for deliveries that took place in WCH for April 2016 to October 2016 were 60% against a trust target of 68%.
- An infant feeding co-ordinator worked across sites four days a week and one day in the community.
- At the time of inspection, the trust had achieved stage 1 of the United Nations Children's Fund (UNICEF) Baby Friendly Initiative (BFI) Accreditation Scheme. A stage two assessment was booked for July 2017.
- Teenage mothers were encouraged to express and store breastmilk. An initiative introduced by the teenage pregnancy specialist midwife. There were facilities for storage of milk when women came into the unit. The service promoted confidence in the ability to breastfeed.
- There was access to breastfeeding peer supporters, however due to a recruitment embargo there were not many peers still in post.
- Snacks were offered to women 24 hours a day as required, and staff were able to order extra food and snacks for pregnant women as required.
- Women told us they had a choice of meals and these took account of their individual preferences including religious and cultural requirements. Women we spoke with said the quality of food was good. There was a dining area for mothers and families on the post-natal ward.

Patient outcomes

- There were no risks identified in: maternal readmissions; emergency caesarean section rates; elective caesarean sections; neonatal readmissions or puerperal sepsis and other puerperal infections. (Hospital Episode Statistics April 2012 to May 2015).
- Between April 2015 and March 2016 the total number of caesarean sections was similar to the expected England average. The standardised caesarean section rates for elective sections were similar to expected and rates for emergency sections was similar to expected.
- The percentage of deliveries by method was similar to the England average for the majority of methods. The trust had a greater percentage of low forceps cephalic delivery (6.9%) compared to the England average (3.3%).

Maternity and gynaecology

- There were no maternal deaths between April 2016 and October 2016**.** There was one neonatal death.
- North Cumbria maternity services perinatal mortality (foetal deaths after 24 completed weeks of gestation and death before 7 completed days) rates compare favourably with UK rates as described in the Mothers and Babies: Reducing Risk through audits and confidential enquiries across the UK (MBRRACE) report (2016). NCUH rate is 4.76 per 1000 births, (which is up to 10% lower (better) than the national UK average)
- The rate of third and fourth degree tears was better than the trust target of less than 5% per month with the exception of May and June which were slightly worse (5% and 6%)
- Post-partum haemorrhage (>2000ml) was better than the trust average of below 1% with the exception of July and September 2016 which was 1.7 and 1.6%.
- There were four maternal readmissions between April 2016 and October 2016.
- Unexpected term admissions of babies to NNU were better than the trust target of below 9%.
- New-born blood spot screening showed avoidable repeat rates were 2.7% which was slightly worse than the national target of 2%. The screening midwife told us that the 0.7% was babies tested in the tertiary centres. Staff completed a competency assessment if they had repeated problems with avoidable repeat screening tests.

Competent staff

- There was a formal preceptorship programme for newly qualified midwives. This ensured appropriate support whilst developing skills and competencies.
- There was rotation of midwives from delivery suite into the community and the day assessment unit to develop a fully integrated service**.**
- There was no practice development midwife due to retirement of the previous post holder. The clinical lead for obstetrics said the service was working towards appointing to the post.
- A scoping exercise of what training and updates were needed for essential midwifery skills was completed so that training was planned appropriately.
- Community midwives competency requirements were being reviewed to ensure they were supported when they were required to work in a hospital setting.
- The service was considering an advanced midwifery practitioner role to enhance maternity care.
- There was a plan to develop a database to allow senior medical staff to view locum staff competencies.
- Between April 2015 and March 2016, 90% of medical, nursing, midwifery, and non-clinical staff within maternity and gynaecology had received an appraisal.
- The 'North of England Local Supervising Authority's (LSA) annual report to the Nursing and Midwifery Council September 2016' showed the trust had met the required standard for two rules partially met compliance in three rules and not met one rule which required the urgent review of systems and processes for the safe and secure storage of records. Some of the other criterion within the standards also needed to be addressed.
- The caseloads held by supervisors of midwives (SOM) were in line with the recommended ratio of 15 midwives for each supervisor. All midwives had 24-hours access to supervisors. The LSA report confirmed that for the practice year 2015/2016 94% of midwives had an annual review which was not compliant with the requirement of 100%.
- Student midwives told us they felt supported and had regular teaching and mentoring. They received a varied range of practical experience and felt part of the team. All student midwives had a named SOM and knew how to contact a supervisor.
- Junior doctors we spoke with said they were satisfied with the training and support they received, particularly that given by consultants. There was a good induction process and mandatory training was provided. Doctors did not express any concerns with workloads.
- The results of the General Medical Council National Training Scheme Survey 2016 for obstetrics and gynaecology showed that the trust was 'within expectations' for induction and local teaching but 'below expectations' for a supportive environment**,** clinical supervision and adequate experience.

Multidisciplinary working

- Midwifery and medical staff worked together ensuring women received care which met their needs. Women and staff we spoke with provided examples of multidisciplinary working in practice, for example working with multiple allied health professionals and medical specialities to support women during pregnancy and childbirth

- Newcastle was the referral centre for high-risk women requiring an antenatal review. There were systems to receive advice including tele-medicine and staff said this was supportive.
- Staff confirmed they could access advice and guidance from specialist nurses/midwives, for example infant feeding, twin pregnancy, mental health services and diabetes.
- Midwives at the hospital and in the community worked closely with GPs and social care services while dealing with safeguarding concerns or child protection risks.
- The health visitors and the community midwifery team worked together to identify and report potential risks to hospital staff. Risks were notified to health visitors, and community midwives had access to pathways about vulnerable women.
- Staff confirmed there were systems to request support from other specialties such as physicians, consultant microbiologists and pharmacy.
- There were no transitional care cots on the post-natal ward for babies requiring additional support however staff worked closely with children's services to care for babies who required additional clinical interventions. Obstetric staff said they received good support from the neonatal unit and could obtain advice at any time.

Seven-day services

- Out-of-hours' services were available in emergencies. All women could report to the hospital in an emergency through either A&E or maternity reception.
- The pregnancy day assessment unit was a Monday to Friday service. Outside of these hours and at weekend women attended the maternity ward.
- Physiotherapy provided a seven day service and 4pm to 8.30am on call service. Access was available to pharmacy and diagnostic services.

Access to information

- All local and national policies were available on the trust intranet for staff to access. Senior staff informed us they were responsible for updating pathways when new policies were approved.
- Staff told us there were processes to ensure medical and hand held records travelled with women in the event of a transfer.
- Communications with GPs summarising antenatal, intrapartum and postnatal care was recorded in medical records.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Women confirmed they had enough information to help in making decisions and choices about their care and the delivery of their babies.
- Consent forms for women who had undergone caesarean sections detailed the risk and benefits of the procedure and were in line with Department of Health consent to treatment guidelines.
- There was a system to ensure consent for the termination of pregnancy was carried out within the legal requirements of the Abortion Act 1967. We looked at a sample of consent forms during our inspection and found these records met legal requirements.
- Staff had a good understanding of relevant legislation about consent, for example applying Gillick competencies for children under 16 years of age to give consent to care and treatment without the need for parental permission.
- The trust reported as at 31 August 2016 Mental Capacity Act (MCA) training had been completed by 97% of staff in maternity and gynaecology.
- Deprivation of Liberty Safeguards training had been completed by 100% of staff required to undertake this training in maternity and gynaecology.

Are maternity and gynaecology services caring?

Good

We rated caring as 'good' because:

- The NHS Maternity Friends and Family Test for August 2016 showed the number of women who would recommend the maternity service was similar or better than the national average. High recommendation rates were also reflected in the 'Two Minutes of Your Time' patient experience survey.
- We observed staff interacted with women and their relatives in a polite, friendly and respectful way. There were arrangements to ensure privacy and dignity in clinical areas.

Maternity and gynaecology

- All women we spoke with were positive about their treatment by clinical staff and the standard of care they had received. Women told us they had a named midwife. They felt well supported and cared for by staff, and their care was delivered in a professional way.
- Women were involved in their choice of birth at booking and throughout the antenatal period. Women said they had felt involved in decisions about their care during labour, and for feeling they were **spoken to** in a way they could **understand** during labour and birth.
- There were effective and confidential processes for women attending the gynaecology ward. Women received emotional support where required; appropriate specialist bereavement and midwifery support was provided which met the individual circumstances of women.

Compassionate care

- Between September 2015 and August 2016 the trust's Maternity Friends and Family Test (antenatal) performance (% recommended) was generally similar to than / to the England average. In latest month, August 2016 the trust's performance for antenatal was 97% compared to a national average of 95%.
- Between September 2015 and August 2016 the trust's Maternity Friends and Family Test (birth) performance (% recommended) was generally similar to than / to the England average. In latest month August 2016 the trusts performance for birth was 98% compared to a national average of 96%.
- Between September 2015 and August 2016 the trust's Maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally similar to than / to the England average. In latest month August 2016 the trusts performance for postnatal ward was 98% compared to a national average of 93%.
- Between September 2015 and August 2016 the trust's Maternity Friends and Family Test (postnatal community) performance (% recommended) was generally similar to than / to the England average. In latest month August 2016 the trusts performance for postnatal community was 98% compared to a national average of 97%.
- The trust maintained a stable test performance for all four areas during the period September 2015 to August 2016. The trust performed better than the national average in the latest month.
- The trust scored 'about the same' as other similar size trusts in all 16 indicators in the CQC Survey of Women's Experience in Maternity Care 2015.
- The service carried out its own 'two minutes of your time' patient experience survey. Results for maternity between April and September 2016 showed a consistently high response of women recommending the services (average score 9.7 out of 10). 97% would highly likely or likely to recommend Honister Ward to their family and friends.
- All women we spoke with were positive about their treatment by clinical staff and the standard of care they had received. Women told us they had a named midwife. They felt well supported and cared for by staff, and their care was delivered in a professional way.
- Women undergoing caesarean sections said they had skin-to-skin with their baby whilst in theatre or recovery.
- The CQC Survey of Women's Experience in Maternity Care 2015 showed the trust scored about the same as other similar size trusts for women '**not** being left alone by midwives or doctors **at a time when it worried them'.**
- We observed staff interacted with women and their relatives in a polite, friendly and respectful manner. There were arrangements to ensure privacy and dignity in clinical areas.
- We observed that the midwife call systems were within reach and women said that staff responded to the call bells quickly.

Understanding and involvement of patients and those close to them

- Women were involved in their choice of birth at booking and throughout the antenatal period. Women said they had felt involved in their care; they understood the choices open to them and were given options of where to have their baby.
- Supervisors of midwives and the consultant team were involved in agreeing plans of care for women making choices outside of trust guidance for example requesting homebirth with either a current or previous high-risk pregnancy.
- Results from the CQC Maternity Service Survey 2015 showed the trust scored 'about the same as' other trusts

for women being involved enough in decisions about their care during labour, and for feeling they were spoken to in a way they could understand during labour and birth.

Emotional support

- Bereavement policies and procedures were in place to support parents in cases of stillbirth or neonatal death; a specialist midwife supported families from their initial loss, throughout their time in hospital and when they returned home.
- There were effective and confidential processes for women attending the gynaecology ward. Staff supported women to make informed choices about their termination of pregnancy options.
- Specialist midwives for substance misuse, mental health, safeguarding and teenage pregnancy provided support to women in clinics and at home.
- There was ongoing assessment of women's mental health during the antenatal and postnatal period. Referral could be made to the joint mental health practitioner/ midwife led perinatal mental health clinic.
- A postnatal listening service had been introduced to provide an opportunity for women to talk to staff, following the birth of their baby, in case of any issues they wished to discuss.

Are maternity and gynaecology services responsive?

Good

We rated responsive as 'good' because:

- The service was working in partnership with other organisations to develop local maternity services and develop strategies to improve care for women during pregnancy.
- Access and flow such as clinic waiting times were managed appropriately. There was access to investigation, assessment, treatment and care at all stages of the maternity pathway.
- Services were planned, delivered and co-ordinated to take account of women with complex needs, there was access to specialist support and expertise.
- There were processes in place for women to make a complaint. There had been three complaints in maternity and gynaecology services in the past 12 months. Learning from complaints was used to improve the service.

Service planning and delivery to meet the needs of local people

- The service worked with clinical commissioners, other stakeholders and lay members to develop local maternity services in response to 'Better Births Together' projects and feedback to the Success Regime, Sustainable Transformation Projects and NHS England processes.
- The service was aware of its risks and the need to ensure that services were planned and delivered to meet the increasing demands of the local and wider community.
- The service worked with Public Health and Cumbria County Council to develop the breastfeeding strategy for Cumbria. Other themes in the Public Health Strategy included alcohol use in pregnancy, domestic abuse, smoking and maternal obesity.
- The specialist midwives worked closely with various external agencies to involve families and support them to access appropriate groups during and post pregnancy.

Access and flow

- Between Q4 2014/15 and Q1 2016/17 the bed occupancy levels for maternity were generally lower than the England average, with the trust having 47.2% occupancy in Q1 2016/17 compared to the England average of 60.1%.
- Between March 2016 and August 2016, there were no closures of the maternity unit at WCH. There were contingency plans for the delivery suite in the event of the unit becoming full.
- Women received an assessment of their needs at their first appointment with the midwife. The midwifery package included all antenatal appointments, ultrasound scans and routine blood tests. Midwives were available on call 24 hours a day for advice. Community midwives were integrated into the service. Women with high-risk pregnancies attended consultant-led clinics.

- The introduction of a healthcare assistant led clinic for glucose tolerance tests had improved waiting times for women and reduced workload for midwives in the Day Assessment Unit.
- Termination of Pregnancy (TOP) clinics were held every Thursday afternoon and treatment was provided on Saturdays. Referrals were from GP and nurse practitioners there were no self-referrals. Medical terminations were up to 18 weeks and surgical terminations up to 14 weeks. At WCH most of women were now treated at first appointment, up until last year some were being deferred for one week due to occasional lack of capacity. Due to the changes in management of miscarriage there was now more capacity for TOP women, very few if any needed to be deferred unless through choice or too early to confirm the pregnancy.
- Discharge arrangements for women following a TOP included access to a 24 hour helpline. A detailed discharge letter was sent to the GP and there was a review of contraception in clinic. For example Intrauterine Contraceptive Devices could be fitted.
- There were guidelines and protocols to trial new methods of induction of labour and for out-patient induction of labour. This would enable low-risk women to go home during the process and reduce demand on hospital beds.
- Midwives performed examination of the new-born. Data showed 99% compliance for examination within 72 hours.
- At the end of November 2016 the proportion of patients waiting within 18 weeks to start treatment in gynaecology was 92.7% against the NHS operational standard of 92%.
- The number of inpatient and day case gynaecology procedures that were cancelled on the day for a non-clinical reason between 1 July 2016 and 31 December 2016 was 12; the highest number (4) was due to unavailable theatre staff.
- Between April and October 2016, the service achieved 92% of booking appointments for delivery before 12 completed week's gestation against a target of 90%.

Meeting people's individual needs

- WCH provided ante-natal telemedicine which was linked with the foetal medicine unit at Newcastle. Any identified scan anomaly was discussed with the team in Newcastle to assess suitability for the telemedicine service or if care required transfer to Newcastle. There were three appointment slots weekly. Medical staff at Newcastle consulted with the patient at West Cumberland using videoconferencing facility, reviewed live scans being performed by a sonographer and a care plan was agreed. This enabled women to be cared for locally without having to travel to Newcastle.
- There was a joint mental health practitioner and midwife led perinatal mental health clinic. This had reduced the number of women attending consultant led clinics and provided a more women focussed service.
- The service had introduced vaginal birth after caesarean section workshops.
- There were designated nurses who administered medication for medical termination of pregnancy. Women would see the same nurse in clinic which ensured continuity of care. Partners were able to stay.
- There were guidelines for smoking cessation. Clinical midwifery managers had ordered CO monitors for each clinical area so that women could be screened at each contact in line with national recommendations.
- Specialist consultant led clinics were held for women with a high body mass index, diabetes, mental health and twin pregnancies.
- Chaperones in clinic areas were available but there was no signage to advise this was an option.
- There were processes to identify women with learning disabilities. The service liaised with the learning disability nurse and staff encouraged family and key workers to be involved in the care pathway.
- There were processes to ensure disposal of pregnancy remains were handled sensitively. Women were provided with a choice of how they would like to dispose of pregnancy remains, following pregnancy loss or termination of pregnancy.
- There was a range of information leaflets available to women. Staff told us these leaflets were available in different languages if required. There was access to interpreters or use of a translation phone service for women who did not speak English.
- The screening midwife was informed of all high risk results and liaised with the consultant and antenatal midwives to refer women for further testing or counselling.
- There was a lead midwife for bereavement who offered support to parents who had lost a baby. There were memory boxes available with items to serve as a memory of the baby.

- Bereavement services included the provision of a private room and use of cold cots to keep the baby with parents for as long as the parents required. Staff offered women the chaplaincy service to provide extra support.

Learning from complaints and concerns

- We reviewed a sample of complaints and found that women were informed of timescales, apologies had been given, a meeting with the consultant was arranged and an action plan agreed.
- At WCH there were 3 complaints: two related to the post-natal (maternity ward); and one related to antenatal clinic. The main theme was about aspects of clinical treatment. Outcomes from the complaints included peer review and improved communication.
- Staff said the learning from these was shared during ward meetings, informal discussions and the monthly governance newsletter.

Are maternity and gynaecology services well-led?

Requires improvement

We rated well-led as 'requires improvement' because:

- Due to the public consultation taking place at the time of our inspection, it was noted that a preferred option and decision was yet to be taken by Cumbria Clinical Commissioning Group on the future of maternity and children and young people's services.
- Although there was some improvement with cross site working the cohesiveness of the two hospital sites for maternity services was not fully embedded with staff describing it as a 'us versus them' culture.
- Certain elements of the obstetric team remained dysfunctional with a lack of clinical engagement and support. It was not clear what action was being taken to resolve this.
- There was some improvement in strengthening of governance processes but the service identified that there were no indicators or metrics to ensure performance and understanding of risk or governance roles. There continued to be gaps in how outcomes and actions from audit of clinical practice were used to monitor quality and in systems to identify where action should be taken.
- Not all staff in the service felt that decisions about the reconfiguration of maternity services had been communicated effectively; they felt that it was a 'tick box' exercise and that their views and opinions were not being listened to.

However:

- Senior leaders in maternity and gynaecology were aware of the challenges in the service. Action had been taken where possible to mitigate risks however some actions were dependent on the outcome of the Success Regime.
- Communication with women who used the service had improved. The Maternity Services Liaison Committee was involved in the consultation on the future of maternity services in West Cumbria. Some further involvement was required in service development and co-design.
- The service had made some changes to improve maternity care for women.

Vision and strategy for this service

- Due to the public consultation taking place at the time of our inspection, it was noted that a preferred option and decision was yet to be taken by Cumbria Clinical Commissioning Group on the future of maternity and children and young people's services.
- The Better Births Together benchmarking exercise was completed with the Clinical Commissioning Group looking at a community midwifery model. The vision was to develop a community hub and transfer services such as ultrasound in to these**.** The Associate Director of Midwifery indicated that midwifery led care was not well defined in the trust and there was a need to change the ethos and re-engage with staff with a low risk philosophy.

Governance, risk management and quality measurement

- The service acknowledged that governance processes were not fully embedded and required strengthening.
- A governance manager worked across sites and was responsible for two risk midwives at each site. The governance manager did not have a job description for the role they were undertaking.
- The role of the risk midwives was two days a week to monitor reported incidents and complete incident

reviews. The ADOM acknowledged that there were no key performance indicators or metrics to ensure performance and understanding of risk and governance roles.
- The ADOM reported that a meeting was arranged to discuss governance responsibilities with the consideration for one full time risk midwife across both sites.
- The governance manager met weekly with the ADOM, clinical and business unit governance lead to discuss incidents, the risk register and monitor actions.
- A number of continuous audits occurred in the service but these were not always presented or analysed. For example, an increase in induction of labour rates was identified as a concern however no actions or themes were reported following the audit. The clinical lead for obstetrics said a business case was being developed to have a designated midwife audit lead working four days a week along with a commitment to release medical staff to participate in audit.
- The service had reintroduced cross site incident reviews to improve impartiality. The service had tried this previously; however, staff were not always available and delays occurred.
- In response to a review by NHS England about an increased level of serious incidents reported, a maternity assurance report was completed by the ADOM outlining themes and trends. The report was presented to the Trust Board in November 2016, Trust Quality Committee and shared with staff. The report identified key areas where further detailed work and action was required.
- There was an action plan in response to the Perinatal Mortality Review (2013) and the learning from the perinatal mortality review day (2014). The action plan (version 5 January 2017 received post inspection) showed that most areas were completed, three areas; scanning slots, review of the intra-uterine transfers and communication and continuity of care showed work was continuing.
- The maternity dashboard followed the RCOG guidance and was used as a tool for monitoring the number of incidents and trends. These were reported to the monthly trust Safety and Quality Committee meeting. Trends and hot topics/learning points were shared with staff in the maternity news magazine.
- There was a maternity risk register which contained all risks identified, with control measures and gaps in the control. Where gaps were identified assurance actions were documented. The risks were reviewed within an identified timescales. The service had produced a Maternity Service Assurance and mapped actions to the report of The Morecambe Bay Investigation which was presented to the Trust Board in April 2016. Actions were completed with some further work identified for staff opportunities with secondments to broaden experience of other units.

Leadership of service

- The maternity and gynaecology service sat in the Emergency Surgery and Elective Care Business unit. The unit was managed by a Divisional Associate Medical Director, Associate Director of Midwifery, Chief Matron and Associate Chief Operating Officer. There was a clinical director for obstetrics and gynaecology covering both sites and a deputy clinical director who was also the obstetrics and gynaecology lead for WCH. The ADOM was ten months in post.
- There were three clinical midwifery managers covering each site that were accountable to the ADOM.
- We found the leadership team were aware of the challenges for the service and these were reflected in the maternity risk register, action had been taken where possible to mitigate risks however some actions were dependent on the outcome of the Success Regime.
- Midwifery staff were positive about their immediate line managers, saying that they were supportive and approachable. Most staff said the ADOM was visible on the wards.

Culture within the service

- Some staff described an 'us versus them' culture between the two hospital sites. There was limited cross site working however there was some improvements made since the last inspection and cross site meetings, standard guidelines and sharing of information was taking place.
- Middle grade doctors said there were good relations with consultants however we found there were issues relating to the cohesiveness amongst some obstetric medical staff. We observed that there remained a lack of clinical engagement and support amongst some members of the consultant body. It was not clear what action was being taken to resolve these current concerns.

- Between April 2015 and March 2016, the service reported a sickness rate of 4% for nursing and midwifery staff and 0.6% for medical staff.

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Public engagement

- The service took account of the views of women through the Maternity Services Liaison Committee (MSLC). The minutes June and July 2016 showed women's experience, Success Regime options, engagement and service design issues were discussed.
- The MSLC were involved in the consultation on the future of maternity services in West Cumbria and had produced briefing sheets on the proposed maternity, paediatric and transport options.
- The chair of the MSLC told us there was good engagement with groups in the community. The MSLC visited hard to reach groups and post-natal groups to gain women's feedback. The chair said they would like more involvement in service development, co-design and guideline development.
- A user representative sat on the labour ward forum.
- There was a 'You Said We Did' board which showed that action had been taken in response to feedback from women, for example women having skin-to –skin in theatre and recovery following a caesarean section and post-natal discharges direct from the labour ward.

Staff engagement

- Some staff said decisions about the reconfiguration of maternity services had not been communicated effectively; they felt that it was a 'tick box' exercise and that their views and opinions were not being listened to.
- The ADOM wanted to support the team to deliver caring staff who were flexible. They told us staff engagement sessions had been held and were well received by midwives when vision and ideas for service provision were discussed.
- A monthly governance and risk management newsletter was sent to all staff. Each ward had a 'take five board' which provided quick feedback on learning from low level incidents**.**
- The service held a Whose Shoes? Improving Maternity Experience workshop. This was a values-led, bespoke approach to change management. It was used to support transformation to a more person-centred, integrated culture of care and support. Key themes included continuity, empowering women, choice, expectations, support and consistency. An action plan to develop these areas was in place.
- Staff could share their views on the caesarean section strategy. This was part of the 'Pathways to Success – a self-improvement toolkit focusing on normal birth and reducing caesarean section rates'. The first survey was undertaken some time ago and was on the theme of 'Caesarean section - keeping birth normal'. The next survey on 'keeping first pregnancy and birth normal' was currently ongoing with the completion date of January 2017.

Innovation, improvement and sustainability

- Plans for the future of maternity services were still under discussion at the time of our inspection with a number of service options under consideration. The outcome of the consultation was not yet known.
- The service was aware of the challenges and risks to sustain the service particularly around staffing and other quality issues. Action had been taken where possible to mitigate these however some actions were dependent on the outcome of the Success Regime.
- The service had made improvements to maternity care. WCH provided ante-natal telemedicine which was linked with the foetal medicine unit at Newcastle. Any identified scan anomaly was discussed with the team in Newcastle to assess suitability for the telemedicine service or if care required transfer to Newcastle. There were three appointment slots weekly. Medical staff at Newcastle consulted with the patient at West Cumberland using videoconferencing facility, reviewed live scans being performed by a sonographer and a care plan was agreed. Patient feedback was very positive.
- There were some challenges with office space for specialist midwives who the majority of the time had to 'hot desk', they told us this was impacting on delivering the service efficiently.

