University Hospitals of Morecambe Bay NHS Foundation Trust

Inspection report

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Ratings

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

Our findings

Our reports

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

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

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

Overall summary

What we found

Overall trust

We carried out an unannounced inspection of urgent and emergency care services, surgery and maternity core services of the (acute) services provided by this trust because at our last inspection we rated the trust overall as requires improvement and we had concerns about the quality and safety of some services.

During our inspection we became aware of concerns about the stroke pathway for patients and did a further unannounced responsive inspection of this service at Royal Lancaster Infirmary and Furness General Hospital.

Overall, we rated the trust and each location as requires improvement. We also inspected the well-led key question for the trust overall. We rated three out of the ten services inspected as good, three as requires improvement and two as inadequate.

Following this inspection, under Section 31 of the Health and Social Care Act 2008, we imposed urgent conditions on the registration of the provider in respect to the regulated activities; Diagnostics and Screening and Treatment of Disorder, disease and Injury. We took this urgent action as we believed a person would or may be exposed to the risk of harm if we had not done so. Imposing conditions means the provider must manage regulated activities in a way which complies with the conditions we set. The conditions related to the stroke services at Royal Lancaster Infirmary and Furness General Hospital. In light of this, we suspended the ratings for Medical care including care for older people.

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

Safe

- Not all staff supporting children had completed paediatric advanced life support training. Not all staff, at the trust, had completed safeguarding level three training.
- Patients identified for the stroke pathway did not always receive care and treatment in line with national guidance or trust policies.

Our findings

- There was not always sufficient staff with the right qualifications, skills, training and experience to provide care and treatment for children in the urgent and emergency departments and sufficient staff to care for women in maternity services.
- Staff did not always adhere to trust and national infection prevention and control guidance with regards to social distancing and wearing of personal protective equipment in urgent and emergency services.
- Controlled drugs were not always stored, administered and recorded safely. The Trust process for the administration of medicines following Patient Group Directions (PGD's) had been reviewed and updated but had not been implemented effectively in some locations.
- The escalation plan for caring for patients in the corridor was not always adhered to.
- Women receiving maternity care, who were assessed as at risk of sepsis, did not always receive care and treatment in line with national guidance. Risk assessments were not always completed for women or for patients identified with mental health concerns.
- It was not clear if national early warning scores were always assessed and used to identify any signs of deterioration as they were not always documented in patient records. It was not always clear if all risks to women in labour were assessed, including when risk levels changed from low to high, with a need to escalate care safely.
- Although harm grading guidance was available, we were not assured that all incidents were graded appropriately to reflect the level of harm.

However;

- Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The trust controlled infection risk well.
- In surgery there was enough staff to care for patients and keep them safe.

Effective

- Current policies were not always available for staff to access during care and treatment of patients.
- The trust did not always submit information for audits, including national audits, and not all services were included in the audit programme.
- The trust did not always manage patient pain effectively including reassessing pain scores in line with trust policy.
- There was not always effective multidisciplinary working in the trust to benefit patient care, treatment and outcomes.

However;

- Staff provided good care and treatment, gave patients enough to eat and drink. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.

Caring

- The trust did not always maintain patients' privacy and dignity, specifically when needing to be cared for in a corridor in the urgent and emergency department.

However;

Our findings

- Staff treated patients with compassion and kindness and took account of their individual needs and helped them understand their conditions. They provided emotional support to patients, families and carers.

Responsive

- The trust did not always manage the flow of patients, in the urgent and emergency care department with patient spending long periods waiting for an in-patient bed.
- The length of stay for patients receiving care for trauma and orthopaedics was longer than the national average.

However;

- The trust planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.

Well-led

- Although the trust had an overall vision and strategies, not all services had their own vision and strategy.
- Trust governance processes were not robust or always effective. Risks were not always identified correctly with appropriate mitigations put in place.

However;

- Most staff felt respected, supported and valued. Staff understood the service's vision and values, and how to apply them in their work. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The trust engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

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

Outstanding practice

We found the following outstanding practice:

Maternity services

- Staff were working with the national research project 'Born into Care'. They worked with external partners to provide memory boxes for women whose baby was being removed into care following birth.

Areas for improvement

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

Our findings

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with 59 legal requirements. This action related to four services.

Trust wide

- The trust must ensure that governance processes are robust and effective (Regulation 17 (1))
- The trust must ensure that risks in the organisation are correctly identified and appropriate mitigations put in place in a timely way (Regulation 17 (1)(2) (b))
- The trust must ensure that incidents are identified, graded appropriately to reflect the level of harm and that they are acted upon and investigated in a timely way. (Regulation 12 (1)(2) (b))
- The trust must improve on the timeliness of responses to complaints. (Regulation 16 (1)(2))
- The trust must continue to make improvements in the culture of the organisation, especially within maternity and trauma and orthopaedics, to enable staff to be supported to perform their duties effectively. (Regulation 18 (1)(2) (a)).
- The trust must ensure that further development and investment in pharmacy resources should be prioritised to make sure medicines reconciliation rates and antimicrobial stewardship are improved across the trust. (Regulation 12 (1)(2) (g)).