Services for children and young people

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

Information about the service

Services for children and young people at West Cumberland Hospital included a 14-bed children's ward and there was a special care baby unit (SCBU) with 9 commissioned cots. The children's outpatient department was situated within the main outpatient department.

The service was last inspected in March 2015 and was rated 'good' in all domains. Inspectors noted there had been improvements in risk management, safeguarding procedures and nurse staffing. There was a visible, child centred culture within the service and staff provided good care. A shortage in medical staffing was highlighted. During this inspection, inspectors reviewed medical and nursing staffing in line with the trust's workforce strategy as well as escalation and contingency plans in these areas. The service was under review with a number of models being considered and evaluated in order to better meet the needs of the population.

An unannounced focussed inspection took place in September 2016. The inspection team reviewed the safe and well-led domains. Although the service was not rated at this time, inspectors found staff had maintained good incident reporting processes, safeguarding procedures and nurse staffing levels. Documentation and record keeping was good and the service had good local processes to monitor changes in a child's condition. There was a clear strategy for the remodelling of services provided by the child health business unit and staff felt supported by the local management team. However, inspectors noted issues in relation to medical staffing had not been resolved.

During this inspection, we visited the children's ward and outpatient department, the special care baby unit and provisions for children and young people in the urgency care department. We spoke with 15 members of staff and seven families. We reviewed 18 sets of care records, including prescription charts. We also looked at six case notes specifically in relation to safeguarding children and young people.

Services for children and young people

Summary of findings

We rated this service as 'good' because:

- The leadership, governance, and culture promoted the delivery of high quality person-centred care. Staff were competent and had the skills they needed to carry out their roles effectively and in line with best practice. Managers were visible and there was a real strength, passion, and resilience across medical and nursing teams to deliver high quality care to children, young people and their families.
- Staff told us they were proud to work for the trust and promoted a patient-centred culture. Children, young people, and parents felt that medical staff communicated with them effectively, kept them involved and informed about care and treatment, promoted the values of dignity and respect, and were kind and compassionate.
- Staff protected children and young people from harm and abuse. Medical and nursing staff understood and fulfilled their responsibilities to raise concerns and report incidents, and managers took appropriate action to investigate and share learning.
- Medical and nursing staff followed appropriate processes and procedures to safeguard children and young people. The trust was represented at local safeguarding children board meetings and other sub-groups. Clinicians shared learning from serious case reviews and care records showed staff provided very good standards of care.
- Children and young people received effective care and treatment, planned and delivered in line with current evidence-based practice and legislation. Children's services participated in national and local audits, and other monitoring activities including service reviews and accreditation schemes. Managers shared the outcomes from audits and actions plans were developed to address areas of concern.
- Children's services were organised to meet the needs of children and young people. Managers and healthcare professionals from the team worked collaboratively with partner organisations and other agencies to ensure services provided choice, flexibility and continuity of care.
- Nurse staffing on the children's ward and in the special care baby unit was compliant with recommendations from the Royal College of Nursing and the British Association of Perinatal Medicine.

However:

- The unit did not meet all Royal College of Paediatric and Child Health (RCPCH) – Facing the Future: Standards for Acute General Paediatric Services (2015 as amended) within contracted hours. Despite ongoing recruitment campaigns, the trust had struggled to recruit appropriate clinicians. The current paediatric consultant team voluntarily worked in excess of their programmed activities to ensure children and young people were safe, however staffing constraints meant this was done in their own time. In a letter to CQC, the trust formally acknowledged our concerns and outlined the actions taken to address the current shortfall, which included robust handovers and ward rounds, plus on-site consultant presence and out-of-hours support. The trust had also secured long-term contracts for consultant locums.
- Healthcare assistants worked within the children's outpatient department without support from a registered children's nurse. This was in breach of Royal College of Nursing staffing standards for children in outpatients as, most of the time; a healthcare assistant was the only member of the nursing team in the unit. In addition, staff did not have documented competencies and had not received additional training.

Services for children and young people

Are services for children and young people safe?

Requires improvement

We rated safe as 'requires improvement' because:

- The unit did not meet all Royal College of Paediatric and Child Health (RCPCH) – Facing the Future: Standards for Acute General Paediatric Services (2015 as amended) within contracted hours. Consultant job plans provided for 10-11 programmed activities a week however in reality most were voluntarily working in excess of this. To keep children safe, most clinicians worked additional hours. Although goodwill and good teamwork contributed to mitigating the risk, there was only one substantive full time consultant supported by five locum clinicians. Despite ongoing recruitment campaigns, the trust had been unable to recruit to the substantive posts, leaving the unit in a precarious and fragile position. In a letter to CQC, the trust formally acknowledged our concerns and outlined the actions taken to address the current shortfall, which included robust handovers and ward rounds, and on-site consultant presence plus out-of-hours support. The trust had also secured long-term contracts for consultant locums.
- Healthcare assistants worked within the children's outpatient department without support from a registered children's nurse. This was in breach of Royal College of Nursing staffing standards for children in outpatients as, most of the time; a healthcare assistant was the only member of the nursing team in the unit. In addition, staff did not have documented competencies and had not received additional training.
- The new patient database system in A&E did not have capacity to flag children and young people who had repeatedly attended the department, children who were looked after or those subject to a protection plan. This meant staff had to rely upon parents and carers to provide an honest history of the child's health.
- Mandatory training compliance was low. Although medical and nursing staff told us they had completed all of the required training, statistical evidence provided by the trust contradicted this. Managers told us they had planned for all staff who had not completed all training modules to do so by the end of the year.

However:

- Staff protected children and young people from avoidable harm and abuse. There were systems and processes to safeguard children and young people. Staff took a proactive approach to safeguarding and focused on early identification. The trust had the appropriate statutory staff in post that were active and engaged in local safeguarding procedures and worked with other relevant organisations.
- Nurse staffing on the children's ward and in the special care baby unit was compliant with recommendations from the Royal College of Nursing and the British Association of Perinatal Medicine.
- Managers and staff discussed incidents regularly at weekly risk meetings and during daily safety huddles when appropriate. They took appropriate action to prevent them from happening again. When something went wrong children, young people and families received a sincere apology.
- Managers regularly reviewed staffing levels to ensure children and young people were safe at all times, and there was a clear escalation process in place.
- On a day-to-day basis, staff assessed, monitored and managed risks to children and young people and this included risks to children who had complex health needs, or who were receiving end of life care.
- Documentation, including completion of care plans, risk assessments, reviews, medication charts, observation and patient involvement, was good.
- All areas were visibly clean. Domestic and nursing staff followed cleaning schedules and updated cleaning logs. There were no cases of clostridium difficile (C Diff), methicillin resistant staphylococcus aureus (MRSA) and methicillin sensitive staphylococcus aureus (MSSA) in the 12 months prior to the inspection.

Incidents

- The trust had an incident reporting policy and staff reported incidents of harm or risk of harm using the risk management reporting system. Medical and nursing staff told us they felt very confident reporting incidents and near misses.
- There were 55 incidents reported between May 2016 and August 2016 relating to children's services at WCH. Of these, the majority of incidents (82%) did not cause any injuries while 47% were classified as negligible or minor. Incidents classified with an initial severity rating

of moderate accounted for 45% of all reported incidents. Of these, 64% related to documentation and health information. The majority of those incidents were due to the unavailability of case notes. Staff we spoke with told us this was an ongoing problem and explained they did not always report this as an incident due to time constraints. Six incidents did not have a final classification, as they were still under review when we received the information.

- Staff on the children's ward reported the majority of incidents (62%) while 35% related to the special care baby unit (SCBU). In addition to incidents about the unavailability of care notes, staff from the children's ward also reported inappropriate admissions of young people who required specialist mental health care. There were 19 related incidents reported in the last 12 months. There was no common underlying theme from incidents reported by SCBU.
- We saw evidence of learning from incidents. For example, staff identified issues with the plastic protective sheath on intubation stylus coming dislodged with potential risk to the children. The unit changed the equipment immediately and now carry out a double check post-intubation to ensure the coating is intact prior to disposal.
- Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. Between October 2015 and September 2016, the trust reported no incidents which were classified as Never Events for children's' services.
- In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SI) in children's services, which met the reporting criteria set by NHS England between October 2015 and September 2016. The incident reported was classed as a treatment delay. The investigation reports included a thorough investigation and root cause analysis, which identified the risks, and highlighted areas of good practice.
- Staff we spoke with understood the duty of candour requirements. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. We saw examples demonstrating where staff had followed the procedure in relation to the serious incident investigations, which included interaction with the family.
- Senior staff held weekly risk meetings to review incidents, which included staff from the children's ward and the special care baby unit (SCBU). Every month, managers reviewed emerging themes and trends from incidents at a unit governance meeting. In addition to meetings, staff also had access to a ward communications book. This included outcomes from incidents and meeting minutes. Incidents and lessons learned were also included in a performance dashboard.
- Staff confirmed they received individual feedback from incident submission by email and face to face with the ward manager. Ward managers tended to share outputs from incidents in ward meetings, in the ward communications book, and by displaying meeting minutes and during appraisals. The trust also cascaded learning from incidents on the 'safety messages of the week' bulletin.
- SCBU shared learning with colleagues from other trusts as part of the wider Northern Neonatal Network (NNN) at regional meetings held each quarter. The NNN aimed to improve outcomes for babies born and cared for across the network region, providing trusts with an opportunity to share good practice.
- Medical and nursing staff discussed paediatric deaths at monthly mortality and morbidity meetings. Managers told us there had been no cases in the last three months. Paediatric community deaths were reviewed in line with the Local Safeguarding Children's Board recommendations and were discussed at the Child Death Overview Panel, attended by the named doctor for child protection.

Safety Thermometer

- Safety Thermometer is used to record the prevalence of patient harms at the frontline, and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.
- The service had adapted and developed an audit tool called 'paediatric clinical indicators' for use across the

business unit to monitor and measure 'harm free' care. Staff used the tool in conjunction with clinical audit measures and patient satisfaction surveys to obtain a holistic view of performance and quality.

- Senior staff audited compliance against the tool's 12 key clinical indicators (communication, elimination, manual handling, food and nutrition, infection control, medicines management, pain management, patient observation, privacy and dignity, tissue viability, record keeping and discharge standards) on a monthly basis.
- On the children's ward between June 2016 and August 2016, clinical indicator compliance averaged 89% (against the trust 'green' rating of 95%). The minor discrepancy was noted in the completion of a property disclaimer, which was omitted from paediatric documentation. SCBU compliance was 100%.
- Ward information boards also displayed ward performance data. Information included percentage scores in relation to cleanliness, infection prevention and control, cannula care and management, hand hygiene, appraisals and mandatory training. The units also shared outputs from 'ideas/issues/successes' and POPPY data (a review of services for the parents of premature babies). On the ward, there were very good compliance results against hand hygiene, cleaning schedules and patient experience surveys with results all in excess of 90%.

Cleanliness, infection control and hygiene

- All areas we visited were visibly clean. There were handwashing facilities at the entrance of each clinical area and we observed staff and visitors using them appropriately upon entering and leaving the ward. Antibacterial hand gel dispensers were also available at various locations within each ward or unit and staff carried personal hand gels, attached to their uniform.
- Domestic and nursing staff followed cleaning schedules and updated cleaning logs. They told us they also cleaned examination equipment (equipment that was in direct contact with patients) after the clinic has ended, including specula for scopes and blood pressure cuffs.
- Infection prevention and control (IPC) was part of the trust's mandatory training programme and the compliance target was 95%. Nurses and healthcare assistants had currently achieved 69% and medical staff had achieved 67%. Managers told us they were confident all training would be complete by the end of the year (March 2017).
- On the children's ward, the play specialist was responsible for cleaning toys. They told us there was a toy cleaning policy and they cleaned toys daily in line with the documented procedure.
- We saw personal protective equipment was readily available for staff to use and we observed staff using it appropriately. We also observed staff adhering to 'bare below the elbow' guidance, in line with national good hygiene practice.
- The unit recorded no cases of clostridium difficile (C. diff), methicillin resistant staphylococcus aureus (MRSA) and methicillin sensitive staphylococcus aureus (MSSA) in the previous 12 months prior to the inspection.
- Staff regularly took part in IPC audits. Hand hygiene audits showed staff from the children's ward and SCBU achieved consistently high results. Between January 2016 and August 2016, both units achieved 100% every month in 'Spray and Glow' audits. IPC nurses confidentially sprayed ward surfaces with UV solution and revisited the area the following day to confirm surfaces had been appropriately disinfected and decontaminated.
- We saw evidence of appropriate waste segregation and clinical waste disposal units. Staff were aware of the importance of and risks involved in handling of sharps. We observed staff safely disposing of needles in appropriate sharp bins and arranging disposal when full.

Environment and equipment

- Access to the children's ward and to SCBU was restricted. Staff monitored visitors entering and leaving the respective unit and granted access via a secure entry system.
- We saw evidence of processes to ensure equipment was safe. Staff completed environmental and equipment checks as part of their daily work and formally through the audit process. Checks included equipment cleanliness (such as commode, drug fridges, and mattresses), accessibility, storage, and integrity. The trust environmental report showed the children's ward and SCBU compliance averaged in excess of 95%

between April and June 2016. Staff displayed audits findings on ward noticeboards. The audit identified some wear and tear to fittings and where cleaning needed to be improved

- The trust's medical electronics department was responsible for the maintenance of all devices and equipment. Equipment we checked had been safety tested. Staff we spoke with told us they knew who to contact if they needed to report any faults and felt confident the system was robust.
- The environment across all areas where children and young people accessed care and treatment was good. The children's ward was very child-friendly and included a large playroom for younger children. There were no separate facilities for older children and young people, however the ward manager explained games consoles and DVD players could be accommodated in rooms upon request. Children and young people did not have access to Wi-Fi on the ward however staff told there were plans to introduce the facility at both hospitals.
- Children attending the accident and emergency unit waited in a separate area that was equipped to meet their needs. Dedicated examination and treatment rooms also included appropriate paediatric equipment. In the resus room, there was a separate bay allocated to children.
- Resuscitation trolleys held appropriate equipment, which was suitable for the needs of children. Staff completed a daily log to confirm the daily resuscitation equipment check was completed. We reviewed the logs and found no omissions. Staff had received training to use the equipment and their competency recorded.
- The children's outpatient department was located within the main outpatient department. There was a dedicated area for children within the main waiting room, which had a small number of appropriate toys and wall displays. Medical and nursing staff reviewed children in one of two dedicated examination rooms, which included toys and appropriate equipment suitable for children of different ages, such as various sizes in blood pressure cuffs.
- The children's ward was equipped with new high flow oxygen machines, which reduced the number of transfers of babies suffering from bronchiolitis to the regional tertiary care centre for additional care and treatment.

Medicines

- The trust had a policy for the administration and storage of medicines and staff we spoke with told us they followed standard procedures. There was dedicated pharmacy support across the service.
- Staff received training on medicines management as part of their local induction into the clinical areas. Managers had introduced a number of local medicines based competencies, for example, in administering intravenous medications. Ward managers assessed and monitored competencies against agreed best practice standards.
- Medicines were securely stored and handled safely. Storage cupboards and fridges were tidy and locked. Staff recorded and monitored the minimum and maximum fridge temperature appropriately, and explained the procedure they followed if there was a problem. There were two refrigerators in SCBU which were clearly labelled confirming which was for medicine storage and which was for the storage of milk.
- We reviewed eight prescription charts. Overall, staff completed the charts accurately and the writing was legible. Staff recorded the date and their signature, allergies were documented, medication that was omitted or not administered had a documented reason, and antibiotics were prescribed as per guidelines. Staff also recorded the weight of the child.

Records

- We reviewed 10 sets of care records. Overall, we saw notes were legible and staff completed them accurately and included appropriate information such as, consent, risk assessments, and nutritional status. There was evidence of consultant review within 14 hours in all cases. However, we noted on three records there was no evidence of sepsis screening.
- On the children's ward, medical records were stored securely in the doctors' office, away from the ward, which was kept locked when staff were not present. Nursing notes and charts were stored safely in folders behind the nurse's station but were not in a locked storage unit. In SCBU, notes were stored in a filing cabinet. At the previous inspection in September 2016, the ward manager explained the lock was broken and they were awaiting a replacement. This time, the cabinet was unlocked and the key had gone missing a few days prior. The ward manager assured us a new cabinet was due to arrive within the next few days. They

explained a member of staff was always located near to the cabinet however; we identified this as a risk, particularly during the night when there were only two nurses on shift.

- The children's ward and SCBU completed case note reviews as part of the NHS Litigation Authority (NHSLA) audit. Managers audited 10 case notes each month against 30 key indicators ranging from demographics to examination findings and treatment plans. The summary from an audit in SCBU recommended staff should date all entries and record the time, and ensure a management plan was included in the notes each day. Managers completed action plans to address shortfalls in audit compliance.
- Patient records were held off site and not in the hospital. Staff from the children's outpatient department told us that notes were not always readily available for children attending clinics. One member of staff told us of occasions when consultants had refuse to see children in clinic if their notes were not there. Although staff had reported some incidents, they told us there were some occasions when they had not due to time constraints. Staff from the children's ward also expressed concerns about the delay in receiving patient notes however did acknowledge the process was beginning to improve.

Safeguarding

- The trust had a safeguarding children policy. Staff we spoke with felt the safeguarding team had a high profile across the organisation and could explain what actions they would take if they had concerns about a child or young person. The named nurses reviewed all of the safeguarding referrals sent to them from staff. Staff we spoke with showed us evidence of the referrals they made and of the feedback they received from the safeguarding team. Recent feedback forms from staff included a concern about an unexplained injury to a young child in foster care. Staff also used the CWILTED (condition, witness, incident, location, time, escort, description) assessment tool to identify potential abuse when a child or young person was triaged by a member of staff.
- The trust had the necessary statutory staff in post, including the named nurse and named doctor. The director of nursing was the nominated executive lead for safeguarding and attended Local Safeguarding Children Board meetings. All members of the team attended relevant sub-groups ensuring information and good practice was shared internally and externally. For example, the team produced a safeguarding children newsletter that included the findings and learning from five recent serious case reviews. The named doctor had also delivered a series of presentations to staff.
- There had been two recent serious incidents. Both related to misdiagnosis, one of a child with a fracture and the other a non-accidental injury. Learning from this incident resulted in a new protocol for the identification of non-accidental injury in the immobile child. This was currently in draft awaiting ratification by the trust safeguarding board.
- The safeguarding team participated in safeguarding audits to monitor safeguarding standards. The named nurse conducted monthly dip-sample audits of case notes and we reviewed the latest safeguarding self-assessment audit submitted to Cumbria Clinical Commissioning Group. The trust was fully compliant with the majority of standards, which included leadership, governance arrangements, policies, procedures and systems, and inter-agency working. Standards against which the trust was non-compliant had an action plan in place and progress was being made within agreed timescales.
- Medical and nursing staff routinely discussed safeguarding concerns including children who were subject to a child protection plan at daily handover meetings on the ward or unit.
- The local authority (LA) provided a weekly list of children looked after and those on a child protection plan. Although the system used by the LA was compatible with the trust electronic system, children from out of the area were not as easily identified.
- In addition, the system in A&E did not have the capacity to flag this information, or children or frequently attended A&E. This meant there was reliance upon nursing and medical staff to manually interrogate the system or contact the safeguarding team if they had any concerns. Staff also had to rely upon the parent or carer to provide an honest medical attendance history as healthcare professionals could only make an assessment based upon the current visit. Senior managers were aware of the risk although it was not included in the child health business unit risk register provided to us by the trust.
- The named nurse had instigated an initiative to introduce safeguarding children champions on the

children's ward, SCBU, A&E and maternity. Safeguarding champions, who ranged from band 5 to band 7 staff grades, had also received training to provide safeguarding supervision to nursing staff.
- The named nurse's professional development included one-to-one supervision with the safeguarding designated nurse and external supervision/mentorship from a designated nurse in another area. The named nurse had also accessed level 4 safeguarding children training and attended regional safeguarding forums.
- National guidance states all clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns should all be trained at Safeguarding Children Level 3.
- The trust set a target of 95 for completion of safeguarding training in 2016/17. Only 50% of medical staff had completed Safeguarding Adults Level 1 and Safeguarding Children Level 3 (specialist) so far in the current year.
- All nursing and healthcare assistant staff had completed Safeguarding Children Level 3.The majority of staff had completed Safeguarding Adults level 1 (76%).
- The safeguarding team had developed a work plan, which identified a series of safeguarding actions, one of which was to improve the overall training compliance across the trust in relation to safeguarding children. The team was working in conjunction with the learning and development department to identify those staff who had not received training and to ensure training statistics were recorded accurately.
- We reviewed six sets of care records from the children's ward and paediatric A&E, specifically in relation to safeguarding children and young people. Overall, the notes were completed to a good standard and, on the children's ward, there was evidence of excellent practice, with nursing staff demonstrating a high level of awareness of child protection processes and procedures. However, we noted in one case, it was not clear if staff had attempted to check if the child had been subject to a protection plan or was a child in need.

Mandatory training

- The trust set a target of 95% for completion of the majority of mandatory training. Mandatory training courses for medical and nursing staff included information governance, fire safety, infection control health and safety and paediatric basic life support.
- All of the staff we spoke with told us they had completed all of their mandatory training for the year.
- However, the average compliance from medical staff for information governance and fire safety was low at 17%, and well below the trust target. Compliance from nurses and healthcare assistants was higher though still below the trust target at 65% and 62% respectively.
- The average compliance for paediatric basic life support was 67% for medical staff and only 35% for nurses and healthcare assistants.
- Managers told us they expected all staff to have completed mandatory training by the current year and a schedule was planned for the upcoming year. The ward manager displayed information in the staff room and regularly kept staff informed about training requirements.

Assessing and responding to patient risk

- The children's ward and staff from the A&E department used the paediatric early warning scores (PEWS), an early warning assessment and clinical observation tool. This included a clinical observation chart, coma scale and additional information such as the pain score tools with an assessment table to assist clinical staff in determining what action nursing and medical staff should take for an ill child. We spoke with medical staff and nurses who demonstrated a clear awareness of how to assess patient risk and what action they would take in response. PEWS charts were audited every month and staff from the children's ward achieved consistently high results.
- Consultants completed ward rounds each morning. Evening ward rounds were flexible to prioritise new admissions and/or poorly children. Staff informed us all children had an immediate paediatric nurse assessment, were reviewed by the attending doctor within four hours and all were reviewed by a consultant within 24 hours (including at weekends). We found evidence of consultant reviews documented in the medical records.
- Daily handovers took place and included discussions about patient safety as well as detailed information sharing about each child. Based on the SBAR principles

(situation; background; assessment and recommendation), the meeting highlighted any risks and enabled medical and nursing staff to reinforce plans to monitor deteriorating patients, for example, increasing observations or 1:1 nursing care. During each day, staff took part in safety huddles on the ward and focused on assessing and responding to individual patient risk.

- Clinicians transferred children who required paediatric intensive care to the regional tertiary care hospital. In the event of a child deteriorating and, for example, requiring intubation, staff from the intensive care unit would stabilise the patient with support from a paediatrician (with or without paediatric nurse) until medical staff had secured appropriate retrieval or transfer arrangements to the tertiary hospital.
- The trust had a transfer of patient policy (including intra and inter hospital transfers) with a designated section for the care and management of paediatric and neonatal patients. SCBU was part of the northern neonatal network, which provided specific transfer guidelines for the movement of babies who required high dependency or intensive care. This included arrangements for baby retrieval, preparation for transfer, and transport requirements.
- The neonatal unit did not use a new-born early warning trigger and track (NEWTT) tool. However, in our review of care records, we saw staff had taken appropriate action when a baby had shown signs of deterioration.
- The unit followed the National Institute for Health and Clinical Excellent (NICE) guidelines for the assessment, treatment and management of babies with risk factors for infection or clinical indicators of possible infection. SCBU also held 'high risk' folders on the unit which included specific information about vulnerable babies and mothers such as congenital abnormalities or mental health concerns.
- The trust had a policy for the management of sepsis and paediatric sepsis six pathway for children under the age of five and between the ages of five and 11. We saw evidence of the UK Sepsis Trust-endorsed paediatric sepsis screening and action tool and a senior nurse told us one of the consultants had delivered training to the medical team.
- Staff at WCH expressed concerns in the care and management of children requiring assessment by an approved mental health practitioner (AMHP) from the child and adolescent mental health service (CAMHS). Staff identified these children to be an additional risk factor on the ward where they required additional support from nursing staff. Staff reported delays in securing CAMHS assessment (provided by another trust) and escalated this concern to unit managers.

Nursing staffing

- The children's ward accommodated 14 children and the unit comprised of seven inpatient beds and seven assessment beds.
- Children's services took into account guidance from the Royal College of Nursing (RCN) in relation to paediatric nurse staffing levels. The RCN standard for bedside deliverable hands-on care recommends one nurse to three children (1:3) under two years of age, and one registered nurse to four children (1:4) over 2 years of age.
- We reviewed rotas from the previous three months and found nurse staffing at WCH met the RCN guidance, with support from bank nurses and a paediatric nurse practitioner (PNP) who, although not part of the ward-staffing establishment, was included in the roster two days a week. All bank nurses were registered children's nurses and provided cover approximately once every two weeks. Two additional ANPs were currently in training and were due to qualify the following year.
- The trust used the Safer Nursing Care Tool (endorsed by National Institute for Health and Care Excellence) to assess safe staffing levels for the children. Managers forward planned nurse rotas to allow for early identification of a staffing shortfall and completed a twice-daily acuity review to manage changing patient need. There was a clear escalation process in place should a shortfall occur. Ward managers advised they obtained support from the wider unit, asked existing staff to extend or work additional shifts, and requested staff from the nurse bank.
- The ward used the trust e-rostering system, and planned for three registered nurses on shift during the day and two registered nurses overnight. A healthcare assistant (HCA) provide additional support on all shifts. The ward manager acknowledged where a third registered nurse could not be rostered to cover the full duration of the day shift, they rostered shorter shifts to cover the ward at busier periods (10.00am to 6.00pm). We reviewed staffing rotas from July to September 2016 and noted actual staffing met establishment. This

broadly correlated with fill rates for the same period which averaged 82% for registered nurses during the day and 100% at night. HCA fill rate figures were 102% and 82% respectively.

- Senior nurses confirmed most of the registered children's nurses had received advanced paediatric life support (APLS) training, and there was always at least one nurse on duty per shift.
- The RCN 'Defining Staffing Levels for Children and Young People's Services' (2013) guidelines recommend one member of nursing staff should be supernumerary and external to the nurse rota. The ward manager confirmed the children's ward did not meet this RCN standard. The ward manager only had one management day a week and was part of the main rota at all other times (Monday to Friday).
- In SCBU, we reviewed rotas for the previous three months and found neonatal nurse staffing at WCH met the British Association of Perinatal Medicine (BAPM) recommendations. BAPM recommends a staffing ratio of one neonatal nurse to four babies (1:4) in units providing level one special care. Neonatal nurses on the unit were all qualified in specialty (QIS).
- SCBU also used the trust e-rostering system and planned for two registered nurses and one healthcare assistant (HCA) during the day and two registered nurses at night. The ward manager also told us they were also hoping to introduce a HCA night shift to further increase the safety of babies during the night. Managers recorded neonatal nurse staffing levels twice daily on BadgerNet (a single record of care for all babies within neonatal services, and used widely across the country).The data was replicated onto the trust's acuity tool which enabled managers to view actual staffing levels and patient numbers.
- Healthcare assistants (HCA) worked within the paediatric clinics in the outpatient department with no involvement from registered children's nurses (RCN), although a manager acknowledged RCNs were occasionally allocated on the roster. Royal College of Nursing staffing standards for children in outpatients states there should be a minimum of one RCN must be available at all times to assist, supervise, support and chaperone children. Our observations and the information provided to us by staff suggested the HCA worked alone in the department most of the time. Royal College guidance also states HCAs who observe and monitor children should be trained and competent in weight management and documentation according to their level of responsibility. The HCA did not have documented competencies for this and told us they had not received any additional training.
- The average vacancy rate for the service across both sites was 4.8% (as of Sept 16).
- The average turnover rate across both sites in 2015/16 was 8%, which was the same as the overall trust average.
- In 2015/16, the trust reported a bank and agency usage rate of 1.08% in children's services. The Cumberland Infirmary reported an average rate of 1.02%. Nursing staff told us agency nurses were not used in SCBU, only one regular bank nurse.
- The average sickness rate for the service across both sites in 2015/16 was 4%. This was better than the overall trust average.

Medical staffing

- According to the Health and Social Care Information Centre, medical staffing skill mix varied in comparison to England average. Overall, the service had a significantly lower proportion of consultant grades (23% compared to 39% average) and a lower number of registrar grades (42% compared to 47%) than the England average. The service had a significantly greater number of middle career grades (doctors with at least three years' experience as senior house officer or at a higher grade) and junior doctors than England average. The total whole time equivalent (WTE) for medical staffing at both hospital sites was 14.
- In September 2016, the trust reported a vacancy rate of 21% in children's services, across both sites in Carlisle and Whitehaven. The trust relied upon locums to support the children's ward and outpatient department, and SCBU. Between April 2015 and March 2016, the trust reported a locum usage rate of 25%. The turnover rate during the same period was 46%.
- WCH had one full time substantive consultant in post. There were five senior locum doctors (four consultants and a middle grade), many of whom were on long term contracts or had worked at the trust for over six months. Senior clinicians told us they were confident the care they provided was safe; however, they acknowledged the fragility of the service due to the reliance on locum medical staff.
- The majority of consultant job plans provided for 10-11 programmed activities a week however in reality most

were voluntarily working in excess of this, in the region of 11-12.5. This meant the consultant team did not meet all Royal College of Paediatric and Child Health (RCPCH) – Facing the Future: Standards for Acute General Paediatric Services (2015 as amended) within their contracted hours. It also created additional pressure on individual members of staff. Specifically, the unit did not meet:

  - Standard 1: a consultant paediatrician is present and readily available in the hospital during times of peak activity, seven days a week.
  - Standard 3: every child who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician within 14 hours of admission, with more immediate review as required according to illness severity or if a member of staff is concerned.
  - Standard 4: at least two medical handovers every 24 hours are led by a consultant paediatrician.
- Recruitment to substantive posts was ongoing however, managers told us they had very clear expectations and would not appoint clinicians who did not meet the specific criteria of the role.
- The medical team operated a consultant of the week (COW) rota from 9.00am to 5.00pm and a hot week where cover was provided out-of-hours from 5.00pm to 9.00am the following day. We reviewed paediatric rotas from June to August 2016 showing consultant cover, staff and middle grade attendees, COW and on-call staffing arrangements (consultant on call from home overnight and at weekends with a combination of speciality doctor/ foundation year doctor/advanced paediatric nurse practitioner (APNP) on site). There were no rota gaps.
- Clinicians provided consultant presence from 9.00am until 7.00pm every weekday and 9.00am until 12.00pm at weekends, with on-call arrangements thereafter. All staff confirmed on call cover to be effective with support easily accessible when required. Junior medical staff and nurses reported no problems contacting a consultant during the night and at weekends.
- Junior doctors spoke positively about senior colleagues, describing them as were accessible and approachable. They commented they felt “safe, supported, and involved”. Consultants and senior paediatric doctors welcomed contact out-of-hours in the event of concern about a child or for treatment advice and told us they were happy to attend the unit when required.
- Consultant-led medical handovers took place every morning. There were less formal evening rounds to review admissions or children of concern. All children were discussed and each summary included a detailed review of the child, an update on progress, ongoing treatment plans and an opportunity for junior medical staff to learn and ask questions.
- Between April 2015 and March 2016, the trust reported a sickness rate of 0.2% in children’s services. This was better than the overall trust average.

Major incident awareness and training

- The unit had a paediatric service escalation plan and a staffing contingency plan to provide guidance and support to staff in the event of a major incident. Staff on the children’s ward confirmed an awareness of the escalation plans.
- The unit took part in a multi-agency table-top exercise in July 2016 to test the resilience of such plans. The exercise primarily focussed on services at WCH however, the impact upon the Cumberland Infirmary formed a key part of the exercise discussions. The exercise identified a number of areas for future consideration and improvement such as the need for more depth and detail for long-term loss of staff, more training, and awareness across the unit to embed the plans and fully integrate the paediatric policies into the wider trust framework.

Are services for children and young people effective?

Good

We rated effective as ‘good’ because:

- The trust had systems and processes in place to review and implement National Institute for Health and Care Excellence (NICE) guidance and other evidenced-based best practice guidance. Polices and guidelines were available on the trust intranet and ward managers held a file centrally within each service area.
- We reviewed information that demonstrated children’s services participated in national audits that monitored patient outcomes when these were applicable.
- Outcomes for children and young people suffering from diabetes were better than the England average

according to data published in the latest national diabetes audit. Statistics from the trust's diabetes annual report showed outcomes were improving for children under ten and were better than the England average. Approximately one third of children receiving treatment for diabetes were in the 15-19 year old age group, which was a higher proportion than other regions in the country. Staff we spoke with acknowledged the challenges to support young people in managing their long-term condition and told us this remained a high priority for the service. Young people also remained in the children's service for longer than expected, due to limitations in the adult diabetes service, which staff explained was a contributory factor.

- Readmission rates were better or similar to the England average in most cases. They were worse for children under one readmitted within two days of discharge following an emergency admission. They were also worse for children and young people between 1 and 17 years who had multiple readmissions for epilepsy. However, the children's ward maintained an 'open door' policy for children with chronic conditions. Families were encouraged to return to hospital if they had further concerns about their child.
- Results from the national neonatal audit programme identified several areas of good practice and some outcomes exceeded the national average. There were also areas for improvement and staff had developed an action plan to address the concerns.
- There were effective arrangements for young people transitioning to adult services or between services. Needs were assessed early, with the involvement of all necessary staff, teams and services and staff applied Gillick guidelines appropriately in relation to obtaining consent. Arrangements reflected individual circumstances and preferences.
- Children and young people had access to effective pain relief and staff used evidence-based pain-scoring and assessment tools to assess the impact of pain. Non-pharmacological methods were also utilised to distract and calm children before, during, and after the administration of treatment.
- There was evidence of positive multidisciplinary working across various disciplines and specialties.
- Nursing and medical staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. Staff had received an annual appraisal and received support and personal development.

Evidence-based care and treatment

- Services for children and young people at WCH adhered to guidelines from the Royal College of Nursing (RCN), the National Institute for Health and Care Excellence (NICE) and other professional guidelines such as the British Association of Perinatal Medicine. Policies and guidelines were available on the trust intranet and ward managers also held a file centrally within each service area.
- Children's services participated in national audits such as diabetes and paediatric pneumonia. We also saw evidence of local audit activity to assess compliance with NICE quality standards. The audit plan for 2016/17 included NICE CG 89: when to suspect child maltreatment and NICE CG149: antibiotics for early onset neonatal infection.
- The neonatal unit had achieved stage one for the UNICEF Baby Friendly Initiative and the team was aiming to achieve stage two in 2017. Both units at Cumberland Infirmary and WCH were also working towards achieving accreditation with the Bliss Baby Charter, a scheme to ensure babies received the best neonatal care and treatment.

Pain relief

- Children and young people had access to a range of pain relief if needed, including oral analgesia and patient-controlled analgesics. We saw evidence of a pain scoring system and completed pain assessments in the care records we reviewed.
- Other non-pharmacological methods were also utilised by staff across the service. The children's ward had a dedicated play specialist who told us they used age appropriate play and activities as a means of helping to prepare children for procedures. For example, staff used 'Buzzy the bumble bee', a sensation distraction tool to help minimise the pain of a cannula insertion or needle injection.
- Staff in the special care baby unit did not use a specific pain assessment tool and instead used oral sucrose analgesia, administered pre-procedure, for new-born infants undergoing painful procedures. The use of

sucrose as an analgesia is common practice across the UK and the rest of the world. The team told us they recognised that sucrose, 'non-nutritive' sucking, breastfeeding and physical comfort all had a role to play in providing relief from the pain associated with certain procedures.

Nutrition and hydration

- The children's ward used the STAMP (Screening Tool for the Assessment of Malnutrition in Paediatrics) nutritional tool. It is a simple five-step tool to identify if a child's condition has any nutritional implications, what the child's nutritional intake is plus their weight and height. Based on the results from the first three steps, the overall risk of malnutrition is calculated and a care plan developed as appropriate.
- We reviewed evidence from STAMP audits conducted in April, May, and June 2016. Outcomes showed the children's ward was not compliant in the completion of the screening tool for every patient. The ward manager told us they had taken appropriate steps to improve the process and had shared this with staff.
- A dedicated paediatric dietician met with families upon admission to discuss any special dietary needs. Dieticians also worked with the ward housekeeper to discuss requirements and make appropriate recommendations to meet the needs of the patients.

Patient outcomes

- Children's services participated in national audits to monitor and improve patient outcomes, such as diabetes and epilepsy. We saw evidence of clinical audit summary forms, assessing compliance against NICE guidelines, which highlighted the standard of current practice and included recommendations.
- According to the 2014/15 National Paediatric Diabetes Audit, the median HbA1c level (which indicates how well an individual's blood glucose levels are controlled over time) was better than the England average which meant, proportionately, more children receiving treatment at WCH had their diabetes under control (Hba1c<58 mmol/mol) than in other parts of the country.
- Approximately one third of children and young people with diabetes were in the 15-19 year age group, which was a higher proportion than nationally). Amongst this age group, the median HbA1c was 77.5mmol/mol, a rise from the preceding 6-months. Data from the trust's diabetes annual report 2015/16 showed the median HbA1c level children under ten years old was better than the England average. Senior clinicians explained although limitations in the Adult diabetes service meant young people were staying longer than expected in the children's service, improving the care for young people remained a high priority for the service.
- Between March 2015 and February 2016, the readmission rate for children under one, within two days of discharge following an emergency admission, was 4.6%. This was worse than the England average (3.4%). The 1-17 age group was the same as the England average, at 2.8%. The readmission rate for children aged between one and 17, within two days of discharge following an elective admission, was 1.7%. This was similar to the England average (0.6%). We spoke with staff and managers who all explained the 'open door' policy for children with chronic long-term conditions. This meant families were encouraged to return to hospital if they had further concerns about their child and was a contributing factor to a higher than average readmission rate.
- Between April 2015 and March 2016, the trust performed better than the England average for the percentage of patients aged 1-17 years old who had multiple emergency readmissions (two or more) for asthma (14% compared to 17%). The trust performed worse than the England average for the percentage of patients aged 1-17 years old who had multiple emergency readmissions for epilepsy (36% compared to 29%). There was no available data for under one's and the number of multiple emergency readmissions for diabetes was less than six.
- The trust participated in the national neonatal audit programme (NNAP). Results from the 2015 audit identified a number of areas of good practice. The neonatal unit at WCH was compliant with the NNAP standard for 98-100% of babies to have their temperature recorded within an hour of birth. The proportion of babies <33 weeks gestation who were receiving any of their own mother's milk at discharge from SCBU was 67%. This was better than the national and northern neonatal network (NNN) averages (65% and 46% respectively).
- There was also a documented consultation with parents by a senior member of the neonatal team within 24

hours of admission in 93% of all cases. Although this was worse than the 100% national standard, it was the same as the NNN average and better than the national average (88%).

- There were also areas for improvement. The percentage of mothers who received any antenatal dose of steroids was 69%, which was worse than the NNAP standard of 85%. In addition, 93% of babies with a gestational age of < 32 weeks or < 1501g at birth had undergone retinopathy screening, which meant the unit was 7% below target. The trust had an action plan to address all of the areas of concern.

Competent staff

- In 2015/16, only 33% of medical staff had received an appraisal compared with 78% of nursing staff from the children's ward and 85% from SCBU. Current data for 2016/17 showed this had improved to 100%, 82% and 85% respectively. Managers told us all staff, with the exception of those on maternity leave or long-term sickness absence, would receive an appraisal by the end of March 2016.
- We found that medical and nursing staff were competent to carry out their roles. Staff told us they received appropriate professional development and supervision. Nurses were encouraged to develop their knowledge in specialist areas. Junior doctors we spoke with told us they had an educational supervisor and attended regular teaching sessions. All staff told us they felt supported in their role.
- Medical and relevant nursing staff had received appropriate advanced paediatric life support training and we noted there was at least one trained nurse on every shift. Healthcare assistants told us they had received training in basic paediatric life support.
- A registered children's nurse (RCN) triaged children who presented at the accident and emergency department. During the day and evening (between 7.00am and 9.00pm), the unit also provided a designated nurse for paediatrics, an adult nurse who held responsibility for looking after children for the duration of the shift.

Multidisciplinary working

- Our observation of practice, review of records and discussion with staff confirmed effective multidisciplinary team (MDT) working practices were in place. Medical and nursing staff worked closely together and with other allied healthcare professionals such as dieticians, speech and language therapists, health visitors and children's community nurses. Staff we spoke with also gave us positive examples of working with child and adolescent mental health services (CAMHS) and social services.
- A senior nurse described the working relationship with the local tertiary care centre as very positive. The ward manager gave examples of working and liaising with the bed manager and of arranging the transfer of children from one hospital to the other.
- Medical and nursing staff told us relationships with obstetricians were very good. There were no reported problems.
- We heard examples of co-ordinated planning and delivery of care between different services and providers. The trust had adopted the NHS 'Ready Steady Go' programme to support young people transitioning from children's services to adult services.

Seven-day services

- Consultants were available out-of-hours and actively encouraged nursing and junior medical staff to contact them if the need arose. Clinicians provided consultant presence until 7.00pm with on-call arrangements thereafter. There were no reported problems accessing out-of-hours support.
- Children's services accessed diagnostic services such as the x-ray department, pharmacy and laboratory services during the weekend. Staff did not raise significant concerns over accessing these services.

Access to information

- Staff we spoke with told us they were readily able to access patient information and reports such as test results and x-rays. The children's ward was supported by ward clerks who provided a seven-day service to ensure medical and nursing staff had access to the information and data they needed.
- Staff told us patient records were not always available, as they were stored off-site. Recent improvements meant the transfer of records had improved, for example, one nurse told us that, when she had requested the notes of a child who had been admitted at night, they had arrived the next morning.
- Policies and guidelines were accessible on the trust intranet and staff we spoke with told us they had experienced no problems in accessing this information.

Services for children and young people

Consent

- The trust had a 'consent to examination and treatment' policy and this included information specifically relating to children and young people. Staff we spoke with understood the Gillick competency guidelines and gave examples of how they had applied it in practice. Staff explained that the consent process actively encouraged young people to be involved in decisions about their care.
- Staff we spoke with fully understood the Mental Capacity Act 2005 as it related to young people and consent to treatment. If they needed further advice, they told us they would contact the safeguarding team. Data provided by the trust showed 95% of staff from children's services had completed the appropriate training module.

Are services for children and young people caring?

Good

We rated caring as 'good' because:

- Children, young people, and parents told us they received compassionate care and emotional support from nursing and medical staff. There was a strong person-centred culture and staff worked in partnership with patients and their families.
- Parents felt fully informed about their child's condition and treatment and staff empowered children and young people to be active participants in their own care. Staff also showed determination and creativity to overcome obstacles and deliver high quality, compassionate care.
- Feedback from patient surveys was positive. Children and young people answered several questions relating to their care. The highest scores across all age groups demonstrated staff were kind, treated patients and families with dignity and respect, and provided timely information.

Compassionate care

- All staff we spoke with were very passionate about their roles and were clearly dedicated to making sure children and young people received the best patient-centred care possible. Throughout our inspection, we observed medical and nursing staff delivering compassionate and sensitive care that met the needs of children, young people, and families.
- We observed members of staff who had a positive and friendly approach towards children and parents. Staff explained what they were doing and took the time to speak with them, offering reassurance and support.
- In addition to promoting interaction with children and young people through play and activity, the play specialist supported children who were anxious and distressed by accompanying them to outpatient and radiology appointments.
- Services for children and young people participated in the national Friends and Family Test. Between January 2016 and January 2017, 83% of respondents said they would be extremely likely to recommend the children's ward, A&E, and the children's outpatient department to friends and family if they needed similar care or treatment.
- The patient experience team regularly gathered feedback from children, young people, and families each month. Data was collated from different age groups, and parents and carers. Between July 2016 and September 2016 adults caring for children under five years of age completed 44 surveys. Out of a possible score of 10, when asked if staff treated themselves and their child with dignity and respect, the score was 9.8. Other questions related to information, involvement, and care, and the children's services team achieved 9.7 out of 10 overall.
- Survey questions for children aged between five and 11 asked children about their care, if staff were kind, if they felt safe and listened to, and if staff helped them to understand what was going to happen. Between July and September 2016, the overall score (out of 10) was 9.1. The highest score (9.5) indicated children felt safe and thought the staff who looked after them were kind.
- Older children and young people between the ages of 12 and 18 also took part in the surveys. During the same period, 24 surveys were completed. 'Feeling involved in their own care' and 'receiving timely information' received the highest scores. The overall average was 8.2 out of 10, slightly lower than other groups. The two questions that received the lowest score asked teenagers if they were offered time to be seen alone and whether confidentiality was explained to them.

Services for children and young people

Understanding and involvement of patients and those close to them

- Overall, parents we spoke with felt well informed about their child's condition and treatment. Medical and nursing staff communicated with children, young people and families openly and checked their understanding of the facts that were presented. For example, one parent told us how a doctor patiently explained all of the different medication her child was to receive and outlined the purpose of each one. Another parent told us a doctor presented drawings to the child to help them understand their condition.
- Children and parents told us they saw medical and nursing staff regularly and they always introduced themselves by name.
- Staff at WCH provided information and support in a child-friendly format. For example, the team used 'Ditto, an electronic tablet that displayed interactive pathways showing children and young people what to expect from their treatment. Using pictures and words, on a touch screen, staff helped children to understand each stage of their care pathway.
- Parents of young children with diabetes participated in 'Tots-Tennis' events which were supported by nursing and other healthcare professionals from the trust. The events presented opportunities for education from diabetes nurses and dieticians, and psychologists met with families to provide psychosocial support.
- Children and families told us communication between staff and families was good. For example, one parent told us staff listened to them and valued their contribution to discussions about their child's care.
- Staff from the special care baby unit had developed 'pouches for parents' which comprised an information booklet (including why the child was being cared for on the unit, details of visiting, direct dial contact telephone numbers) and a teddy bear for use by the parents and baby as a bonding tool.

Emotional support

- Parents told us they felt staff understood the impact the condition and treatment had on their children. Parents told us staff constantly offered reassurances and support throughout the treatment process. Medical and nursing staff kept families informed at every stage and children and parents felt empowered to ask questions.
- Parents also told us they felt very confident their children were receiving the best care possible. They felt confident leaving their child on the ward, reassured their child was safe, supervised, and cared for.
- Support was available for children with long-term health conditions. All children and young people with diabetes had an annual assessment of their psychological well-being by the multi-disciplinary team responsible for their care. All newly diagnosed children were offered routine psychology appointments within one month.

Are services for children and young people responsive?

Good

We rated responsive as 'good' because:

- Managers and staff planned and delivered services to meet the needs of children and young people, and worked collaboratively with partner organisations and other agencies.
- Care and treatment was coordinated with other services and other providers, and the facilities and premises were appropriate for children and young people. The service also provided facilities for parents to remain with their child during the night.
- Children and young people were able to access the right care at the right time. Ward occupancy rates were low and there were no reported issues with referral to treatment or waiting times in clinic, and consultants reviewed children within 14 hours of admission.
- The service provided appropriate pathways to support young people transitioning to adult services and ensured appropriate provision of care for children with chronic, long-term conditions and those in receipt of end-of-life care.
- There was an open and transparent approach to handling complaints. Information about how to make a formal complaint was widely available however; families tended to contact the service directly when they had a concern.

Service planning and delivery to meet the needs of local people

- Senior managers worked collaboratively with the Cumbria Clinical Commissioning Group (CCG), the West

North and East Cumbria Success Regime, Cumbria Partnership NHS Foundation Trust, Cumbria County Council, North West Ambulance Service, NHS England and neighbouring NHS Foundation Trusts to develop a business case to remodel services for children and young people. The primary aim was to ensure services were safe by creating a one-team, sustainable, integrated service across both acute sites.

- Managers acknowledged developing such an integrated model of care meant the service was better able to respond to the demands upon it. This included the needs of its population, geography, local infrastructure, and recruitment issues, and the evaluation of any reconfigured services would need to involve a 'whole-system' model across multi-agencies. The unit management team had developed several proposals and options to achieve the model, which have since been incorporated into the wider strategy of the Success Regime.
- Managers and staff also worked with other NHS providers to ensure services were flexible, provided choice and ensured continuity of care. For example, the unit had successfully submitted a bid to the Children's Heart Unit Fund (CHUF) to purchase paediatric ECHO probes for new machines that the cardiology team had procured. Senior clinicians were working with representatives from the specialist paediatric centre in Newcastle to establish paediatric cardiology outreach clinics in North Cumbria.
- The facilities and environment in the children's ward and outpatient department were suitable for children and young people. There was also a child-friendly waiting area and treatment rooms in the A&E department.

Meeting people's individual needs

- The children's outpatient department provided a range of specialist clinics to meet the needs of children and young people. These included cystic fibrosis, rheumatology, respiratory medicine, ophthalmology, and diabetes. Clinicians also held diabetes outreach clinics in different venues across the county.
- Leaflets for children and families were widely available in the ward and outpatient areas; however, staff told us information was not readily available in other languages. In relation to interpreting services, although the majority of staff told us they had not needed to access an interpreter, they could describe the process. There were no reported problems.
- There were appropriate facilities for parents and carers who chose to stay overnight. The children's ward offered a fold away camp bed so parents could sleep beside their child while they were in hospital. There were also facilities for parents and carers to wash and dress. Although staff provided parents with beverages and snacks upon request, parents did not have a dedicated sitting room. Managers told us they were working towards developing a similar facility to the one provided at Cumberland Infirmary.
- There were arrangements to support children and young people with complex needs or who required psychiatric support. The child and adolescent mental health service (CAMHS) was provided by the local community NHS trust. Staff form CAMHS visited the ward once a referral had been received from a clinician. Staff we spoke with told us CAMHS usually visited the same day or the following day if a child or young person had been admitted the previous evening.
- Staff did acknowledge it was difficult to access CAMHS support at a weekend or out-of-hours. The children's ward had experienced a number of inappropriate admissions due to a lack of mental health beds across the county. In the last 12 months, there had been 27 young people admitted inappropriately across both sites. Of these, 19 related to WCH. Staff told us they reported each occurrence as an incident to highlight the ongoing demand for improved provision of care for children and young people suffering from mental health problems. To mitigate any risk and to ensure that staff from the children's ward provided appropriate care, nurses had received additional training which included suicide prevention and mental health in adolescents. The ward manager had also instigated meetings with the local community trust provider and met with the CAMHS manager every few months to highlight issues and discuss concerns.
- Clinicians and managers were developing a local specialist epilepsy clinic, supported by a paediatrician with a specialist interest and a community paediatric epilepsy nurse specialist. The purpose was to improve services for children and families and meet epilepsy best practice standards.

Services for children and young people

- The trust followed NHS England's 'Ready Steady Go' programme to support young people transitioning to adult services. For example, all young people from age 16, who suffered from diabetes, completed the "Ready" questionnaire prior to attending their first transition clinic. The "Steady" and "Go" questionnaires were provided during the transition clinics to inform discussion and to ensure young people knew what to expect when transferring to the adult diabetes service. Staff provided young people with a "welcome" pamphlet describing the adult service and a 'Starting Uni with Diabetes' booklet produced by Diabetes UK. Paediatric dietitians were also available to provide input with young people and their families at transition clinics.
- The children's ward was a designated paediatric oncology shared care unit (POSCU). This meant children and young people who were receiving treatment for cancer could receive medication such as antibiotics at WCH instead of travelling to the specialist regional centre in Newcastle. The lead consultant paediatrician at WCH and ward staff met with the regional POSCU team every month to discuss each child in their care. The medical and nursing team also cared for oncology patients who were in receipt of end-of-life-care. With support from the regional Paediatric Oncology and Outreach Nursing (POON) team, based in Newcastle, and local children's community nurses, the team at WCH provided palliative and end of life care for children and young people with progressive malignant disease.
- A play specialist was available five days a week. Children and families we spoke with described them as 'fantastic' and we saw children interacting with them positively and confidently. The play specialist also ensured older children were included in all activities.

Access and flow

- Children and young people were admitted to the children's ward through A&E or via a direct referral from a GP. Some children and young people were granted long-term open access to the ward or SCBU, particularly those suffering from chronic conditions or babies who had recently been discharged.
- There were 964 admissions to the children's ward between June 2016 and November 2016. Out of 2562 beds available beds during this period, the ward occupancy rate was 37%, which equated to 939 occupied beds.
- There was an escalation policy when the number of patients exceeded the number of available beds. Staff we spoke with could explain what actions they would take in such an event. Ward managers at both hospital sites also had regular contact with each other throughout each day to maintain oversight of bed capacity on each ward.
- There were 69 admissions to SCBU during the same period. Out of 1647 available cot spaces, the occupancy rate was 50% (824 occupied beds).
- We spoke with children and families in the children's outpatients department who told us they never waited very long see a doctor, in the unit or for an appointment following a referral from their GP. We requested statistical data from the trust in relation to actual clinic referral to treatment times however; we did not receive any information to include in this report.
- A senior nurse told us there had been an increase in the number of children who did not attend outpatient appointments. Between June 2016 and November 2016, the DNA rate at WCH was 17.8% (from 542 attendances). Staff could explain the process outlined in the DNA policy when a child or young person did not attend and told us what action they would take. One of the paediatric consultants was currently undertaking an audit to investigate and identify any themes.
- On all of the records we reviewed, a consultant saw a child or young person within 14 hours of admission.

Learning from complaints and concerns

- Services for children and young people received 45 Patient Advice and Liaison Service enquires between August 2015 and July 2016. WCH received four complaints in the same period, two of which were concluded in a 30-day window. Overall, complaints received by the unit were low.
- Parents we spoke with told us they felt they could raise concerns if they felt they wanted to and told us they knew how to make a complaint. There were posters and leaflets in visiting areas about how people could raise concerns. Staff explained, in most cases, parents spoke to nurses on the ward and issues tended to be resolved informally.

Are services for children and young people well-led?

Services for children and young people

Good

We rated well-led as 'good' because:

- The leadership, governance, and culture promoted the delivery of high quality person-centred care.
- There was a clear strategy for the unit. This was consistent with the trust vision, which was linked to the Success Regime agenda to review proposals for the improvement and sustainability of the service. Concerns were expressed by medical and nursing staff at West Cumberland Hospital about future plans for the service, and the impact this would have on children and young people.
- The service had an embedded governance and assurance structure, which had patient safety, risk management, and quality measurement at its core. Managers understood the key priorities within the unit and developed proposals and action plans to mitigate risk and manage performance.
- Managers and leaders were visible, and there was a real strength, passion, and resilience within ward based staff to deliver quality care to children, young people and their families. Staff told us they were proud to work for the trust and promoted a patient-centred culture.

Vision and strategy for this service

- The Child Health Clinical Business Unit strategy aligned with the trust vision to provide patient centred, quality healthcare services underpinned by the values of patient's first, safe and high quality care, recognition of the importance of wider contribution, responsibility, accountability and respect.
- The management team, in conjunction with trust executives, developed an internal success regime implementation plan in which they highlighted eight objectives to support the changes being considered. These priorities focussed on developing self-care pathways, clarifying routes to access services, development of an integrated approach to the management of the sick child, plans for the management of long term conditions, complex needs and vulnerable children, improving mental health services, improving multi-disciplinary working and optimising the use of telecommunication technology.
- The inspection team noted the options which had been set out for paediatric services across North, East and West Cumbria as part of the success regime, which were currently being formally consulted on. Proposals included a consultant-led paediatric inpatient service at Cumberland Infirmary and a short-stay paediatric assessment unit and nurse-led unit for low acuity beds at West Cumberland Hospital.Staff we spoke with were all clear in their understanding of the overarching trust vision and values. We saw posters displaying the values in areas around the hospital. Staff at all levels also understood the priorities of their own service.
- Managers reviewed the progress of the business plan at regular unit level governance and operational meetings, involving medical, nursing and managerial staff groups.

Governance, risk management and quality measurement

- The Child Health Business Unit held cross-site monthly governance and operation board meetings chaired by the governance lead and clinical director accordingly. Each group was well attended. The governance group considered compliance, safety, standards, experience, risk, audits, education, safeguarding, and exception reports. Attendees developed action plans following each meeting, which they discussed at the next. Minutes from these meetings were accessible on the trust intranet, displayed on wards and discussed at ward level gatherings.
- The operational board held cross-site monthly meetings. Standard agenda items included action logs, finance, performance dashboards, human resource matters, site-specific issues and team brief cascades. Meeting minutes recorded specific actions and lessons learnt, for example, the provision of fire evacuation pods for the wards and SCBU and learning from issues staff had with infusion pumps.
- Nursing and medical staff also represented the unit at the patient safety panel where incidents, incident themes, complaints, and serious incident investigations were discussed.
- The service received good exposure at Board meetings and in view of its positioning within the Success Regime.
- There was a comprehensive risk register across the business unit with 36 identified risks, seven of which were rated 'red'. These included service resilience, a lack of community paediatric clinicians increasing out-patient attendances, transfer of babies who

required high dependency care, lack of 24 hour senior medical cover, unavailability of clinical records for review at clinics and adherence to 'Safer Children (2007) guidelines regarding on-site senior cover.

- Staff regularly reviewed identified risks at governance meetings and managers recorded progress against each risk along with risk controls, gaps in controls and assurance measures within the risk register. There was evidence of re-evaluation of risk grading and ongoing review.
- We saw evidence of an ongoing programme of internal quality audits and NICE guideline reviews undertaken routinely across children's service to ensure safe and effective care. Clinical leads told us they felt the governance and level of audit activity across the service and the trust was very robust. The unit did not have a dedicated consultant to lead on clinical audit however; the unit governance group allocated audit activity and monitored progress.
- Following previous inspection activity, the unit developed a strategic performance improvement plan, identifying key priorities aligned to the domains of safe, effective, caring, responsive and well-led. These plans provided very detailed improvement projects, for example, ward compliance with PEWS and more strategic plans such as integrated working with community based services. The plans used SMART principles (specific, measureable, action, results and timing), outcomes/metrics and considered financial implications of each priority. The unit also extended the reach of the plan to address financial, strategic and partnership working aims.
- There was evidence of good working relationships with other trusts and organisations across the region, for example, community partners, specialist service providers, and neighbouring NHS trusts.
- SCBU worked closely with the Northern Neonatal Network. The team submitted data from the service to BadgerNet, the network reporting system, which informed quarterly analysis reports about neonatal services across the region.
- Unit managers captured quality measurements and key performance indicators on the governance dashboard such as admission data, staffing, incidents, and risks.
- Staff told us they were encouraged to report incidents and near misses, concerns from patients and identify risks to the organisation. Patient Safety issues were cascaded into daily handovers and ward meetings.

Leadership of service

- Staff told us the executive team were visible and had visited the wards. The executive team, senior clinicians, and ward staff completed a detailed '15 Steps' (safety and quality assessment tool) in July 2016.
- Generally, staff felt managers were supportive and part of the team. They felt there was a clear management structure across the unit. If there was any conflict within the service, they would go to their ward manager and seek support.
- Senior staff were clear about their responsibilities toward their staff. They spoke about the importance of listening to staff concerns, being open and honest about the reality of issues affecting their wellbeing such as recruitment difficulties and supporting the ward in the delivery of safe care.
- Managers recognised the strength and resilience of their ward based teams and their commitment to the service, especially during difficult periods and acknowledged a strong 'team' ethos.

Culture within the service

- Medical and nursing staff told us they were proud to work for the trust and spoke positively about their role, their team and the care provided. Some of the comments we heard included 'I love working in this team' and 'everyone works together'. Staff we spoke with recommended the trust as a place to work and reported no bullying, intimidation or harassment behaviour from managers or colleagues.
- We found the ward culture was positive and everyone agreed the needs of the children and their families were the top priority for the unit.
- Ward based staff worked well together and there were positive working relationships between the multidisciplinary teams and other services involved in the delivery of care for children. Staff also told us they felt safe to question and challenge their peers on the ward.
- Staff felt the organisation could do more to listen to staff concerns to support health and wellbeing as this would bring individual, team and unit benefits.
- We spoke with staff who told us about the physical and emotional pressures they experienced caring for very

sick children and babies. Staff talked about the supportive and informal ward based debriefs and reflective practice sessions to help deal with stress associated with the role.

Public engagement

- Medical and nursing staff engaged daily with the children and young people in their care and ensured parents were included. We saw evidence of positive and caring interactions between staff of all grades with the children and their families.
- Staff invited formal and informal feedback from children, young people, and families through ward satisfaction and patient experience surveys. The child, parent, or both could complete a number of the surveys and staff displayed the feedback on accessible notice boards in a child-friendly format. Recognising that some children were too poorly to put their thoughts in writing, staff also engaged with them face-to-face to capture their views.
- SCBU had set up parent support and breast-feeding support groups. The unit had built strong working relationships with Surestart and Barnardos.

Staff engagement

- The unit provided GMC Survey findings for 2016 (trainee responses regarding training programmes under four categories of learning environment and culture, governance, support to learners and developing and implementing curriculum and assessment). There were varying results across the domains. In 11 of the 15 sub-sections, the unit were the same as other trusts. In the remaining four, the unit were below outcome in two (clinical supervision) and above outcome in two (local and regional training).
- Staff told us they were encouraged to participate and contribute to new developments in the service. Staff on SCBU had proactively participated in the BLISS accreditation application process (a scheme to ensure babies received the best neonatal care and treatment).
- The trust communications team distributed regular bulletins, newsletters and uploaded trust information onto the intranet for staff access.

Innovation, improvement and sustainability

- The unit was actively involved and engaged in the trust quality improvement plans 2016/17. This identified 17 work streams which required a more detailed improvement focus. In children's services, the unit concentrated on improving the management of the deteriorating child (use of PEWS and sepsis policy), workforce planning and recruitment, reporting incidents and supporting a safe and learning culture.
- SCBU was working towards BLISS accreditation. The pre-BLISS visit assessment confirmed overall compliance in excess of 93% which indicated the team would be successful in its bid. The formal visit from BLISS champions and auditors was pending at the time of our inspection.
- The unit was involved in some limited cost improvement projects (CIPs) around a review of administrative functions, and continually monitored and reviewed financial spend.
- The unit was successful in achieving the 'UNICEF UK Baby Friendly Initiative' Stage 1 in recognition of its work to meet key neonatal care standards.
- The unit had secured funding to develop PEWS and SBAR cards for all paediatric staff as a personal reference source to improve patient safety and effective communications.
- The unit was working closely with partners under the Success Regime to review children's services to ensure an improved and sustainable model of care for the local people.

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

Information about the service

West Cumberland Hospital (WCH) is part of North Cumbria University Hospital Trust (NCUH). Patients at the end of life were nursed on general hospital wards. Between April 2015 and March 2016 there had been 1,185 in-patient deaths across the three hospital sites within the trust as a whole.

The Specialist Palliative Care Team (SPCT) service at NCUH Palliative care was commissioned by the Clinical Commissioning Group and delivered in the Trust by staff from Cumbria Partnership Trust. The Specialist Palliative Care Team (SPCT) at WCH comprised of one 0.8 whole time equivalent (WTE) consultant post shared with the community and the Loweswater Suite with two sessions per week of hospital support. One 0.8 WTE staff grade doctor who mainly worked in the Loweswater Suite, and two WTE Macmillan nurse.

An End of Life Care team was established at NCUH and consisted of a Lead Bereavement Nurse, chaplain and a bereavement officer.

The (SPCT) worked collaboratively with clinical teams to support end of life care and there were good working relationships throughout the two hospitals particularly with the acute oncology services. The SPCT offered a five-day a week service. Cover after 5.30pm and at weekends was provided via telephone advice by the local Eden Valley Hospice.

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

During this inspection we visited a number of inpatient wards including acute, elderly care, respiratory, general medicine, oncology, gastroenterology and general surgery. In addition we visited the chapel, the bereavement office, and the hospital mortuary. We observed care and viewed twelve care records including three where patients were being cared for using the care of the dying patient (CDP) care plan. We spoke with two patients and four relatives. We also spoke with a range of staff including the SPC consultant, SPC clinical nurse specialists, the chaplain, a mortuary technician, two porters, and ward-based medical and nursing staff. In total we spoke with 15 staff members. We looked at policies and procedures and reviewed performance information about the trust.

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Summary of findings

During our last inspection of End of Life Care Services at Cumberland Infirmary in April 2015 we rated requires improvement overall. At this inspection there was evidence of ongoing improvement. We rated the service as good overall with effective as requires improvement because:

- The trust had developed a care of the dying patient (CDP) care plan that provided prompts and guidance for ward based staff when caring for someone at the end of life. We observed the use of these and saw that information was recorded and shared appropriately and that the plans were completed.
- Records within the mortuary were comprehensive and included processes for appropriate checking.
- The palliative care end of life communication training (Sage and Thyme) is part of the mandatory training for all staff at WCH.
- An early warning scoring system was in use throughout the trust to alert staff to deteriorations in a patient's condition. Patient's recognised as being at the end of life had their care plan transferred to the care of the dying patient framework when they were expected to die within a few days.
- The Trust had an organ donation policy, which adhered to national guidelines. The framework process made reference to specialist nurses, clinicians and nursing staff supporting the family throughout the process.
- Porters had face to face mortuary training that included the transfer of the deceased including promoting dignity and respect and an understanding of bereavement.
- Care plans for patients at the end of life included an assessment of nutritional needs and aspects of nutrition and hydration specifically relating to end of life care.
- The trust ensured that there was timely identification of patients requiring end of life care on admission. Systems were in place where a patient admitted who was known to the palliative care team would generate an alert to the team.
- We observed staff caring for patients in a way that respected their individual choices and beliefs and we saw that records included sections to record patient choices and beliefs so that these were widely communicated between the teams.
- The chaplaincy team worked with ward staff and other professionals for patients receiving end of life care.
- An Integrated End of Life and Bereavement group was now in operation. This was headed by the Deputy Director of nursing the members of the group the SPCT, chaplaincy, the bereavement lead, education and training and consultant medical staff.
- Referrals to the SPCT could be made any time during a patient's treatment. This allowed early involvement of the SPCT and time to facilitate the most appropriate care and treatment. The SPCT encouraged referrals from nursing, medical and allied health professional staff from across the trust.
- The trust had developed "Welcome to Hospice at Home – West Cumbria" initiative. All services provided are free of charge This service included the provision daytime and night nursing care, Respite Care - day, evening or night and also volunteer support in the home They can also refer patients to other services within the organisation including complementary therapies for patients, carers and those bereaved, one to one or group support, bereavement support and Lymphoedema support. All services provided are free of charge
- The specialist palliative care team developed a care pathway tool for patients in all areas of the hospital. This was to ensure that patients who required end of life care. Patients were identified at the earliest opportunity and to facilitate the most appropriate care in the most appropriate place for each patient.
- A clear vision had been established where 'All people who die in Cumbria are treated with dignity, respect and compassion at the end of their lives and that regardless of age, gender, disease or care setting they will have access to integrated, person-centred, needs based services to minimise pain and suffering and optimise quality of life
- The Lead Bereavement Nurse and the chaplain had leadership roles in terms of end of life care and raising awareness of aspects of their service across

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the trust. This involved attending meetings and working collaboratively across services and departments to raise awareness of end of life care issues.
- Staff were consistently positive about delivering quality care for patients at the end of life.
- There was a commitment at all levels within the trust to raise the profile of death and dying and end of life care. This included improving ways in which conversations about dying were held and engaging with patients and their families to ensure their choices and wishes were achieved.
- Discharge coordinators were available to support the process of rapid discharge at the end of life and the trust had recently implemented a community service where patients could be supported by trust staff in their own homes where care packages were difficult to access in the community.

However:

- For patients who did not have mental capacity, DNACPR forms we viewed at this inspection were inconsistently completed. We saw DNACPR forms that did not provide evidence of a best interest decision or a mental capacity assessment being undertaken and recorded. In a letter to CQC, the trust formally acknowledged our concerns and outlined the actions to be taken to address this issue.
- The trust had not achieved two clinical indicators and three organisational indicators in the End of life care Audit: Dying in Hospital in 2016
- The trust had not produced an action plan to address areas where performance was lower than the England average at the time of our inspection with key responsibilities and timelines for achievement.
- The trust could not provide the number of referrals to the SPCT.
- Both the SPCT and on general wards supported patient's to die in their preferred location. However the trust did not collate or hold the data that would demonstrate the percentage of patients who had died in their preferred location. This information was held by the Clinical Commissioning Group and could not be provided by the trust.
- There was no regular audit of the CDP to demonstrate that the trust supports patient's to die in their preferred location.
- Specialist palliative care was not provided across a seven day service.
- The trust did not have formal contract meetings with members of the Cumbria Healthcare Alliance to monitor that the service being commissioned and provided is of an appropriate standard in terms of quality and meeting patient need.

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Are end of life care services safe?

Good

We rated safe as 'good' because:

- There were no serious incidents reported between April 2015 and March 2016.
- Staff were aware of reporting procedures and the importance of thorough analysis of incidents, duty of candour, and sharing lessons learnt.
- Clinical areas were visibly clean, personal protective equipment and hand sanitiser was readily available and used.
- Waste was handled and disposed of in accordance to trust policy
- The mortuary was secured, monitored and accessible only to relevant staff. Mortuary records were complete and accurate.
- Appropriate anticipatory prescribing of medicines was used at the end of life.
- There was good identification of patients at risk of deterioration and identification of patients in the last days of life.
- Equipment was generally available for the care of patients at the end of life.
- Patient records were recorded on an electronic system, allowing notes to be clear, organised and legible.
- Staff assessed and responded to patient risks.

Incidents

- In the preceding 12 months this service had not reported any Never Events. (A Never Event is a serious incident that is wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers).
- Staff were confident in reporting incidents and 'near misses' on the hospitals incident reporting system.
- Feedback was given back through e-mail at ward meetings during handover and weekly updates. There were no incidents reported which specifically related to the care of patients at the end of their life.
- Staff told us that if an incident was related to a patient at the end of life then the palliative care team would be involved in the investigation and subsequent learning as a result.
- Staff we spoke with had an awareness of their responsibilities in relation to Duty of Candour.

Environment and equipment

- There were infection control and prevention systems to keep patients safe with appropriate signage around the wards.
- We saw staff had access to personal protective equipment (PPE), such as gloves and aprons and were seen to be using the equipment and facilities
- We saw there were hand wash basins, liquid soap, paper towels, hand gels and protective equipment available.
- There was a mortuary at WCH. We viewed mortuary protocols and spoke with mortuary and portering staff about the transfer of the deceased. The mortuary was manned by two staff with support as needed from porters within the hospital Staff told us that the equipment available for the transfer of the deceased was adequate and we saw that this included bariatric equipment.
- The mortuary fridges were temperature monitored and alarmed. We saw that if the alarm was triggered this would alert reception staff who would contact the mortuary staff.
- We observed the use of McKinley syringe drivers on the wards and saw that regular administration safety checks were being recorded. Ward staff told us that syringe drivers were available when they needed them.

Medicines

- There were clear guidelines on the trust's intranet for medical staff to follow when writing up anticipatory medicines for patients. The guidance included different treatment options for a range of symptoms that could be experienced at the end of life. This is medication that patients may need to make them more comfortable.
- Anticipatory medicines for patients nearing the end of their life were prescribed appropriately by medical teams. Medical staff were aware of how to access guidance on intranet.
- We spoke with members of staff with regards to anticipatory medicines. These staff told us that patients

requiring end of life care were written up for anticipatory medications. We examined the records of three patients receiving end of life care and found that anticipatory medicines had been appropriately prescribed.
- We observed staff witnessing, checking the identity of the patient and recording the administration of pain medicines to a patient at end of life.

Records

- The trust had developed a care of the dying patient (CDP) care plan that provided prompts and guidance for ward based staff when caring for someone at the end of life. We observed the use of these and saw that information was recorded and shared appropriately and that the plans were completed.
- Care plans reflected national guidance and included risk assessments such as those for the risk of falls or pressure area damage.
- The trust used a DNACPR (do not attempt cardio-pulmonary resuscitation) form that was used across Cumbria. They had audited the use of the forms in 2016 and had identified areas for improvement including the recording of discussions around DNACPR.
- We viewed 35 forms and they were generally completed well. All forms were kept at the front of the patient's notes, included clear documentation and clinical reasoning for the DNACPR decision. Decisions were appropriately recorded by a clinician and had been countersigned by a consultant.
- Records within the mortuary were comprehensive and included processes for appropriate checking.

Safeguarding

- We spoke with two members of staff in the specialist palliative care office about protecting people from the risk of abuse. The specialist palliative care team knew how to contact the safeguarding team. They also knew they could contact the local safeguarding team in and out-of-hours.
- Staff could give examples of what constituted a safeguarding concern and how they could raise an alert. Staff could give examples of what constituted a safeguarding concern and how they could raise an alert.

Mandatory training

- The Specialist Palliative Care Team (SPCT) service at NCUH was provided by the Cumberland Partnership Foundation Trust and was not directly employed by North Cumbria University Hospital Trust (NCUH).
- The palliative care end of life communication training (Sage and Thyme) is part of the mandatory training for all staff at WCH. Sage and Thyme training included advanced communication skills training.
- Porters had face to face mortuary training that included the transfer of the deceased including promoting dignity and respect and an understanding of bereavement. One porter we spoke with told us that the training they received had helped them to feel more confident when transferring the deceased.

Assessing and responding to patient risk

- The hospital used a recognised national early warning score (MEWS) to monitor patients at risk of deteriorating clinical conditions. This was monitored through the electronic records system.
- Staff assessed and managed patient risk as part of an ongoing holistic assessment process. We observed good use of general risk assessments for patients receiving end of life care. This included the assessment of risk in relation to nutrition and hydration, pressure ulcers and falls.
- Nursing, medical and therapy staff recorded daily changes to patients' conditions in their notes. In the community, advice and support regarding deteriorating patients was available from the SPCT.
- Patients were referred to the SPCT by staff on the wards by telephone or paper based referral. Nursing staff told us that if they were unsure they could ask for advice from the team and they were always helpful and supportive.
- Ward staff told us the in-reach SPCT nurse had a visible presence on the wards. Any changes to patient's conditions generally instigated a visit by the SPCT. We saw patient's daily notes by nursing, medical and therapy staff with updates on any changes.
- An early warning scoring system was in use throughout the trust to alert staff to deteriorations in a patient's condition. Patient's recognised as being at the end of life had their care plan transferred to the care of the dying patient framework when they were expected to die within a few days.

Nursing staffing

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- The Cumbria Partnership Trusts' Specialist Palliative Care Team (SPCT) provided nursing services to North Cumbria University Hospitals NHS Trust through the Northern England Strategic Clinical Network (NESCN) agreement.
- The SPCT worked collaboratively with clinical teams to support end of life care. The SPCT aim was to provide the best quality of life for patients and their families.
- In addition to specialist palliative care nurses the trust had appointed a Bereavement Liaison Nurse Specialist and also a bereavement officer who would be commencing the following month.
- Specialist palliative care nurses worked closely with ward based nurses and wards had end of life care link nurses.
- Specialist palliative care attended ward rounds to provide support to ward staff around end of life care issues.

Medical staffing

- There was on call palliative care consultant cover and out-of-hours advice was available from local hospices.
- We saw that ward based doctors were supported to deliver end of life care by the specialist palliative care team and we observed the specialist palliative care nurses discussing prescribing guidelines with doctors on the wards.
- Medical staff we spoke with told us the specialist palliative care team were available for advice as needed and responded quickly to urgent referrals. All referrals were responded to within 24 hours.

Major incident awareness and training

- The trust had a major incident awareness plan which detailed how all departments to respond in the event of a major incident.
- Staff had an understanding of the major incident plan.

Are end of life care services effective?

Requires improvement

We rated effective as 'requires improvement' because:

- For patients who did not have mental capacity, DNACPR forms we viewed at this inspection were inconsistently completed. We saw DNACPR forms that did not provide evidence of a best interest decision or a mental capacity assessment being undertaken and recorded. In a letter to CQC, the trust formally acknowledged our concerns and outlined the actions to be taken to address this issue.
- The trust had last completed a DNACPR audit in 2015.
- The trust had not achieved two indicators in the End of life care Audit: Dying in Hospital in 2016
- The trust did not achieve three organisational indicators, in the End of Life Care Audit – Dying in Hospital 2016.
- The trust had not produced an action plan to address areas where performance was lower than the England average at the time of our inspection with key responsibilities and timelines for achievement.
- Specialist palliative care was not provided across a seven day service.

However:

- An evidence-based care of the dying patient (CDP) document was in place and in use throughout the hospital.
- There was evidence of multidisciplinary working and involvement of the specialist palliative care team throughout the hospital.
- Patient's symptoms including pain were managed and medication was prescribed for anticipatory medicines
- Patients were properly assessed and supported with their nutritional needs.

Evidence-based care and treatment

- The trust had introduced a 'caring for the dying patient' (CDP) care plan. The plan had been adapted from strategic clinical network guidance and was based on national guidance. Sources included the supporting documentation and care plans for End of Life care we saw had been developed by the Northern England Strategic Network.
- We saw that the CDP documentation had included national guidance from sources such as the Leadership Alliance for the Care of Dying People, the Department of Health End of Life care Strategy, and the National Institute of Clinical Excellence (NICE).

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- The guidance included identifying patients at the end of life, holistic assessment, advance care planning, coordinated care, involvement of the patient and those close to them and the management of pain and other symptoms.
- The CDP document had been implemented to replace the Liverpool Care Pathway that had been discontinued in 2014.
- The trust had introduced the "When Someone is Dying Booklet". This booklet provided information for families and others in relation to caring for a person at the end of their life. This booklet contained information concerning symptoms that may be experienced, the care and support which may be given and also some questions that have been frequently asked at this difficult time.
- The trust had also introduced the "Care after Death" document. The document provided a standard operating procedure for healthcare staff to understand end of life extends beyond death to provide care for the deceased person and support to their family and carers.
- The trust participated in the End of life care Audit: Dying in Hospital 2016. We looked at the results from 'Is there documented evidence in the last 24 hours of life of a holistic assessment of the patient's needs regarding an individual plan of care'? The National Care of the Dying Audit in Hospitals (NCDAH) March 2016 showed that the trust performed below the national average in this area at 44% compared with the national average of 66%.
- The Trust had an organ donation policy, which adhered to national guidelines. The framework process made reference to specialist nurses, clinicians and nursing staff supporting the family throughout the process.

Pain relief

- Patients who were considered to be in the last days/ weeks of life were appropriately prescribed anticipatory medicines for the symptoms sometimes experienced at the end of life, including pain.
- Staff told us there were adequate stocks of appropriate medicines for end of life care and that these were available as needed both during the day and out-of-hours.
- Patients and relatives we spoke with told us that the nursing staff supported them well in managing their pain.
- Patients within end of life care services had their pain control reviewed daily. Regular pain medication was prescribed in addition to 'when required medication' (PRN), which was prescribed to manage any breakthrough pain.
- Care plans included pain assessment prompts and clear records of pain assessments.
- 'Just in case' medicines were prescribed appropriately for patients at the end of life.

Nutrition and hydration

- Staff were clear that patients at the end of life should eat and drink as they wished and that staff would support them to do that.
- Care plans for patients at the end of life included an assessment of nutritional needs and aspects of nutrition and hydration specifically relating to end of life care.
- Patients were encouraged to eat and drink as and when they were able to and for as long as they were able to in their last days of life. For example on one ward we saw a family assisting their relative to eat lunch.
- We reviewed three sets of nursing records relating to patients in the last days of life. We found evidence patients were screened for their risk of malnutrition using the Malnutrition Universal Screening Tool (MUST).
- The trust had completed a nutrition and hydration audit in Q3 2016. The audit provided evidence that 100% of patients had a documented assessment of their ability to eat in the last 24 hours of life, 24 % of patients were supported to eat, whilst 22% attempted to eat in their last 24 hours of life.
- We observed SPCT staff visiting patients and discussing care including nutrition and hydration options with the patient.
- Staff told us that snacks were available for patients throughout the day and night.

Patient outcomes

- The trust participated in the End of life care Audit: Dying in Hospital 2016 and performed similar to the England average for three of the five clinical indicators. The two indicators below the England average were:
- The trust scored 35% compared to the England average of 56% for 'Is there documented evidence that the needs of the person(s) important to the patient were asked about?'

End of life care

- The trust scored 44% compared to the England average of 66% for 'Is there documented evidence in the last 24 hours of life of a holistic assessment of the patient's needs regarding an individual plan of care?'.
- The trust answered yes to five of the eight organisational indicators. The trust answered no to the following questions:
- 'Did your trust seek bereaved relatives' or friends' views during the last 2 financial years (i.e. from 1 April 2013 to 31 March 2015)?'
- 'Was there face-to-face access to specialist palliative care for at least 9am to 5pm, Monday to Sunday?'
- 'Does your trust have one or more end of life care facilitators as of 1 May 2015?'
- The trust had not produced an action plan to address areas where performance was lower than the England average at the time of our inspection.
- Ward staff said the specialist palliative care team (SPCT) normally responded within 24 hours to referrals.
- The trust ensured that there was timely identification of patients requiring end of life care on admission. Systems were in place where a patient admitted who was known to the palliative care team would generate an alert to the team.

Competent staff

- The trust provided end of life communication skills training (Sage and Thyme) mandatory training to all staff.
- The specialist palliative care team provided a range of specialist training to general staff caring for patients at the end of life. This included training on symptom control, spiritual support, bereavement support and communication skills.
- There were formal seminars for medical students, Foundation Year1 doctors, Foundation Year 2 doctors, and Specialist Registrars on a variety of topics, such as symptom control and communication skills, including 'breaking bad news'.
- Ward staff told us that the specialist nurses would support them in caring for patients at the end of life when needed, all staff told us the specialist team were accessible and supportive.
- Porters received training on induction and on an ongoing basis from mortuary staff around the transfer of the deceased to the mortuary. This included aspects of dignity and respect and well as communication with the bereaved.

Multidisciplinary working

- Weekly MDT meetings were held at WCH where trust specialist palliative care staff would attend to discuss their most complex patients.
- We were told that the palliative care consultants on the West Cumberland and Cumberland Infirmary sites used a video conference MDT based in the community for complex cases and peer support.
- Specialist palliative care staff would attend regular ward based meetings including 'board rounds' as part of their routine visits to review patients on the wards. This enabled them to work closely with medical and nursing staff on the wards to support patients at the end of life.
- Consultant staff from the SPCT attended some of the MDT meetings such as oncology and respiratory meetings.

Seven-day services

· The trust provided access to Specialist Palliative Care 9-5 five days a week and therefore did not provide a seven day face to face service.

- Cover after 5.30pm and at weekends was provided via telephone advice operated by Cumberland Partnership Foundation Trust.
- Out-of-hours telephone support was also provided by the Eden Valley Hospice.
- The chaplaincy service provided pastoral and spiritual support, and was contactable out-of-hours on a 24 hour basis.

Access to information

- The CDP document provided a guide to clinical staff in the assessment and identification of patients' needs. Information was recorded in a clear and timely way so that staff had access to up to date clinical records when caring for and making decisions about patient care.
- Staff had access to a number of resources through the trust intranet. Staff we spoke with said this information was accessible and easy to use.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a policy in place relating to consent. This included advance decision making, mental capacity guidance and best interest decision making and the use of Independent Mental Capacity Advocates (IMCAs).

End of life care

- Staff we spoke with had all undertaken MCA and Deprivation of Liberty Standards (DoLS)
- We viewed 35 forms and found 16 of those were generally completed well. Of the other 19 forms we viewed, for patients who did not have mental capacity, records were inconsistently completed. We saw DNACPR forms that did not provide evidence of a best interest decision or a mental capacity assessment being undertaken and recorded.

Are end of life care services caring?

Good

We rated caring as 'good' because:

- Staff were very supportive to patients and to those close to them, and offered emotional support to provide comfort and reassurance.
- Relatives we spoke with told us their loved ones had all their care needs met by dedicated staff and they were involved with their loved ones care and felt supported in making decisions as a family.
- Care and support was clearly a priority for patients and relatives.
- In all interactions staff were seen to treat patients and relatives with dignity and respect.
- Staff were highly motivated and inspired to offer care that was kind and promoted dignity. Relationships between people who use the service, those close to them and staff were strong, caring and supportive. These relationships were highly valued by people and their families.
- Patients and their relatives had good emotional support from the specialist palliative care team, chaplaincy, and bereavement office and ward staff.

Compassionate care

- Staff were seen to be caring and compassionate. We observed communication between staff and patients and their relatives and saw that staff were caring and respectful.
- We observed staff caring for patients in a way that respected their individual choices and beliefs and we saw that records included sections to record patient choices and beliefs so that these were widely communicated between the teams.
- The trust provided Sage and Thyme communication skills training for all staff.
- Families and friends of patients at the end of life could access car parking concessions and open visiting was available.
- Where possible patients at the end of life were cared for in a side room. Staff we spoke with told us that generally patients at the end of life at WCH could be nursed in a side room.
- We saw that the care of the dying patient document used by the trust included prompts to assist them with patients and their relatives.
- We saw that bereavement packs were available in the ward areas with information about access to support.

Understanding and involvement of patients and those close to them

- Patients and family members we spoke with told us they felt involved in the care delivered.
- Staff discussions with patients and relatives about care issues were clearly recorded in patients' notes.
- The caring for the dying patient document used by the trust included prompts for discussing issues of care with patients and relatives.
- We observed multiple discussions between patients and nursing, medical and allied health professionals that were caring and considered the wishes of the patient.
- The trust produced an Audit report for compliance of end of life care against the standards of priorities for care of the dying person. There was documented evidence that 50% (an increase of 17% from the previous year) of patients had the opportunity to have questions or concerns listened to and 46% (an increase of 13% from the previous year) were given the opportunity to have questions about their concerns answered.

Emotional support

- Information was available in the form of a bereavement leaflet that included contact numbers for relatives of a variety of support agencies they could contact should they need to.
- The chaplaincy team worked with ward staff and other professionals for patients receiving end of life care.
- The chaplain attended the Bereavement and End of Life Group meetings and was instrumental in developing the end of life strategy and documentation.

End of life care

- The chaplaincy service provided spiritual support for patients and their families together with the Bereavement Nurse Specialist.
- The specialist palliative care team, the chaplaincy staff and ward based staff provided emotional support to patients and relatives.
- During our inspection we visited the newly renovated bereavement centre we were told this would be opening within the next month.
- Staff in all ward areas told us they had sufficient staffing levels which enabled them to provide end of life care which included emotional support.
- Throughout our inspection we saw that staff were responsive to the emotional needs of patients and their visitors.

Are end of life care services responsive?

Good

We rated responsive as 'good' because:

- The palliative care team was available for referrals throughout a patient's treatment and was easily contactable.
- End of life patients had access to side rooms when they were available.
- The bereavement team provided a follow up scheme for additional support for families.
- End of life care patients were identified in a timely manner.
- The hospital had a discharge team who were proactive to discharge patients, who wished to die at home, as quickly as possible.
- The mortuary provided care for the individual needs of the deceased patient and their families.
- The trust had developed "Welcome to Hospice at Home – West Cumbria" initiative.

Service planning and delivery to meet the needs of local people

- Referrals to the SPCT could be made any time during a patient's treatment. This allowed early involvement of the SPCT and time to facilitate the most appropriate care and treatment. The SPCT encouraged referrals from nursing, medical and allied health professional staff from across the trust.
- An Integrated End of Life and Bereavement group was now in operation. This was headed by the Deputy Director of nursing the members of the group the SPCT, chaplaincy, the bereavement lead, education and training and consultant medical staff.
- The hospital had a discharge team that facilitated fast track discharge and end of life care planning for those patients wishing to die at home.
- We also noted that wards allowed open visiting times for relatives of end of life care patients. Pull out beds and comfortable chairs were available for visitors to stay the night. This ensured family and friends could spend unlimited time with the patient.
- A Bereavement Team has now been established headed by the Bereavement Nurse Specialist, along with Bereavement Officers who had recently been recruited to support this.
- Both the SPCT and on general wards supported patient's to die in their preferred location. However the trust did not collate or hold the data that would demonstrate the percentage of patients who died in their preferred location. This information was held centrally at the Clinical Commissioning Group.

Meeting people's individual needs

- Staff carried out holistic assessments of patients' needs at the end of life. This included their emotional and spiritual needs and their preferred place of care.
- Patients who were in the last days and hours of life were identified and support from the specialist palliative care team was accessible, with staff reporting that they would respond on the same day for urgent referrals.
- Discharge coordinators were available to support the process of getting people home, including for those patients at the end of life. Staff consistently told us that where care packages were accessible in the community they could get patient's home in a matter of hours if necessary.
- The trust had developed "Welcome to Hospice at Home – West Cumbria" initiative. All services provided are free of charge This service included the provision daytime and night nursing care, Respite Care - day, evening or night and also volunteer support in the home They can also refer patients to other services within the organisation including complementary therapies for

patients, carers and those bereaved, one to one or group support, bereavement support and Lymphoedema support. All services provided are free of charge
- The chaplaincy team engaged with other faith leaders to ensure that the needs of patients from different faiths would be met. This work included formalising links with key faith groups through service level agreements.
- The trust produced a quarterly Bereavement and Chaplaincy Newsletter.
- We viewed the new premises that encompassed the Bereavement Offices and chapel services. We were told by staff this would improve facilities for patients, staff and visitors.

Access and flow

- Face to face palliative care was available Monday to Saturday 9am to 5pm including bank holiday Mondays. At other times a hospice telephone advice was provided on an on call basis.
- The SPCT worked closely with the specialist discharge team to discharge people to their preferred place of dying if they were not on the rapid discharge plan.
- Referrals to the specialist palliative care team came through by phone and in writing but that a good deal were picked up through routine ward visits.
- Ward staff told us they had referred patients to the team, both reported that the response was prompt and the support from the team had been valuable and beneficial to patients.
- The specialist palliative care team developed a care pathway tool for patients in all areas of the hospital. This was to ensure that patients who required end of life care. Patients were identified at the earliest opportunity and to facilitate the most appropriate care in the most appropriate place for each patient.
- Ward staff spoke positively of the fast track discharge system and felt delays were due to getting external care in place, rather than any trust procedures.
- The trust recorded through the CDP document how patients could be supported to die in their preferred location. However, the trust did not audit these figures.
- Patients were identified as requiring end of life care in a timely manner. We noted that this was discussed at both ward hand over meetings and the daily multidisciplinary palliative care meetings.
- Porters made patient transfers to the mortuary a priority and a timely manner. Wards were sometimes flexible on these times if the families wished to remain and spend time with the deceased.
- We also noted that the mortuary transfer was sensitive and discrete, porters used a concealment trolley.
- The number of referrals to the SPCT was provided to the Clinical Commissioning Group and the Cumbria Partnership however the NCUH trust did not hold this data.

Learning from complaints and concerns

- Information was available for patients on how to complain or feedback about the service experienced.
- Staff we spoke with told us that if a patient or relative had concerns about care being delivered they would try and address the issue at the time in order to resolve the concerns as quickly as possible.
- People were signposted to the Patient Advice and Liaison Service (PALS) where concerns were unable to be resolved at ward level.
- Between April 2015 and March 2016 there were no complaints about end of life care services.
- Members of the specialist palliative care team told us they would be involved in investigations and supporting learning from complaints if these centred on patients at the end of life.

Are end of life care services well-led?

Good

We rated well-led as 'good' because:

- There was good leadership from the specialist palliative care team and from ward based nursing staff.
- There was active involvement strategically from the Executive Director of Nursing and deputy chief nurse.
- There was a formal strategy in place for end of life services.
- Regular meetings of the End of Life Bereavement Group ensured good management overview of the service.
- We found that staff on the ward areas shared the visions and values that the specialist palliative care team were working to promote.

End of life care

- The culture was seen to be that End of Life care is 'everybody's business' and all staff shared a priority to ensure the care provided was right for the patient.

However:

- The trust could not provide the number of referrals to the SPCT.
- Both the SPCT and on general wards supported patient's to die in their preferred location. However the trust did not collate or hold the data that would demonstrate the number of patients who had died in their preferred location. This information was held centrally with the Clinical Commissioning Group and could not be provided by the trust.
- There was no regular audit of the CDP to demonstrate that the trust supported patients to die in their preferred locations.
- The trust did not have formal contract meetings with members of the Cumbria Healthcare Alliance to monitor that the service being commissioned and provided is of an appropriate standard in terms of quality and meeting patient need.

Vision and strategy for this service

- A strategy had been developed by NCUH with the aim to provide opportunities available for people to talk about and record their wishes in relation to their own end of life. The provision of integrated, person-centred, needs led end of life services across Cumbria. The equitable access to high quality end of life services across Cumbria, regardless of disease, condition, age, ethnicity, religious belief, disability, gender or place of care
- A framework for the delivery of services was in place that would allow all adults in Cumbria who are approaching the end of their life, "to live as well as possible until they die" in accordance with their own wishes and preferences.
- The framework within the strategy aims to provide end of life care services to support people with advanced progressive illness in the last six months to year of their lives. These services should meet the end of life care needs of both patient and family throughout the last phase of life and into bereavement. It includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support.
- A clear vision had been established where 'All people who die in Cumbria are treated with dignity, respect and compassion at the end of their lives and that regardless of age, gender, disease or care setting they will have access to integrated, person-centred, needs based services to minimise pain and suffering and optimise quality of life. These services will respond sensitively to the dying person's wishes and preferences. Carers and families were provided with appropriate information and support to enable them to function effectively leading up to and after death. An Integrated End of Life and Bereavement group was in operation. This provided representation around Education and Development, the implementation of the CDP and the introduction of the co-ordination of the bereavement services.
- An Integrated End of Life and Bereavement group was now in operation. This provided representation around Education and Development, the implementation of the CDP and the introduction of the co-ordination of the bereavement services.

Governance, risk management and quality measurement

- Specialist palliative care reports within the directorate of medicine.
- There was a trust wide risk register but not one specific to end of life care. At the time of our inspection there were no risks specific to end of life care identified.
- There was representation from the SPCT at regular mortality review meetings. Their remit was to support the review of the quality of care and decision making at the end of life.
- The End of Life and Bereavement Group oversees the delivery of the priorities within its strategy and reports to the Safety and Quality Committee.
- There was an end of life care executive and clinical lead. We found they had an active role in end of life care and its plans and improvements.
- The trust produced a board report for end of life or palliative care.
- The trust recorded through the CDP document how patients could be supported to die in their preferred location. However, the trust did not audit these figures.
- The number of referrals to the SPCT was provided to the Clinical Commissioning Group and the Cumbria Partnership however the NCUH trust did not hold this data.

End of life care

- A structured service level agreement with Cumbria Partnership Trust which makes clear how work will continue together, using specific parameters to measure performance and delivery was not in place.

Leadership of service

- There was clear leadership in end of life care across the trust. The Executive Director of Nursing was the executive lead for end of life care, and there was evidence of clear nursing leadership with management and involvement bereavement service and chaplaincy.
- The Bereavement Nurse Specialist and the chaplain had leadership roles in terms of end of life care and raising awareness of aspects of their service across the trust. This involved attending meetings and working collaboratively across services and departments to raise awareness of end of life care issues.
- We saw more examples of the development of End of Life Care services through the role of the Bereavement Nurse Specialist. This included the development of the Education and Training Strategy and the introduction of the bereavement offices. This role was evolving and we saw good progression of the service whilst the position had only been existence for a short period of time.
- There was a clear commitment to quality end of life care across wards within the hospital and we saw ward managers and staff alike focused on improving and developing end of life care in general ward settings.

Culture within the service

- Staff were consistently positive about delivering quality care for patients at the end of life.
- There was a commitment at all levels within the trust to raise the profile of death and dying and end of life care. This included improving ways in which conversations about dying were held and engaging with patients and their families to ensure their choices and wishes were achieved.
- Staff were open and honest and admitted when things went wrong, in line with duty of candour regulations.
- We saw emails off different departments sending thank you notes to each other on the service they provided.
- There was evidence that the culture of end of life care was centred on the needs and experience of patients and their relatives. Staff told us they felt able to prioritise the needs of people at the end of life in terms of the delivery of care.
- We observed good joint team working with the SPCT and ward staff. Staff told us there were opportunities to learn and that the delivery of high quality end of life care services within the trust was a priority.

Public engagement

- The chaplaincy had co-ordinated and developed the Bereavement and Chaplaincy newsletter. The aim is to share developments and news from the Chaplaincy and Bereavement teams.
- The bereavement follow up service also gives the opportunity for bereaved families to talk to hospital staff for advice and support, in the weeks following a death.

Staff engagement

- Staff we spoke with told us they felt they had an opportunity to feedback to management and that they felt listened to.
- The mortuary team had regular debriefs; staff felt this reduced stress after upsetting cases.
- The chaplaincy team regularly engaged ward staff with the aim of raising awareness, improving conversations and engaging staff in discussions around end of life care.

Innovation, improvement and sustainability

- All staff we spoke to were passionate to do their best for patients and continuously improve.
- The use of the Swan scheme which is discussed in the document service introduction and mission statement, and the teaching that also discusses this and bereavement nursing, which in itself is also innovative. The Swan logo is a reminder that there are bereaved families who need extra care and support; that dignity and respect is needed and that care and compassion for the patient and their loved ones is essential; to be kind and considerate when dealing with bereaved families, and to have an understanding that bereaved people may need more time and patience.
- Discharge coordinators were available to support the process of rapid discharge at the end of life and the trust had recently implemented a community service where patients could be supported by trust staff in their own homes where care packages were difficult to access in the community.
- The trust had developed “Welcome to Hospice at Home – West Cumbria” initiative. All services provided are free of charge This service included the provision daytime

and night nursing care, Respite Care - day, evening or night and also volunteer support in the home They can also refer patients to other services within the organisation including complementary therapies for patients, carers and those bereaved, one to one or group support, bereavement support and Lymphoedema support. All services provided are free of charge.

Outpatients and diagnostic imaging

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

Information about the service

The outpatient departments held clinics for various specialities throughout the trust across the different hospital sites. Diagnostic imaging was available at Cumberland Infirmary and WCH. Clinics were held in the main outpatient department and departments such as Ophthalmology.

The trust had 488, 353 outpatient appointments between April 2015 and March 2016. Of these, 321, 336 appointments were held at Cumberland Infirmary and 124, 856 appointments were held at West Cumberland Infirmary. All other appointments were held at other trust hospitals such as Workington community hospital, Penrith hospital and Cockermouth Community Hospital.

WCH had been in the newly built outpatient department for around 12 months at the time of our inspection. Most outpatient clinics had moved to the newly built unit, however there were a small number of clinics still offered in the previous building. We were told during the inspection these were being moved out of the previous building in 2017.

During our inspection we visited the main outpatient department, dermatology, ophthalmology and physiotherapy.

Diagnostic imaging services were mainly provided from two locations: Cumberland Infirmary and West Cumberland Hospital with a limited service at Workington Community Hospital, Penrith Hospital and Cockermouth Community Hospital. Diagnostic imaging at WCH provided plain film x-rays, ultrasound, CT, MRI, and interventional treatments. The acute clinical work including fluoroscopy was concentrated at the two main sites, Cumberland Infirmary and West Cumberland Hospital, and offered a range of diagnostic imaging, image intensifiers in theatres, and interventional procedures. The trust provided diagnostic imaging figures for all sites for each modality; West Cumberland Infirmary staff carried out 10024 CT scans, 5632 MRI Scans, 9002 non-obstetric ultrasound scans, 6266 obstetric scans, 774 nuclear medicine procedures, 881 fluoroscopy procedures, 32312 plain film x-rays.

Diagnostic imaging services were available from 9am to 5pm on weekdays for outpatients and patients referred by their GPs. There was no imaging provision for outpatients at weekends. For inpatients and trauma there was a 24 hour, seven days a week plain film and ultrasound service with CT and MRI provision. Diagnostic imaging services organised and booked appointments for procedures and follow ups.

During the inspection at WCH we spoke with nine patients, two relatives, and 31 members of staff, some of whom worked across the three hospital sites, including managers, doctors, nurses, allied health professionals, and support staff. We observed the, diagnostic imaging and outpatient environments, checked 19 patient records, which were a mixture of electronic and paper based, checked equipment in use, and looked at information provided for patients. We received comments from people who contacted us about their experiences. We also reviewed the trust's performance

data and looked at individual care records and images. Records we reviewed confirmed that there continued to be a steady increase in demand for outpatients and diagnostic services.

Summary of findings

We rated this service as 'good', with responsive as 'requires improvement', because:

- There was an electronic system to report incidents in the services. Staff were aware of how to report incidents.
- The environment of the services were visited were found to be clean and tidy and hygiene standards were good. Equipment was mostly available, except for bariatric wheelchairs and a recliner chair in the phlebotomy clinic.
- Medicines were found to be securely stores and medicines checked were in date. Data for medical records showed the improvement made previously had been generally maintained, however a recent change in the storage of the medical records had led to some challenges such as notes arriving late for clinics. Data provided by the trust showed that in September 2016, 94.38% of notes were available at the start of clinic
- Outpatient and Diagnostic services were delivered by caring, committed and compassionate staff. Patients were positive about the way staff looked after them and the care received.
- Care was planned and delivered in a way that took account of patients' needs and wishes. Patients attending the outpatient and diagnostic imaging departments received effective care and treatment. Care and treatment was evidence based and followed national guidance.
- Staff had attended courses and further training to enhance competence in their services. Staff had access to the required information and systems, for example the electronic incident reporting system.
- Staff provided compassionate care and took into account the privacy and dignity of patients.
- The services had been responsive to the increasing demand for clinics by putting on addition clinics on a weekend where required. There had previously been issues with diagnostic six week waiting times; however there had been a steady trend of improvement at this inspection.
- The service had received a low number of complaints in the preceding 12 months.

Outpatients and diagnostic imaging

- Outpatient managers were able to describe the risks to the services and what they action they were taking to mitigate the risks, however not all identified risks such as staffing levels were on the risk register.
- Staff were mostly positive about local leadership in the service. Staff we spoke with enjoyed their role and overall felt respected and valued by the trust. Staff described good team work and supportive teams.

However:

- Safeguarding mandatory training completion rates were below the trust target. Mandatory training completion rates were generally below the trust targets.
- The imaging department quality assurance system had been suspended when new equipment was installed and not re-introduced until eight months later. Diagnostic imaging did not carry out daily refrigerator temperature checks.
- Orthopaedic practitioner staffing levels were not at the planned levels.
- Referral to treatment time (RTT) data varied across the specialities. The service did have patients which the see by date had been breached.
- There were a number of clinics cancelled within 6 weeks of the clinic across the trust and there was no current action plan in place to address cancelled clinics in outpatients. The trust did not measure how many patients waited over 30 minutes to see a clinician in outpatient departments.

Are outpatient and diagnostic imaging services safe?

Good

We rated safe as 'good' because:

- Staff we spoke with were aware of how to report incidents on the electronic reporting system and said that they would also notify their managers when an incident had occurred.
- The departments used an electronic system to report incidents. All the staff we spoke knew how to use the system if they needed to. Managers and governance leads investigated incidents and shared lessons learned with staff.
- There had been one serious incident reported involving diagnostic imaging at WCH regarding a diagnostic delay. This had been investigated and a new process implemented to prevent a future recurrence.
- Areas we visited were visible clean and tidy. Hand gel dispensers were in place throughout the outpatient services.
- Radiology departments were clean and hygiene standards were good. Equipment was new and had been installed when the hospital was built a year before our inspection. Staff had enough personal protective equipment in all the areas we inspected and staff knew how to dispose of all items safely and within guidelines. Staff ensured equipment was clean and well maintained, so patients received the treatment they needed safely.
- Medicines were found to be stored securely.
- Accessibility to medical records data showed that between April 2016 and June 2016, 93.5% of records were available at the start clinic. Records were securely stored and when issues around record security were raised with staff in ophthalmology outpatients, we found during our unannounced inspection this had been rectified and notes were securely stored.
- Actual staffing levels matched the planned staffing levels in general across the services, with the exception of orthopaedic practitioners, however the trust was taking action to mitigate the risk.
- The trust had reviewed its staffing investment to develop the allied health professional workforce to meet the growing demand for services. Diagnostic imaging

services were working proactively to train staff to work across modalities and to take on extended roles. National shortages meant that recruitment was difficult but there had been some improvements.
- Patient records were completed and available, and diagnostic imaging contributed towards efficiency and effectiveness for outpatient services, such as the availability of test results and timely access to information. We also found that improvements in the processes for reporting and learning from incidents were maintained.

However:

- Safeguarding levels were below the target of 95% and most staff did were not aware of the safeguarding level training they required. Most completion rates for mandatory training were below the 95% across outpatients.
- Mandatory training rates were generally below the 95% target at the trust.
- The imaging equipment quality assurance system had been suspended when new equipment was installed. This had not been reintroduced until eight months later.
- There were no daily refrigerator temperate checks carried out in diagnostic imaging.
- We found that although recruitment had been successful in some areas, there remained a shortage of radiographers and radiologists.

Incidents

- The trust had an incident reporting system which could be accessed through the computer system in the department. Staff we spoke with confirmed that this was where they would report incidents, as well as notifying their managers.
- There had been 195 incidents reported between May 2016 and August 2016 across all hospitals which provide outpatients and diagnostic imaging across the trust. At West Cumberland Infirmary, there were 46 reported incidents. These were a mixture of diagnostic imaging and outpatient incidents.
- There had been one Never Event reported in the last 12 months in outpatients. This had occurred in Ophthalmology outpatients at WCH. The Never Event had been reported through the incident reporting system and an investigation had been conducted. The service had introduced new measures to help prevent the event occurring again. This included implementing a new form which staff had to complete prior to a procedure for intravitreal injections. Management confirmed duty of candour had been carried out and this was documented in the incident investigation report. A recommendations section was completed on the serious incident investigation report and an action plan was attached.
- The services reported two serious incidents (SIs) in outpatients between October 2015 and September 2016, trust-wide. These incidents were related to a surgical or invasive procedure and one of the serious incidents related to a diagnostic incident.
- Staff we spoke with told us that, when they had logged an incident through the electronic reporting system, they had received feedback from the incident. There were weekly or monthly meetings in outpatients at which these would be shared, and updates on incidents and learning were logged in a folder kept in the manager's office for staff to review. Meetings in the last 12 months varied between weekly and monthly due to staffing levels.
- Most staff we spoke with were aware of duty of candour and could describe being open and honest.

Diagnostic imaging:

- There had been no 'Never Events' in the diagnostic imaging department.
- The diagnostic imaging department had had one serious incident that met the Strategic Executive Information System (STEIS) criteria. This related to a delay in reporting and a subsequent delay in treatment.
- There had been two recent radiological incidents reported under ionising radiation medical exposure regulations IR(ME)R at WCH. Both were attributed to CT imaging and were thought to have been caused by referrer errors. The diagnostic imaging safety team had carried out an investigation and implemented a new process where the referrer must use a free text box to manually add the patient's name and date of birth.
- Incidents were discussed at the monthly governance meetings and we saw minutes of meetings that confirmed this. There was evidence of discussions about RCA (root cause analyses) being carried out, serious incidents and monitoring of action plans.
- Radiology discrepancy incidents were discussed by case review with radiologists and reporting radiographers. Sonographers discussed discrepancies formally in their own meetings. Medical staff took the opportunity to

learn and work as a multidisciplinary team with referrers and clinical teams. Outsourcing reporting companies carried out discrepancy and quality assurance reviews as part of their service level agreements (SLA) with the trust.
- Staff we spoke with knew that they should be open and honest with patients if anything went wrong with their treatment or care. Departmental managers took responsibility for ensuring that the duty of candour processes were carried out appropriately.

Cleanliness, infection control and hygiene

- Areas visited were visibly clean and tidy. There was hand gel available in the areas visited and access to personal protective equipment such as gloves were available in clinic rooms.
- Staff complied with the 'Bare below the elbow' policy.
- The outpatient department had a daily check list on the wall in each clinic and treatment room which was to be completed daily to confirm that cleaning had been completed by staff and equipment listed was available. We found these to be completed during our inspection.
- The outpatient department was cleaned daily by a domestic staff member.
- Cardiology outpatients were included in the infection, prevention and control audit and between January 2016 and June 2016, the department achieved 100%.
- During our inspection we saw a main outpatient department performance board. This showed that hand hygiene rates were 100%.

Diagnostic imaging:

- Personal protective equipment (PPE), such as gloves, masks and aprons, was provided and used appropriately throughout the imaging department and, once used, was disposed of safely and correctly. We observed PPE being worn when treating patients and during cleaning or decontamination procedures. All areas had stocks of hand gel and paper towels.
- The department's different areas such as changing rooms and reception were clean and tidy and we saw staff maintaining the hygiene of the areas by cleaning equipment in between patient use, reducing the risk of cross-infection or contamination. Where possible, staff scheduled patients with known infections at the end of procedure lists.
- The department quality board showed that the most recent hand hygiene audit had achieved 100% compliance.

Environment and equipment

- In the last 12 months a new build outpatient department had been opened for outpatients. A small amount of clinics were held in the previous outpatient building, however these were transferring to the new department in 2017.
- Patients checked in with staff at reception in the new outpatient department for their appointment, the reception desks provided enough space between the desk and the people waiting to ensure patients could not be overhead speaking.
- The department had a waiting area with a central check in desk for patients. There was an electronic check-in board; however this was not in use at the time of the inspection. The previous department was used for a small number of clinics, and had a waiting room area with seats, toilets, and a check-in desk, from where patients were directed to the appropriate clinic area. There were four waiting zones in the main outpatient department.
- Staff told us the signage had been recently changed to make the signage into the clinic areas better and easier to use for patients.
- There was a 'welcome to outpatients' poster on display, which had information attached, including car parking information and check-in and cancellation information. There were telephones available in the main outpatient area for patients to contact the contact centre should they have queries about appointments.
- Outpatients had eighteen clinic rooms, treatment rooms, access to toilets and disabled toilets. There were areas specifically for medicines storage in the department.
- The resuscitation equipment was kept in the manager's office; staff had access to this if they needed the equipment. The equipment checked was in date and securely sealed where required, for example the medicines bag. The resuscitation grab bag had been checked daily.
- Management told us of the challenges of not having enough space and the effect this could have on capacity. The ophthalmology department at WCH had limited capacity and waiting room space due to limited space in the department.

- There were emergency call bells available in clinics rooms except the UV clinic room. The phlebotomy room was used daily, however the chair used in phlebotomy did not have the facility to recline if required.
- Wheelchairs were available in outpatients; however there were no bariatric wheelchairs available for patient use.

Diagnostic imaging:

- In diagnostic imaging, quality assurance (QA) checks had been implemented in June 2016 and were in place for all equipment. These were mandatory checks based on the ionising regulations 1999 and the ionising radiation (medical exposure) regulations (IR(ME)R) 2000. These protected patients against unnecessary exposure to harmful radiation. However, from installation in November 2015 until June 2016 there had been no QA process in place. A new Trust lead radiographer had been appointed and had taken on the QA role throughout the Trust.
- Staff wore dosimeters and lead aprons in diagnostic imaging areas. This was to ensure that they were not exposed to high levels of radiation and dosimeter audits were used to collate and check results. Results were within the acceptable range as set by IRMER.
- The department provided local rules for each piece of equipment and we saw a user guide for each room.
- Risk assessments were carried out with ongoing safety indicators for all radiological equipment, processes and procedures. These were easily accessible to all diagnostic imaging staff.
- Staff in diagnostic imaging were able to demonstrate safety mechanisms to ensure patient doses for radiation were recorded.
- The design of the environment kept people safe. Waiting and clinical areas were clean. There were radiation warning signs outside any areas that were used for diagnostic imaging. Illuminated imaging treatment room no entry signs were clearly visible and in use throughout the departments at the time of our inspection.
- Crash trolleys throughout the departments were all locked and tagged and we saw checklists to show staff made regular checks of contents and their expiry dates.
- There was sufficient seating to meet demand. The department had designated trolley areas and wheelchair spaces. There were separate areas for inpatients and outpatients. This made sure that the privacy and dignity of patients was preserved.

Medicines

- We found medicines to be managed securely. The medicines refrigerators were locked and the medicines that we checked were in date. Refrigerator temperature logs that we saw were complete.
- Main outpatients stocked a small amount of medicines. Staff in ophthalmology told us that they date checked medicines and consumables when stock was being put away and that medicines keys were always kept with a registered nurse during the day.

Diagnostic imaging:

- In the diagnostic imaging department some interventional procedures required sedation and pain relief. These medicines were prescribed and administered by the consultant radiologist carrying out the procedure. All medication used, including contrast agents, was stored securely and documented appropriately.
- Radiology specialist nurses ordered medicines and liaised with pharmacy.
- Staff undertook monthly stock checks and checked expiry dates. We saw evidence of dated and signed checklists and drugs we checked were all in date. However, there was no other pharmacy input or audit of medicines in the department.
- We did not see evidence of fridge temperature checks. Fridges were a year old and staff told us they trusted their temperatures would be within the correct range for storage of medicines. Checklists would show temperature fluctuations or equipment failure, to prevent drugs from becoming unsafe for use.
- The principal radiographer maintained a list of PGDs (patient group directions) for drugs used commonly in the department including contrast agents. PGDs are authorised by doctors and pharmacists to allow non-medical staff to supply and administer specified medicines to patients.

- Staff had been trained to administer contrast agents. The trust pharmacist had signed previous years' lists and staff were in the process of completing competency checks before the list would be sent to the pharmacist for signature for the current year.

Records

- In past inspections, there had been concerns raised regarding the availability of medical records for use in the outpatient clinics. This had improved at the previous inspection and we found these improvements had been generally maintained. Management told us they had recently altered the way they audit records, this had started during the week of our inspection.
- Information provided by the trust showed for Cumberland Infirmary that between April 2016 and June 2016, 93.52% of case notes were available at the start of clinic and between July 2016 and September 2016, 94.38% of notes were available at the start of clinic.
- Management told us that staff would complete an incident form if medical records for the clinic had not arrived in time for clinic. Incident data provided by the trust showed that there had been incident forms logged in the last 12 months regarding the availability of medical records.
- The medical record storage centre had recently moved off site and records were delivered to the clinics daily. Staff told us this had led to some challenges such as records arriving late for clinics.
- Management told us there were regular operational meetings where medical records were discussed and the medical record management were in attendance at these meetings.
- Records in main outpatients were stored securely in locked cupboards when clinics had finished and behind a locked door in a room when being delivered and were being made ready for the clinics that day.
- The services had recently introduced an electronic system which allowed clinics to view outpatient letters electronically. Medical records were in paper format at the trust.
- Records we looked at were found to be completed as required.

Diagnostic imaging:

- Diagnostic imaging records and reports were digitised, stored electronically and available to clinicians across the trust via electronic records systems; CRIS (Computerised Radiology Information System) and PACS (Picture Archiving and Communications System).
- We looked at 12 electronic patient records and all were completed correctly.
- Risk assessments were carried out with ongoing safety indicators for all radiological equipment, processes and procedures. These were stored electronically and were easily accessible to all diagnostic imaging staff.

Safeguarding

- Most staff we spoke could describe how they would report a safeguarding concern. Staff told us that they would ask their managers for advice, and most staff told us that they would report to the safeguarding team in the trust. Staff we spoke with were not always aware of the level of safeguarding training they had received.
- Safeguarding mandatory training levels varied. The trust had a safeguarding target of 95%. Safeguarding training compliance as at August 2016 showed that the trust were at 77% completion rate for safeguarding adults level 1 and 76% for safeguarding children level 2. Safeguarding children level 1 compliance was at 100%. These figures relate to medical staff, nursing staff and healthcare assistants in outpatients.

Diagnostic imaging:

- In diagnostic imaging trust records showed that 57% of staff had completed level 1 safeguarding adults and children training and 71% had completed level 2. These courses were completed once every three years and the business unit manager told us all staff who were due to complete this year had time booked in duty rotas to complete their training before the end of the financial year.
- Staff had a good understanding of safeguarding vulnerable adults or children principles and processes. Staff we spoke with knew that there was a policy on the intranet and staff within the organisation who they could speak with for advice. Staff had referred two cases to the trust safeguarding team when they were concerned about individuals attending from the emergency department. All of the staff we spoke with said they would escalate any concerns to their manager in the first instance.

Outpatients and diagnostic imaging

Mandatory training

- Mandatory training was a mixture of face to face training and online training. Staff we spoke with confirmed their mandatory training was mostly up to date.
- Mandatory training targets were 95%. Nursing and Healthcare assistant compliance levels were mostly below the target. Equality and diversity training was the only mandatory training course which achieved the target with 100% compliance. Information governance compliance was the lowest rate with 42% completion, fire and safety compliance rate was 51%, infection control compliance was 72%, health and safety compliance was 73% and adult basic life support training compliance was 61%.
- Medical staff completion rates were generally below the target of 95%. Only equality and diversity achieved the target with a compliance rate of 100%. Information governance training compliance was 75%, fire safety training was 75%, infection control training compliance was 75%, health and safety training compliance was 63% and adult basic life support training compliance was 86%.
- The trust set the target of 95% completion of training by the end of March 2017.

Diagnostic imaging:

- Mandatory training was well managed. The diagnostic imaging departments had systems and processes to ensure staff training was monitored.
- Records showed and managers told us compliance with mandatory training in radiology across the trust was 78%. There were plans and training scheduled to ensure staff met the trust target of 95% before the end of March 2017.
- Staff we spoke with confirmed they had attended mandatory training. Managers had access to an online system to identify staff mandatory training completion rates and would use this system to ensure staff had completed or were booked on mandatory training.

Assessing and responding to patient risk

- Staff we spoke with in outpatients could describe the action they would take if a patient deteriorated in the clinics. Staff told us they would seek advice from the doctor and assess the patient and/or take the patient to the emergency department if required. Staff we spoke with were aware of the crash team being available in the hospital.

Diagnostic imaging:

- The department had a process for prioritising the urgency of diagnostic imaging referrals and requests. All urgent referrals were flagged and escalated to ensure they were given an early appointment. All other requests were triaged and appointments were allocated accordingly. This process had been amended following a serious incident where an urgent referral had not been identified and the procedure had not been booked, leading to a delay in treatment.
- Diagnostic imaging policies and procedures in the diagnostic imaging department were written in line with the Ionising Radiation (Medical Exposure) 2000 regulations (IR(Me)R) to ensure that risks to patients from exposure to harmful substances were managed and minimised.
- The Radiation Protection Advisor (RPA) and medical physics expert (MPE) was contracted from a local NHS Trust to support all North Cumbria University Hospitals NHS trust sites. The RPA and MPE visited and provided advice remotely as required.
- There were named certified Radiation Protection Supervisors (RPS) on each site to give advice when needed and to ensure patient safety at all times.
- The Administration of Radioactive Substances Advisory Committee (ARSAC) certificate holder for the Medical Physics elements of diagnostic imaging was employed by the trust within the Medical Physics department at Cumberland Infirmary, Carlisle. The role of the ARSAC advisor is to be contactable for consultation and provide advice on aspects relating to radiation protection concerning medical exposures in radiological procedures.
- Arrangements were in place for radiation risks and incidents defined within the comprehensive local rules. Local rules are the way diagnostics and diagnostic imaging work to national guidance and vary depending on the setting. Policies and processes were in place to identify and deal with risks. This was in accordance with (IR(ME)R 2000). Local rules for each piece of radiological equipment were held within the immediate vicinity of the equipment.

- Staff asked patients if they were, or may be, pregnant in the privacy of the x-ray room. Therefore preserving the privacy and dignity of the patient. This was in accordance with the radiation protection requirements and identified risks to an unborn foetus. We saw different procedures were in place for patients who were pregnant and for those who were not. For example patients who were pregnant underwent extra checks and if the x-ray was still necessary, could wear a lead apron to protect their unborn baby.
- Staff told us that the risks of undergoing an x-ray whilst pregnant were fully explained to patients.
- We observed and records showed diagnostic imaging staff used the WHO safer surgical checklist for all interventional procedures.

AHP Staffing

- Physiotherapy had a staffing document showing the planned against actual staffing levels and where there were differences an area for mitigation was described. There were vacancies in the physiotherapy team. The June 2016 to October 2016 staffing document showed that there were three whole time equivalent vacancies with one having been appointed to and other vacancies were generally less than one whole time equivalent within the different teams. The document had a mitigation section which highlighted that bank staff were used to enhance staffing levels.

Diagnostic imaging :

- At the time of our inspection, within the diagnostic imaging departments, there were sufficient radiographers, clinical support workers, and nursing staff to ensure that patients were treated safely. There were current vacancies and these were being recruited to.
- Managers told us they were supportive of staff and planned to recruit more qualified radiographers to support a new shift system. Staff we spoke with were able to corroborate this.
- There had been difficulties in recruitment of qualified radiographers in the past and managers told us this was improving slowly. This was in line with the national picture regarding radiographer recruitment.
- Managers were carrying out succession planning whereby current junior and general radiology staff were undergoing training to specialise in modalities including CT and ultrasound.
- The radiology department had nurses and health care assistants who assisted with interventional procedures.
- The trust had appointed radiographer advanced practitioners who were undergoing training for their role. Managers were aware that radiographer training was helping to reduce the burden on radiologists but it affected the radiographer numbers and further staff were required to backfill as staff qualified in advanced roles.
- Sonographers reported their own ultrasound scans at the time of each procedure. A lead sonographer was responsible for ultrasound across all sites.
- Due to the shortage of sonographers the trust had looked at development of knowledge and experience of existing staff and had identified radiographers to train to a sonographer role.
- Radiographers undertook fluoroscopy including barium swallows and video fluoroscopy in corroboration with speech and language therapists (SALT) to identify swallowing problems for stroke patients. CT radiographers undertook CT colon imaging.

Nursing staffing

- During our inspection we found that there had been difficulty with ensuring staffing levels in some services were at their planned established amount. Management told us outpatient registered nurse staffing was generally suitable, however some staff groups, for example orthopaedic practitioners were not staffed at the planned levels. The planned staffing level was 3 orthopaedic practitioners and the actual staffing level was 0. This risk was being mitigated by staff from Cumberland Infirmary working each morning during the week at the West Cumberland hospital. This meant that there was limited orthopaedic practitioner support at West Cumberland in the afternoons each weekday. Low staffing levels had not been identified on the risk register.
- The service had allocated further staff to complete the orthopaedic practitioner training which would help ensure the required staffing levels.
- Managers told us there were generally no concerns regarding nurse and healthcare assistant staffing levels in the main outpatient department. There had been lower than planned staffing levels in main outpatients due to sickness levels, however this had improved recently.

Outpatients and diagnostic imaging

- Staffing levels and skill mixed were managed by department managers. The services had recently changed to a new electronic roster system and managers were now required to complete the roster a month at a time. This was still new and staff and managers were still getting used to the change in practice.
- Outpatients had a vacancy rate of 5% as at September 2016 and between April 2015 and March 2016 the trust reported a turnover rate of 4% in outpatients. Between April 2015 and March 2016, the trust reported a sickness rate of 5% in outpatients. Bank and agency use between April 2015 and March 2016 was 0.3% in outpatients.
- Ophthalmology nurse staffing planned levels for WCH were 1.8 WTE for the band 7 role, and the actual was 1.8. The planned level for the band 6 role was 6.99 and the actual was 5.55 WTE. The actual staffing level for band 5 nursing staff was 8.45 and the actual was 8.4 WTE. The planned staffing level for healthcare assistant staffing was a total of 4.41 WTE; the actual level was 2.89.
- Haematology outpatient nurse actual staffing levels were 4.4 whole time equivalent each month between April 2016 and November 2016 and the planned staffing level was 4.4 whole time equivalent. Oncology outpatient nurse actual staffing levels varied each month between April 2016 and November 2016, these varied between 11.68 whole time equivalent and 14.53 whole time equivalent. The planned staffing level was 13.27 whole time equivalent.

Diagnostic imaging:

- There were 1.6 whole time equivalent (WTE) specialist nurses to support interventional radiology procedures with a vacancy for 0.6 WTE. Nurses sometimes travelled between hospitals to support interventional lists.
- Radiographer helpers moved between modalities to provide help and support to staff and patients where required.

Medical staffing

- Medical staffing was managed by the individual speciality delivering the service in outpatients.
- During our previous inspection consultant ophthalmologist staffing levels had been raised as an issue. During this inspection we were told that new consultant ophthalmologists had been recruited. Three consultants had been recruited with one in post and two still to start at the trust. The service was still reliant to an extent on locum medical staffing in ophthalmology and there were three locums across the service.
- Ophthalmology medical staffing consultant planned staffing levels were 8.5 whole time equivalents (WTE) and the actual staffing level was 8.3 WTE. Middle grade and junior medical posts were at full establishment for ophthalmology outpatients. Medical staff for ophthalmology worked across both hospital sites and staff told us that, even though staffing numbers had improved, cover fell short on occasions.
- As at September 2016, outpatients reported a vacancy rate of 26% and a staff turnover rate of 23% between April 2015 and March 2016. Between April 2015 and March 2016, medical staffing had a sickness rate of 5% in outpatients. Bank and agency use in outpatients between April 2015 and March 2016 was 17% in outpatients.
- We received a clinic list rota for oncology and haematology outpatients and this showed that locums were in use at the trust for these services. Out of the eight medical staff listed on the rota for oncology outpatients, two were locum staff. The haematology outpatient clinic list showed there was one consultant vacancy; however it stated that a consultant was starting in the new year.
- The trust provided a document showing actual staffing levels against planned staffing levels. In Haematology, this showed that between April 2016 and November 2016, the planned medical staffing level in haematology outpatients was 3.6 whole time equivalent staff and the actual staff level was 3.2 whole time equivalent each month. In Oncology, this showed that between April 2016 and November 2016, the planned staffing level was 6.7 whole time equivalent and the actual varied each month between 5.86 whole time equivalent and 7.27 whole time equivalent. In November 2016, the planned level was 6.7 whole time equivalent and the actual staffing level was 5.91 whole time equivalent.
- The haematology and oncology risk register included lack of consultant provision on the risk register.

Diagnostic imaging:

- The department had a funded establishment of 10.85 whole time equivalent (WTE) consultant radiologists. They employed 5.83 WTE staff at the time of the inspection. This meant there were five WTE vacancies.

Outpatients and diagnostic imaging

- The department contracted the reporting of some X-rays and scans to external companies to enable them to meet the demands on the service. There were formal service level agreements (SLA) in place for this process. Trust consultant radiologists fed reporting discrepancies back to outsourcing companies.
- There was a national shortage of radiologists. However, there was an ongoing recruitment drive to attract radiologists and the trust employed long-term locum consultants to fill gaps.
- The trust hadn't recorded any sickness levels for radiologist staff.
- There was consultant cover across the trust out-of-hours and at weekends.
- At the time of this inspection the trust had an establishment target of three WTE consultant radiologists. The trust had one employed consultant in a substantive post. The trust had appointed one full time locum. However, the current locum planned to leave the trust at the end of December 2016 and another full time locum vacancy remained.
- At the time of this inspection there were sufficient staff to provide a safe and effective service. Managers stressed that the establishment figure had been set some years ago and did not account for increased capacity and demand for radiology services so they estimated that the service would require more consultants now and in future.
- There were two specialist radiology trainees completing four-month placements with the trust.

Major incident awareness and training

- The trust had an emergency preparedness policy in place.

Diagnostic imaging:

- Staff were aware of the action they should take in the event of a radiation incident. There were standard operating procedures in place.
- The various teams within the diagnostic imaging department had business continuity plans in place. In the event of equipment failure the trust had agreements with local providers to allow them access to equipment. There were also maintenance contracts in place to ensure that any mechanical breakdowns were fixed as quickly as possible.
- Staff knew their roles in the event of a major incident.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We did not rate effective, however:

- Staff we spoke with could describe the national guidance they used and a number of staff had undertaken further training and development in their services.
- Staff had access to the relevant computer systems such as electronic reporting systems in the outpatients departments.
- Staff we spoke with could describe when they get consent, for example when they get verbal consent. Staff understood about consent and followed trust procedures and practice.
- Diagnostic imaging services ran every weekday for outpatients and GP patients and a full 24hour service was in operation for plain film, CT and ultrasound for inpatients and trauma. Care and treatment was evidence-based and staff followed national guidelines to provide best practice for patient care. Staff were competent, and multidisciplinary teams met regularly across a range of services, local networks and specialties, and included both medical and non-medical staff.
- Radiologists undertook clinical audits to check practice against national standards and to improve working practices.
- Staff we spoke with could describe when they get consent, for example when they get verbal consent.
- Staff knew the various policies to protect patients and people with individual support needs. Staff asked patients for their consent before treating them. Staff were clear about how to support patients when they lacked, or had changes in, mental capacity.

However:

- There was no formal clinical supervision in place for outpatient staff and ophthalmology outpatient staff.
- Appraisal rates were low, at 51% completion across the outpatients service.

Evidence-based care and treatment

- Pro formas and protocols were in place in the fracture clinic, for example, to provide streamlined fracture care.
- Staff we spoke with in clinic's told us they follow National Institute of Clinical and Care Excellence (NICE) guidelines within their work.

Diagnostic imaging:

- We saw reviews against IR(ME)R regulations and learning disseminated to staff through team meetings and training.
- The trust had a radiation safety policy in accordance with national guidance and legislation. The purpose of the policy was to set down the responsibilities and duties of designated committees and individuals. This was to ensure the work with Ionising Radiation undertaken in the Trust was safe as reasonably practicable.
- The trust had radiation protection supervisors for each modality to Lead on the development, implementation, monitoring and review of the policy and procedures to comply with Ionising Radiation (Medical Exposure) 2000 regulations. IR(ME)R.
- National Institute for Health and Care Excellence (NICE) guidance was disseminated to departments. Staff we spoke with were aware of NICE and other specialist guidance that affected their practice.
- Procedures were in place to ensure the diagnostic imaging department were following appropriate NICE guidance regarding the prevention of contrast induced acute kidney injury.
- Consultant radiologists told us and we observed they used a WHO checklist for every interventional radiology procedure.
- The departments were adhering to local policies and procedures. Staff we spoke with were aware of the impact that they had on patient care.
- The diagnostic imaging department carried out quality control checks on images to ensure that the service met expected standards.

Pain relief

- The outpatient department's kept a small stock of medicines, which included pain relief medication.

Diagnostic imaging:

- Diagnostic imaging staff carried out pre-assessment checks on patients prior to carrying out interventional procedures. Pain relief for procedures such as biopsies was prescribed by radiologists and administered safely as required.

Nutrition and hydration

Diagnostic imaging:

- A water fountain was provided for patients' use in the shared waiting area between the outpatients and x-ray departments. However, there was no access to drinks once patients or visitors entered the department. There was a café nearby where people could purchase drinks and snacks.

Patient outcomes

- The follow up to new rate for Cumberland Infirmary, WCH and Workington Community Hospital was mostly lower than the England average between April 2015 and March 2016. Penrith Hospital and Cockermouth Community Hospital was mostly higher than the England average for follow up to new rate. During March 2016, Cockermouth Community Hospital was more than four times higher than the England average.

Diagnostic imaging:

- All diagnostic images were quality checked by radiographers before the patient left the department. National quality standards were followed in relation to radiology activity and compliance levels were consistently high.
- Some elements of the quality assurance programme had not taken place for six months following installation of new equipment. Staff told us this was because equipment was new and had been calibrated and checks carried out during installation. However, a newly appointed lead radiographer told us they had prioritised this to be actioned in the near future.

Competent staff

- Medical and nursing staff appraisal rates between April 2015 and March 2016 were at 51% for staff who had completed an appraisal. Staff we spoke with told us they had completed an appraisal.
- There was no formal clinical supervision in main outpatients or ophthalmology outpatients. Staff told us they were generally able to attend training and

development courses. Some staff we spoke with had completed further training, such as wound care, and other staff were waiting to go on additional training, such as the orthopaedic practitioner course. Some staff we spoke with had undertaken the trust's leadership programme.

- The dermatology outpatient department had regular monthly clinical supervision and staff met with their line managers each month which provided additional support to staff. Staff felt well supported when completing in house training and external training in the dermatology service. Staff had attended a conference specific to dermatology nursing as this was appropriate to their role.
- Staff in main outpatients worked between the clinic areas. Managers told us this allowed flexibility within the team and service.
- Different staff groups and specialities had access to training. The service offered an in house phlebotomy training course to staff. This was a mixture of eLearning and face to face training. This involved being observed in practice and then being signed off as competent by a senior member of staff. Specialist nurses in the haematology service had attended training specific to their role at a local university.
- New staff at the trust had to complete a one day induction.

Diagnostic imaging:

- Staff we spoke with confirmed that they received one-to-one meetings with their managers on a monthly basis, which they found beneficial. Senior staff told us appraisal rates for diagnostic imaging staff were 97% across all sites.
- Medical revalidation was carried out by the trust. There was a process to ensure that all consultants were up to date with the revalidation process.
- Allied health professionals were supported to maintain their registration and continuous professional development.
- Radiology staff were assessed against radiology competencies, and medical devices training was provided for new and existing staff. Staff were supported to complete mandatory training, appraisal, and specific modality training.
- Students were welcomed in all departments. Radiography students came for elective placements and managers told us they had recruited new graduates from their student cohorts.
- The department provided local rules and MRI safety training trust-wide for medical and non-medical referrers.
- Radiographers were trained to use each piece of new equipment by applications specialists from suppliers. We observed applications engineers demonstrating new cardiac CT equipment to radiologists.
- Radiographers had been trained for lead roles in CT and MRI.

Multidisciplinary working

- Staff told us the orthopaedic clinic and virtual fracture clinics had multi-disciplinary team (MDT) meetings each week. These MDT meetings included medical staff, pharmacists and specialist practitioners.
- The outpatient services provided clinics where specialist nurses ran the clinic or were present, for example dermatology had specialist nurses in place to provide further support and advice to patients attending the services. The ophthalmology outpatient service had specialist nurses available at WCH and Cumberland Infirmary.
- One stop clinics were available in Urology where patients were able to see a consultant and the nurse specialist at the clinic. The cataract clinic ran a one stop clinic service where patients received diagnosis and pre-assessment before surgery.

Diagnostic imaging:

- There was evidence of multidisciplinary working in the imaging department. For example, nurses, radiographers and medical staff worked together in interventional radiology theatres.
- We saw that the diagnostic imaging departments had links with other departments and organisations involved in patient journeys such as GPs and support services. For example the radiology department worked with the Accident and Emergency department to ensure that X-rays, CTs and other scans were carried out and reported in a timely manner.
- Radiologists attended multi-disciplinary meetings to discuss diagnosis and treatment plans for suspected cancer patients.

Outpatients and diagnostic imaging

Seven-day services

- Outpatients generally operated Monday to Friday between 08:00 and 17:00; however there were weekend clinics across different specialities. These had been introduced to address the capacity and demand issues and were used to assist in reducing waiting times. There were limited evening clinics available, however management told us they would consider evening clinics if requested or required.

Diagnostic imaging:

- Diagnostic imaging services including plain film, CT, and ultrasound were available 24 hours seven days a week for trauma and inpatients with an on call radiographer and radiographer helper on site providing overnight cover and a second on-call available if necessary.
- Outpatients and GP patients could attend for x- rays 5 days a week. When demand increased the department could provide additional appointments at the end of planed lists.

Access to information

- Staff had access to computers and the relevant systems in clinics and in the departments. Staff could use the incident reporting system in their departments and had access to a trust intranet.
- Main outpatients had a daily huddle where they would discuss the day and raise anything that would benefit staff and managers. This was located on a board in the department.

Diagnostic imaging:

- All staff had access to the trust intranet to gain information relating to policies, procedures, NICE guidance and e-learning.
- Staff were able to access patient information such as imaging records and reports and medical records appropriately through electronic records.
- Diagnostic imaging departments used picture archive communication system and computerised radiology information system (CRIS) to store and share images, radiation dose information and patient reports. Staff were trained to use these systems and were able to access patient information quickly and easily. Systems were used to check outstanding reports and staff were able to prioritise reporting so that internal and regulator standards were met. There were no breaches of standards for reporting times.
- The diagnostic imaging department kept an electronic list of approved referrers and practitioners. This ensured that all staff, both internal and external, could be vetted against the protocol for the type of requests they were authorised to make. During our inspection a doctor asked for help accessing their PACS account and the radiographer followed protocol to provide a new password.
- There were systems in place to flag up urgent unexpected findings to GPs and consultants. This was in accordance with the Royal College of Radiologist guidelines.
- Diagnostic results were available through the electronic system used in the department. These could be accessed through the system available in clinics.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with could describe where they ask for consent. Staff could describe when they use verbal consent. Ophthalmology outpatients had specific written consent forms which were used to document consent.
- As at August 2016 99% of clinical staff in outpatients had completed mental capacity act (MCA) level 1 training. Deprivation of Liberty standards training had been completed by 100% of clinical staff.

Diagnostic imaging:

- Diagnostic imaging and medical staff understood their roles and responsibilities regarding consent and were aware of how to obtain consent from patients. They were able to describe to us the various ways they would do so. Staff told us consent was usually obtained verbally although consent for any interventional radiology was obtained in writing prior to attending the diagnostic imaging department.
- Staff we spoke with were aware of who could make decisions on behalf of patients who lacked or had fluctuating capacity. They were aware of when best interest decisions could be made and when Lasting Power of Attorney could be used.

Outpatients and diagnostic imaging

- Patients told us that staff were very good at explaining what was happening to them prior to asking for consent to carry out procedures or examinations.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring as 'good' because:

- Staff provided compassionate care and interacted with patients in a caring way
- During the inspection, we saw and were told by patients, that the staff working in the outpatient and diagnostic imaging departments were kind, caring and compassionate at every stage of their journey and patients were given sufficient time for explanations about their care and were encouraged to ask questions.
- People were treated respectfully and their privacy was maintained in person and through actions of staff to maintain confidentiality and dignity.
- Patients we spoke with were overwhelmingly positive about the way staff looked after them. Care was planned and delivered in a way that took account of patients' needs and wishes.
- There were services to emotionally support patients and their families. Staff reacted compassionately to patient discomfort or distress and to suit individual needs. Staff involved patients by discussing and planning their treatment and were able to make informed decisions about the treatment they received.
- The trust had a number of clinical nurse specialists and lead nurses available for patients to talk to about their condition.

Compassionate care

- Staff provided compassionate care and interacted with patients in a caring way. Staff provided further care where required, for example we observed staff keep patients informed of the care and treatment being provided in clinic.
- We spoke with nine patients during our inspection. Patients we spoke with were positive about the care received and the services provided in outpatients.
- The patient survey carried out by the physiotherapy department showed that the service scored 9.5 out of 10 for patients recommending the hospital to family and friends. The trust scored 10 out of 10 for patients being treated in a courteous and respectful manner.
- Staff told us they ensure privacy and dignity is respected in the services. Staff would reassure patients during their appointments and explain the process in outpatients clearly to patients. Staff made sure clinic room doors were closed when in use and curtains in rooms were used to enhance the dignity and privacy of patients.

Diagnostic imaging:

- Staff in diagnostic imaging were caring and compassionate to patients. We observed positive interactions with patients. Staff approached patients and introduced themselves, smiling and putting patients at ease.
- We observed patients being supported in a way that preserved their privacy and dignity.
- Staff were kind and patient with patients. They welcomed patients with a smile and a cheerful manner.
- Staff ensured that patients felt comfortable and safe in the department and were good at putting patients at ease.
- There were gowns available to patients to maintain their dignity.
- There were designated areas for patients on trolleys to maintain their privacy.
- The department had been designed to provide as much privacy and dignity as possible with changing rooms and toilets close to procedure rooms and away from public thoroughfares.
- We spoke with seven patients and two people close to them and all said that staff were friendly with a caring attitude. There were no negative aspects highlighted to us.
- We observed staff behaving in a caring manner towards patients they were treating and communicating with and respecting patients' privacy and dignity throughout their visit to the department.

Understanding and involvement of patients and those close to them

- Staff confirmed they provide chaperones to patients during clinics. Staff told us they used the butterfly scheme for dementia patients and had a dementia link

nurse available in the department who had undertaken further dementia training to better support patients with dementia who attend the department and provide advice to staff.
- Staff told us interpreter services were available across outpatients and diagnostic services.
- In the physiotherapy patient survey, the service scored 9.9 out of 10 for patients feeling involved in decision being made about their care.
- Staff spoke with patients about their care and treatment and asked patients if they understood the information being provided and questions being asked during treatment. Staff provided further information where required to patients attending clinics. Staff in ophthalmology told us they discuss treatment options with patients.
- There was no specific 'quiet' area for patients to go in outpatients, however if a patient required or requested a quiet area, staff told us they would accommodate this and find an available room.

Diagnostic Imaging:

- Patients told us that they were involved in their treatment and care. Those close to patients said that they were kept informed and involved by nursing and medical staff. All those we spoke with told us that they knew why they were attending for a procedure or scan.
- Outpatients and diagnostic imaging staff involved patients in their treatment and care. We saw staff explaining treatment. We observed examples in outpatients and diagnostic imaging where staff gave patients and families time and opportunities to ask questions.
- Radiology reception was situated near to the department entrance and staff frequently checked the entrance area for trauma patients and inpatients, to greet people and assist them where required. Staff we spoke with described examples where they would provide further support to patients if required.

Emotional support

- The chronic kidney disease team provided further information and support to patients regarding dialysis transplantation in clinics at during patient visits.
- Staff provided reassurance to patients in the clinics where necessary and provided patients in outpatients with support as required. Specialist nurses were available in clinics such as dermatology to provide further advice and support. Services such as haematology outpatients had contact cards available for patients; however these contact cards were not available from all clinics.
- Staff told us they had previously held 'best interest' meetings in outpatients for vulnerable patients where staff met with carers to discuss the patients' needs and consent prior to the appointment. These meetings were organised mostly by the pre-orthopaedic surgery teams.

Diagnostic Imaging:

- Staff told us that on request, if someone was anxious about a procedure such as a scan, they could visit the department first to look at the equipment and understand what to expect. This was also available for patients living with a learning disability.
- In the case of children, parents could be in the x-ray room, protected by a lead apron to ensure that the child felt safe. There was a similar process in place to support patients living with dementia or a learning disability who needed extra support in the scanning or x-ray room.
- We observed staff working with a small child and their family to encourage the child to comply with the process for taking an x-ray image. The radiographers spoke to the child and the parents and explained what would happen.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We rated responsive as 'requires improvement' because:

- Referral to treatment time (RTT) data varied across the specialities. The service did have patients which the see by date had been breached.
- There were a number of clinics cancelled within 6 weeks of the clinic across the trust and there was no current action plan in place to address cancelled clinics in outpatients.
- The trust did not measure how many patients waited over 30 minutes to see a clinician in outpatient departments.

Outpatients and diagnostic imaging

- Turnaround times for inpatient plain film radiology reporting did not meet Keogh standards, which require inpatient images to be reported on the same day.

However:

- We found that outpatient and diagnostic services were responsive to the needs of patients who used the services. Extra clinics and imaging sessions were added to meet demand and waiting times for diagnostic imaging appointments were within acceptable timescales. Patients were able to be seen quickly for urgent appointments if required.
- There were facilities and processes in place to support the individual needs of patients in diagnostic imaging. For example, all new x-ray equipment was suitable for the needs of bariatric patients, and there were quiet areas for patients who needed extra support.

Service planning and delivery to meet the needs of local people

- The 'did not attend' (DNA) rate between April 2015 and March 2016 was lower than the England average for all hospital outpatient sites except Workington Community Hospital where the DNA rate was higher.
- The chronic kidney disease team carried out home visits to patients to discuss different options for dialysis transplantation.
- The orthopaedic outpatient department offered virtual fracture clinics. The virtual fracture clinic was developed to manage patients attending the fracture clinics and attempted to prevent unnecessary attendance of patients. A consultant and orthopaedic clinic staff would discuss patient's care and where it is determined a patient could be discharged, staff would telephone the patient to discuss discharge. Staff told us this had reduced patients needing to come into hospital.
- These virtual appointments were offered by telephone. This work and the virtual clinics had enhanced capacity within the orthopaedic outpatient department. Staff told us patients were given the opportunity to attend the hospital if they preferred.
- Outpatient management told us that, if new clinics were being offered and more staff were required in outpatients, the service would request further clinical nurse and administration support before the new clinics were introduced.
- Outpatient management told us they were considering offering more clinics in the evening at the hospital and that if evening clinics were requested by specialities, they would put these on. Weekend clinics were provided at the hospital to help deal with the demand for the services and address waiting lists.
- The service was considering being part of the nurse cadet scheme for the hospital, to assist in recruiting more healthcare professionals.
- The ophthalmology outpatient service held two slots during each clinic for emergency patients. Staff told us they would triage the patient over the telephone and if they needed to attend, these emergency slots were accessible. The telephone triage was also used to provide advice to patients.

Diagnostic imaging:

- The diagnostic imaging department had good processes in place and the capacity to deal with urgent referrals and additional scanning sessions were arranged to meet patient and service needs.
- Diagnostic imaging reporting and record-keeping was electronic and paperless methods were used to reduce time and administration requirements. Urgent reports were flagged for prioritisation.

Access and flow

- The trusts referral to treatment time (RTT) for non-admitted pathways between September 2015 and August 2016 has been similar to the overall England performance. Eight specialities were above the England average and seven specialities were below the England average. For example rheumatology was at 96.9% against an England average 93.4% and ophthalmology were at 96.4% against an England average of 93.8% for non-admitted RTT performance.
- Data from the non-admitted RTT performance of specialties below the England average show that Urology was at 88.3% against a 90.3% England average and Trauma and Orthopaedics were at 93.8% against an England average of 90.1%.
- The trusts referral to treatment time (RTT) for incomplete pathways between September 2015 and August 2016 was worse than the England overall performance and worse than the operational standard of 92%. There were ten specialities above the England average for incomplete pathways (RTT) and there were five specialties that were below the England average for

incomplete pathways for RTT. For example, dermatology was at 96.7% against an England average 94.2%; however ophthalmology was at 86.8% against the England average of 93.3% for RTT incomplete pathways.

- The trust was performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral.
- At quarter 2 2016/2017 the trust performed better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis. Before quarter 2 the performance showed a downward trend from quarter 3 2015/2016 to quarter 1 2016/2017.
- The trust previously performed worse than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. At Q2 2016/2017 the trust performance was slightly above the England average, at Q3 this was above the England average at 86.65%.
- In a previous inspection, 6 week diagnostic waiting times were raised as a concern. Data at this inspection showed that between September 2015 and June 2016, the percentage of patients waiting more than six weeks to see a clinician was higher than the England average, however in July 2016 and August 2016 the waiting times have been better than the England average. Over a 12 month period between September 2015 and August 2016, there had been a trend of improvement.
- During our inspection we found that clinics had been cancelled within 6 weeks in outpatients. The trust were unable to provide the percentage of clinics cancelled, however the number of clinic cancellations within 6 weeks in July 2016 was 98, in August 2016 it was 71 and in September 2016 175 clinics were cancelled within 6 weeks. In July 2016 148 clinics were cancelled over 6 weeks, 168 clinics were cancelled over 6 weeks in August 2016 and 286 clinics were cancelled over 6 weeks in September 2016. Information provided by the trust showed that the main reasons for cancelled clinics were industrial action, sickness absence, and locum medical staff turnover. There was no current action being taken to address cancelled clinics in outpatients.
- The trust did not measure the percentage of patients waiting over 30 minutes to see a clinician. This meant to trust could not assess performance of the time patients wait to see a clinician in the outpatient clinics. Staff did highlight the waiting time on the performance boards in their departments; however this was not regularly audited.
- The trust provided data showing that some areas did have patients where they had breached the see by date. For example, in trauma and orthopaedics, 51 patients had breached the see by date in August 2016 and in cardiology, 47 patients had breached the see by date in August 2016.
- Ophthalmology had a small backlog in the cataract service. This figure was around 50 patients a month, staff and management told us that extra clinics were added each week and some clinic slots were double booked to ensure patients are seen when required. Weekend clinics were also offered to deal with the backlog. Staff told us demand was high in the ophthalmology clinics.
- Physiotherapy waiting times was highlighted as an issue in the previous inspection report. At this inspection, staff told us there were no current issues with waiting times for outpatient appointments in the physiotherapy department. The service had increased capacity by moving from two physiotherapy groups per week to one group and increasing the number of patients in the group. This had increased capacity elsewhere in the service.
- Data provided by the trust for physiotherapy showed that the waiting time in weeks had generally decreased in December 2015 from eight weeks to five weeks in August 2016. Between December 2015 and August 2016, the maximum waiting time was 12 weeks for physiotherapy outpatients.
- Outpatient 'did not attend' (DNA) rates were 11% in September 2016 and this had reduced to 9% in October 2016. These DNA rates include new and follow up patients.

Diagnostic imaging:

- The department provided a radiology coordinator to assess capacity and demand and make adjustments to staffing where necessary.
- Radiology managers told us diagnostic imaging waiting times, measured over all sites, from all urgent and non-urgent referrals met national targets. Members of the administration team in radiology told us that they checked request lists for any urgent referrals before they were vetted by the senior radiographer and radiologist.

Outpatients and diagnostic imaging

Average wait times across all modalities, including CT, MRI, and fluoroscopy, for outpatients and GP referrals ranged between 11 days and 35 days. The department did not provide figures for average wait times for inpatients. However staff told us most inpatient and emergency patient imaging was carried out on the day of the referral.

- Staff carried out a continuous review of planned diagnostic imaging sessions in relation to demand and 7-day working arrangements. They monitored waiting times and were able to identify any possible breach dates. This enabled the team to take action such as adding extra appointments at the end of planned list times. They organised additional sessions to accommodate urgent diagnostic imaging requests.
- Turnaround times for radiology reports were monitored and most of those recorded were in line with Keogh national standards. Average turnaround times were reported across all sites as the average number of days between imaging and reporting:
  - Angiography reporting for inpatients ranged from 0.3 days to 3.6 days and urgent outpatients ranged from 0 days to 1 day.
  - CT reporting for inpatients ranged from 0.1 days to 0.4 days and urgent outpatients ranged from 0.4 days to 1.3 days.
  - MRI reporting for inpatients ranged from 0 days to 0.26 days and urgent outpatients ranged from 1.2 days to 3.4 days.
  - Reporting for inpatients ranged from 0.3 days to 3.6 days and for urgent outpatients ranged from 0 days to 1 day.
  - Plain film reporting for inpatients ranged from 5.9 days to 13.8 days and urgent outpatients ranged from 1 day to 4.2 days. This did not meet Keogh standards, which require inpatient images to be reported on the same day.
- Reporting times for urgent and non-urgent procedures consistently met national and trust targets for all scans and x-rays for outpatients.
- Managers told us that they worked closely with staff from other departments and specialties on their performance in providing a good and prompt service to meet targets. These included Accident and Emergency imaging and reporting as well as timely imaging for specialties to support referral to treatment targets.
- Staff liaised with the wards to request a porter to bring inpatients into the department near the time of their procedure.

Meeting people's individual needs

- Staff confirmed interpreter services were available and accessible when required.
- Outpatient appointments time for each patient per appointment was dependant on the individual speciality in outpatients. Where appointment times were running late, staff would approach patients individually and inform them of the delay.
- The butterfly scheme was in use for patients who had dementia. Staff told us they communicated information to vulnerable patients and respected the privacy and dignity of patients, for example by ensuring clinic doors were closed and curtains were in use where required.
- Patient information leaflets were available for patients. There were different leaflets for the different specialities and these were provided to patients when attending clinic.

Diagnostic imaging:

- Patients with complex individual needs such as those with learning difficulties were given the opportunity to look around the department prior to their appointment. Staff could provide a longer appointment or reschedule an appointment to the beginning or end of the clinic.
- There were separate toilets and waiting areas for patients who had received radioactive injections. This reduced the risk of radioactive exposure to visitors and ensured correct waste procedures were adhered to.
- Staff told us the bookings team could produce information for patients in different languages.
- Bariatric equipment was available and accessible. New x-ray and scanning tables had been selected to accommodate patients of larger weight and size.
- Staff were aware of how to support people with dementia. They told us that most patients with dementia were accompanied by carers or relatives and provisions were made to ensure that patients were seated in quiet areas and seen quickly.
- Departments were able to accommodate patients in wheelchairs or who needed specialist equipment. There was sufficient designated space to manoeuvre and position a person using a wheelchair in a safe and sociable manner.

- Patients had access to a wide range of information. Information was available on notice boards and leaflets. There was information that explained procedures such as x-rays. There was information about various illnesses and conditions including where to go to find additional support.
- Patient information leaflets were plentiful, of good quality and up to date.

Learning from complaints and concerns

- The services visited had received 31 complaints over the previous 12 months. Of these 21 were informal and 11 were formal. The departments kept a log of complaints and all actions taken. This included lessons learned across departments and sites.
- There was a patient advice and liaison office located near the main outpatient area in the hospital. We saw 'how to make a complaint' forms located around the main outpatient department.

Diagnostic imaging:

- None of the patients we spoke with had ever wanted or needed to make a formal complaint.
- The department displayed a quality board with "You said: We did" comments and changes implemented as a result of patient comments.
- Staff told us that complaints were few and far between.
- Staff were aware of the local complaints procedure and were confident in dealing with concerns and complaints as they arose. Managers and staff told us that complaints, comments and concerns were discussed at team meetings, actions agreed and any learning was shared.
- Information was accessible on the Trust web site including the complaints policy. We saw information distributed within the departments. Most patients we asked did not know how to make a complaint but said that they would initially complain to the clinician seeing them or at reception.

Are outpatient and diagnostic imaging services well-led?

Good

We rated well-led as 'good' because:

- Outpatient managers were able to describe the risks to the services and what they action they were taking to mitigate the risks, however not all identified risks such as staffing levels were on the risk register.
- Staff were mostly positive about local leadership in the service. Staff in diagnostic imaging felt supported by their line managers, who encouraged them to develop and improve their practice. The department supported staff who wanted to work more efficiently, be innovative, and try new services and treatments.
- Staff we spoke with enjoyed their role and overall felt respected and valued by the trust. Staff described good team work and supportive teams.
- The department had a five year plan in place to ensure that the diagnostic imaging department was future proof.
- There were governance processes in place to ensure that any risks, incidents or complaints were able to demonstrate lessons learned.
- Staff worked well together as a productive team and had a positive and motivated attitude.

However:

- There was limited public engagement throughout outpatient services.

Vision and strategy for this service

- We found that staff being able to describe the values of the trust varied.
- A strategic overview document provided by the trust highlighted that outpatient services were supplied by the clinical specialities which provide the services. Outpatient services were provided across the five hospital sites at the trust.

Diagnostic imaging:

- The diagnostic imaging department had some new members of the leadership and management team and staff told us they were kept informed and involved in strategic working and plans for the future.
- The management team were keen to tell us about the business plan they were working on to ensure that the department was able to cope with future demands on services. This involved the expansion of the diagnostic imaging department and the purchase of further MRI and CT machines.

Outpatients and diagnostic imaging

Governance, risk management and quality measurement

- During our inspection we found that access to performance measurement and quality measurement information varied. For example, outpatient clinics did not measure the time patients waited in clinic for their appointment.
- Management told us the governance structure for escalating risks was through a number of regular meetings. For example, staff in clinics would raise concerns with local managers, who would then raise them with the outpatient senior managers. This would then be discussed at the monthly governance meeting which was attended by senior managers in outpatients.
- Managers we spoke with were able to describe risks to the services in outpatients such as the orthopaedic practitioner staffing levels, however during our inspection these were not documented on the risk register. Management of outpatients confirmed that they had requested staffing levels was put on the risk register during our inspection. Managers could also describe the action being taken to address risks such as staffing levels such as training further staff as orthopaedic practitioners. All incidents reported through the electronic incident reporting system were sent to the outpatients managers.
- Medical record provision was still highlighted on the risk register, however data provided by the trust showed that medical record accessibility had improved. Management told us they encouraged staff to complete an incident form when records did not arrive for clinic. Staff also told us they would only see patients if there was adequate information available to see the patient in clinic. Outpatient managers would liaise with medical records around issues of availability in clinics as required.
- During our inspection we saw a main outpatient department performance board. This highlighted that the outpatient department were at 90% completion of mandatory training and 90% completion of staff yearly appraisals in the department.
- The outpatient department had a governance file which was available for staff to view. This contained information such as safety newsletters and urgent patient safety notices. This allowed managers to share with staff important information from the trust and the service.

Diagnostic imaging:

- The department had a risk register that it shared with the outpatient department. Risks were rated high, moderate and low. These had been reviewed regularly. There was evidence of mitigation in place and action taken to reduce risks to patients.
- Serious incidents were discussed at multidisciplinary clinical governance meetings and where appropriate, escalated through the governance committees.
- Department managers carried out investigations of incidents and reported back to teams. Where necessary, policies and procedures were updated in line with guidance received.
- There were governance arrangements which staff were aware of and participated in.
- Consultants took part in radiology reporting discrepancy meetings. These were held to discuss the quality of images and reporting. This forum was used to promote learning. Radiologists and radiographers were able to attend.
- Staff told us they understood the management and governance structure and how it reported up to the executive board and back down to staff with lessons learned across the trust.
- Diagnostic imaging had a separate and additional risk management group consisting of modality (specialist diagnostic imaging services for example CT and MRI) leads, radiology risk assessors and radiology protection specialists.
- In diagnostic imaging radiation protection supervisors (RPS), from specialties within the department and across all sites, raised, discussed and actioned risks identified within the department and agreed higher level risks to be forwarded to the divisional manager.
- The organisation had systems to appraise NICE guidance and ensure that any relevant guidance was implemented in practice. In diagnostic imaging these included guidance around biopsy procedures.

Leadership of service

- Staff were positive about local leadership and we were told that most managers were visible and approachable; however staff views on senior management being visible varied. Outpatients managers told us that they had an open door policy.
- Outpatient managers reported to senior managers who had responsibility for all trust outpatients services. Main

outpatients was managed locally by senior nurses, however some outpatient services such as ophthalmology were managed by senior staff across the trust and would alternate their time between the trust sites.
- Managers from the outpatient department attended a weekly meeting where they discussed general issues. These meetings were attended by managers from other trust departments.

Diagnostic imaging:

- The trust had employed a lead radiographer on secondment to lead the teams across all sites and reinstate effective quality assurance systems.
- Staff told us diagnostic imaging department leadership was in parts new, it felt stable and was positive and proactive. Staff told us that they knew what was expected of staff and the department and that every effort was being made to recruit and train more staff.
- Departmental managers were supportive in developing the service and practice, and the trust as a whole valued its staff. Staff felt that they could approach most managers with concerns and feel listened to. We observed good, positive and friendly interactions between staff and managers.
- Managers told us that IR(ME)R incidents were looked on as an opportunity to learn. We saw notes in regular staff meeting minutes that stated staff completed a reflection exercise and learning points were disseminated in team meetings.

Culture within the service

- Most staff we spoke with told us they felt respected and valued. Overall staff we spoke with enjoyed their roles and were proud of the service they provided. Staff we spoke with told us there was good team work and that teams were supportive. Morale varied in outpatients services because of the number of changes to the service in recent times; however staff told us that this was improving.
- Some staff we spoke with told us they had attended national conferences relevant to their practice and they shared information gathered with the team.

Diagnostic imaging:

- Staff were encouraged to report incidents and complaints and felt that these would be investigated fairly.
- Managers told us that they felt well-supported by the organisation.
- Staff were passionate about their patients and felt that they did a good job. Staff we spoke to in all the diagnostic imaging departments said that they felt part of a team and empowered to do the job.
- Diagnostic imaging staff told us there was a good working relationship between all levels of staff. We saw that there was a positive, friendly but professional working relationship between consultants, nurses, radiographers and support staff.
- Diagnostic imaging staff told us that they felt there was a culture of staff development and support for each other. Staff were open to ideas, willing to change and were able to question practice within their individual modalities.
- Department managers told us that there were formal team meetings as well as informal meetings and managers walked around departments every day to speak to staff.

Public engagement

- There was limited public engagement in outpatients. The main outpatient department had a performance board on display in the waiting area. This outlined some of the performance information related to the department such as nurses on duty and waiting times. This allowed patients to see some of the performance indicators for the department.
- The services used a patient survey called 'two minutes of your time' to receive feedback about the services.

Diagnostic imaging:

- Information was displayed on message boards to engage the public in messages about the service and to seek feedback. We saw a "You said: We did" section showing examples of comments that had been made by patients and how the department had addressed them.
- A patient assessment group had been involved in the planning stages for the new department and staff had maintained communications to ensure the service remained aware of patient requirements.

Staff engagement

- There were team meetings where staff could discuss operational issues and information was shared from the trust and service.

Outpatients and diagnostic imaging

Diagnostic imaging:

- Staff told us diagnostic imaging managers shared new information and news with staff through team meetings and information was attached to meeting minutes
- Staff told us they met informally with team leaders each morning. We saw evidence of notes from meetings and other communications, and information for staff on noticeboards.
- Policies and procedures were available to staff via the trust intranet and lead radiographers helped staff to access information.
- Departmental staff liaised with teams and specialists from other hospitals within the trust and neighbouring trusts to keep updated with new practices and developments to ensure that services offered were in line with current practice and effective.

Innovation, improvement and sustainability

- The fracture clinic had introduced a virtual fracture clinic which was developed to help prevent unnecessary attendance.

Outstanding practice and areas for improvement

Outstanding practice

- The trust was a finalist in the National Patient Safety Awards for 'better outcomes in orthopaedics'.
- The trust had the only surgeon between Leeds and Glasgow doing a meniscal augment in the knee.
- Honorary Professorship University of Cumbria received by a consultant for work on applying digital technologies in Health Care for elderly population in rural setting, a part of CACHET.
- Multinational multicentre prospective study in the use of intramedullary nail in varus malalignment of the knee. The trust had the largest international experience of this technology for this application.
- WCH was one of only 18 Hospitals in England and Wales referred to in the first NELA audit for contributing examples of best practice in care of patients undergoing emergency laparotomy.
- There was real strength of MDT working and positive patient outcomes in the stroke service;
- The 'expert patient programme' and 'shared care initiative' in the renal business unit exhibited real patient integration, empowerment and care partnerships; and,
- There were a variety of data capture measures in use to monitor 'real-time' patient experience and collate patient feedback.

Areas for improvement

Action the hospital MUST take to improve

In urgent and emergency services

- Meet the target to see and treat 95% of emergency patients within four hours of arrival linked to meeting the locally agreed trajectory to see and treat emergency patients within the standard agreed with regulators and commissioners.
- Ensure medical and nursing staff use the computer system fully as intended so that patient real time events are recorded accurately and this is demonstrated through audit.
- Take further steps to resolve the flow of patients out of the hospital.

In Medicine

- Ensure systems and processes are established and operated effectively to assess, monitor and improve the quality and safety of the services provided and evaluate and improve practice to meet this requirement. Specifically, improve the management of medical outliers by reducing the number of patients receiving care on a non-designated medical ward, improving repatriation processes and minimising service user moves after 10 pm.

In Surgery

- Must ensure the peri-operative improvement plan is thoroughly embedded and that all debrief sessions are undertaken as part of the WHO checklist to reduce the risk of Never Events.
- Improve compliance against 18 week referral to treatment standards for admitted patients for oral surgery, trauma & orthopaedics, urology and ophthalmology.
- Improve rate of short notice cancellations for non-clinical reasons specifically for orthopaedic surgery.
- Ensure patients whose operations are cancelled are treated within the 28 days.

In Maternity and Gynaecology

- Review staffing levels; out-of-hours consultant paediatric cover and surgical cover to ensure they meet the Royal College of Obstetricians and Gynaecologists (RCOG) guidelines (including 'safe childbirth: minimum standards for the organisation and delivery of care in labour')
- Ensure that systems are in place so that governance arrangements, risk management and quality measures are effective.

In Services for Children and Young People

Outstanding practice and areas for improvement

- The trust must ensure children and young people services meet all Royal College of Paediatrics and Child Health (RCPCH) - Facing the Future: Standards for Acute General Paediatric Services (2015 as amended).

In End of Life Care

- Ensure that DNACPR forms are fully completed in terms of best interest assessments in line with the Mental Capacity Act.

In Outpatient and Diagnostic Services

- Outpatients must address the number of cancelled clinics in the services.
- Outpatients must ensure referral to treat (RTT) targets are met across the services.

Action the hospital SHOULD take to improve

- Ensure that levels of staff training continue to improve in the hospital so that the hospital meets the trust target by 31st March 2017.

In urgent and emergency services

- Increase the complement of medical consultant staff as identified in the accident and emergency service review
- Extend the scope and consistency of staff engagement.

In Medicine

- Continue to progress patient harm reduction initiatives;
- Ensure IPC compliance improvement and consistency in standards, in particular regarding catheter and cannula care;
- Ensure best practice guidelines for medicines related documentation is reinforced to all prescribers;
- Ensure oxygen prescribing is recorded and signed for accordingly;
- Ensure medicines management training compliance improves in line with trust target;
- Ensure all relevant clinical observations are recorded at the required frequent, NEWS scores are accurately calculated and trigger levels are adhered to (or document deviation/individual baseline triggers in the clinical records);
- Ensure care and treatment of service users is appropriate, meets their needs and reflects their preferences. Specifically, ensure the endoscopy pathway design meets service user preferences and care or treatment needs.
- Ensure staff are given time to complete all necessary mandatory training modules;
- Ensure all fields within medical and nurse clerking documentation are completed in full, in line with local policy and best practice guidelines;
- Ensure all equipment checks are completed in line with local guidance;
- Progress JAG accreditation application for new endoscopy suite at WCH;
- Continue to proactively recruit nursing and medical staff, considering alternate ways to attract, such as utilising social media;
- Ensure measures are put in place to support units where pending staffing departures will temporarily increase vulnerability;
- Progress the 'Composite Workforce Model' and further embed support from substantive medical colleagues at CIC;
- Ensure food satisfaction standards are maintained and where relevant improved;
- Work with partnership colleagues to address static diabetes patient outcomes;
- Evidence improvements in patient outcomes for respiratory patients around time to senior review and oxygen prescribing;
- Support staff development in line with organisational/ staff appraisal objectives protecting/negotiating study time where required;
- Ensure appraisal rate data recorded at trust level coincides with figures at divisional/ward level;
- Ensure patients are given sufficient time to converse with staff regarding care related matters;
- Revisit the patient journey, booking and listing procedures at the endoscopy suite at WCH;
- Ensure where escalation beds are utilised, they are staffed accordingly with due consideration of existing ward staffing requirements;
- Consider local leads for patient flow initiatives and reinforce processes with staff;
- Ensure processes seek to repatriate medical outliers at the earliest opportunity to minimise impact into surgical services;
- Continue to minimise patient moves after 10 pm;

Outstanding practice and areas for improvement

- Ensure the ambulatory care suite is utilised as intended;
- Reinforce the dementia strategy across the division to ensure consistency of practice with support initiatives;
- Ensure reasonable adjustments available for visually impaired, those with hearing difficulties and those who require translation services are known to all staff;
- Consider options available to extend ambulatory care services across seven days;
- Ensure senior divisional staff make every reasonable effort to attend divisional governance meetings regularly;
- Ensure the risk register is current and reflects actual risks with corresponding accurate risk rating. Ensure all actions and reviews of risk ratings are documented;
- Ensure progress continues against QIP, realign completion dates and account for deadline breaches;
- Ensure staff feel involved and integrated into engagement activity for their benefit and ensure all staff are aware of existing provisions available to them;
- Ensure staff involved in change management projects are fully informed of the aims and objectives of the proposal and these are implemented and concluded in appropriate timeframes;
- Ensure divisional leads and trust leaders promote their visibility when visiting wards and clinical areas; and,
- Consider promoting divisional and trust wide success stories to share good news and positive outcomes to improve staff morale.

In Surgery

- Ensure robust recruitment and retention policies continue to improve staff and skill shortages.
- Continue to embed the perioperative quality improvement plan.
- Improve debrief in theatres post-surgery.
- Improve the proportion of patients having hip fracture surgery on the day or day after admission.
- Improve the rate of patients receiving a VTE re-assessment within 24 hours of admission.
- Improve cancellation rates.
- Ensure all mandatory training is completed by March 2017.
- Reduce the management of medical patients on surgical wards.
- Ensure bullying allegations in theatres are addressed.

In Critical Care

- Senior staff should continue to monitor the staffing shortfall an impact in the unit as a result of increased staff sickness. The action plan produced should be reviewed to ensure achievement of the key points. Staff should be able to provide assurance that the staffing ratios for intensive care are protected as per Intensive Care Society guidance.
- CCOR staff should not be moved to cover ward area staff shortage as part of routine escalation plans. This issue needs to be monitored and CCOR staff should be supported to provide the role across the trust as per practice in line with GPICS (2015), NICE CG50 and against the seven core elements of Comprehensive Critical Care Outreach, (C3O 2011).
- We observed that pharmacy cover in the unit did not provide enough opportunity to be involved in unit activity, deliver care to nine patients that was in line with GPICS (2015) and reduced opportunity to develop standards and audit. The trust should take action to improve pharmacy staffing in line with GPICS (2015).
- The role of the supernumerary clinical coordinator should be protected as per GPICS (2015) standards. Currently this is not the case in the unit and should be in place to support the team in line with the standards.
- The clinical educator should provide a role in the WCH unit in order to meet GPICS (2015) standards for a unit of this size.

In Maternity and Gynaecology

- Ensure that processes are in place for midwives to receive safeguarding supervision in line with national recommendations.
- Continue to improve mandatory training rates to ensure that trust targets are met by the end of March 2017.
- Ensure that there are processes in place so that record- keeping, medicine management, and checking of equipment are consistent across all areas.
- Review the culture in obstetrics to ensure there is cohesive working across hospital sites and improved clinical engagement.

In Services for Children and Young People

- Ensure a registered children's nurse (RCN) should support healthcare assistants working in the children's outpatient department with. Royal College of Nursing staffing standards for children in outpatients states a minimum of one RCN must be available at all times to

assist, supervise, support and chaperone children. Healthcare assistances should also be trained and competent in weight management and documentation according to their level of responsibility.

In End of Life Care

- Arrange formal contract meetings with members of the Cumbria Healthcare Alliance to monitor that the service being commissioned and provided is of an appropriate standard in terms of quality and meeting patient need.
- Ensure that it is aware of the number of referrals to the SPCT within their hospitals.
- Ensure that it is aware of how many patients are supported to die in their preferred location and there is regular audit of the CDP to demonstrate this.
- Produce an action plan to address areas in national audits where performance was lower than the England average with key responsibilities and timelines for completion.

In Outpatient and Diagnostic Services

- Continue to ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed in order to meet the needs of the patients. Ensure mandatory training and safeguarding training completion rates and met in line with the trust target.
- Ensure there are sufficient staffing levels in place and ensure actual levels match planned levels.
- Ensure equipment such as refrigerators in diagnostic imaging are checked as required.
- Consider ways of making performance and quality information available for use.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The provider has not ensured the provision of appropriate care and treatment that meets people's needs. Regulation 9(2).** **Reg. 9 (3b) - The care and treatment of service users must be appropriate, meet their needs, and reflect their preferences. Without limiting paragraph one designing care or treatment with a view to achieving service users' preferences and ensuring their needs are met;** **How the regulation was not being met:** • The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the A&E. The trust breached the standard continuously between September 2015 and August 2016. • Between September 2015 and August 2016 performance against this metric showed a decline from September 2015 to January 2016. There was a general improvement from January 2016 to July 2016 however this declined again in August 2016. In August 2016, the percentage of patients, admitted, transferred or discharged within four hours was 90.1 % compared with an England average of 91.0%. • Four surgical specialities are not meeting the 18 week referral to treatment standards for admitted patients (oral surgery, trauma & orthopaedics, urology and ophthalmology). • Short notice cancellations for non-clinical reasons are high specifically for orthopaedic surgery. • High percentage of patients not receiving their procedure within 28 days of the initial cancellation.

This section is primarily information for the provider

Requirement notices

- There were a number of cancelled clinics in outpatient services.
- There were a high number of medical outliers at this hospital.
- DNACPR forms were not fully completed in terms of best interest assessments in line with the Mental Capacity Act.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Reg. 18 (1) There must be sufficient numbers of suitably qualified, competent, skilled and experienced staff on duty.** **How the regulation was not being met:** • Children and young people services did not meet all Royal College of Paediatrics and Child Health (RCPCH) - Facing the Future: Standards for Acute General Paediatric Services (2015 as amended). **Specifically, the unit did not meet:** • Standard 1 – A consultant paediatrician is present and readily available in the hospital during times of peak activity, seven days a week; • Standard 3 – Every child who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician within 14 hours of admission, with more immediate review as required according to illness severity or if a member of staff is concerned; • Standard 4 – At least two medical handovers every 24 hours are led by a consultant paediatrician. • Out-of-hours consultant paediatric cover and surgical cover did not meet the Royal College of Obstetricians and Gynaecologists (RCOG) guidelines (including 'safe childbirth: minimum standards for the organisation and delivery of care in labour').

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Reg. 17 (2a, f) Ensure systems and processes are established and operated effectively to assess, monitor and improve the quality and safety of the services provided. Evaluate and improve practice to meet this requirement.

How the regulation was not being met:

- There were gaps in how outcomes and actions from audit of clinical practice were used to monitor quality in maternity services.
- Escalation process, specifically 'floor working' initiatives across medical wards were not effective.