Lancaster Royal Infirmary – Urgent and Emergency Care

- The trust must ensure that stroke patients receive treatment in line with best practice guidance and in line with the trust's stroke pathway so there are no delays to treatment. (Regulation 12 (1)(2) (i))
- The trust must ensure that risk assessments and mental capacity assessments are carried out for mental health patients in line with trust policy. (Regulation 12 (1)(2) (a))
- The service must ensure that there is enough staff with the right qualifications, skills, training and experience to provide care and treatment, specifically in relation to medical staffing including taking into account national guidance for the care of children and specifically paediatric emergency medicine consultant cover – This in line with the Royal College of Paediatrics and Child Health "Facing the Future – standards for children and young people in emergency care settings". (Regulation 18 (1))
- The service must ensure that audit information (including national audits) is submitted, up to date, accurate and properly analysed and reviewed by people with the appropriate skills and competence to understand its significance. When required, results should be escalated, and appropriate actions taken to improve. (Regulation 17 (1)(2) (a))
- The trust must ensure that controlled drugs are safely prescribed, administered, recorded and stored and that registers are correctly and fully completed. The trust must ensure there is a system in place to assess and monitor formal competencies for nursing staff to administer medicines under patient group directions. (Regulation 12 (1)(2) (g))
- The trust must ensure that robust action plans to improve and manage the flow of patients through the emergency department are put in place, taking into account known factors contributing to the hindrance of flow through the department and mitigating the ongoing risks and issues identified in the department. (Regulation 17 (1)(2) (b))
- The department must ensure that the corridor escalation plan is adhered to and that incidents are appropriately recorded when the plan dictates. (Regulation 12 (1)(2) (a) (b) (d))

Our findings

- The service must ensure that privacy and dignity of patients is maintained, particularly when patients are in non-designated cubicle areas. (Regulation 10 (1)(2) (a))
- The trust must ensure that patients' pain is effectively managed including that pain scores are re-assessed within 60 minutes as per trust policy. (Regulation 12 (1)(2) (a) (b))
- The trust must improve the multidisciplinary working and culture between the department and specialities and speciality teams to maximise patient care and outcomes. (Regulation 12 (1)(2) (i); Regulation 17 (1)(2) (a))
- The department must ensure that all known risks are singularly identified on the risk register and that risks are supported by robust action plans that can reduce or mitigate the risks. They must also ensure that these action plans are regularly reviewed to ensure effectiveness and action plans amended where progress cannot be achieved. (Regulation 17 (1)(2) (b))

Royal Lancaster Infirmary – Medical Care

- The trust must implement an effective risk and governance system for the whole stroke pathway. (Regulation 17 (1)(2) (a) (b))
- The trust must operate an effective clinical escalation system to ensure stroke care and treatment is assessed and implemented in a timely way. (Regulation 12 (1)(2) (a) (b))
- The trust must implement an effective system to ensure that all clinical staff have the knowledge, competence, skills and experience to care for and provide treatment to patients presenting with symptoms of stroke. (Regulation 18 (1)(2) (a))

Royal Lancaster Infirmary – Surgery

- The trust must continue to monitor and take appropriate actions to improve average length of patient stay for patients having trauma and orthopaedics surgery. (Regulation 12 (1))
- The trust must continue to monitor and take actions to improve referral to treatment waiting time performance in line with national standards. (Regulation 12 (1))

Royal Lancaster Infirmary – Maternity

- The service must ensure staff have access to up-to-date and evidence-based guidelines and policies. (Regulation 12 (1))
- The service must ensure all women assessed as at risk of having sepsis receive care and treatment in line with national guidance and requirements. (Regulation 12 (1))
- The service must continue to develop a vision and strategy through engagement with staff, focused on sustainability and aligned to local plans within the wider health economy. (Regulation 17 (1) (2) (a) (e))
- The trust must ensure they establish and operate effective governance processes and systems, with robust action plans to monitor and improve the safety and quality of services and mitigate risks to women and families using the service. (Regulation 17 (1) (2) (a) (b))

Furness General Hospital – Urgent and Emergency Care

- The trust must ensure that staff in the service adhere to trust infection prevention and control policy in the use of personal protective equipment and maintain patient and staff safety through social distancing at all times and in all areas. (Regulation 12(1)(2)(h))

Our findings

- The service must ensure they participate in clinical audit to demonstrate the effectiveness of care and treatment. (Regulation 17(1))
- The service must ensure that care is provided in line with national performance standards for waiting times from referral to treatment and arrangements to admit, treat and discharge patients. (Regulation 12(1)(2)(i))
- The trust must ensure that, patients with mental health concerns are seen in a timely way (Regulation 12(1)(2)(i))
- The trust must ensure pain is assessed in line with clinical standards, administered in a timely way and recorded in patient notes. (Regulation 12(1)(2)(i))
- The trust must ensure all patients are clinically assessed and National Early Warning Scores are documented for all patients. (Regulation 12(1)(2)(i))
- The trust must ensure all relevant staff have completed Paediatric Advanced Life Support when supporting paediatric provision in the emergency department. (Regulation 12(1)(2)(i))
- The trust must review the service's paediatric staffing provision, including the environment they wait in and the paediatric nursing and medical cover in line with The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency settings (2012) (Regulation 18(1))
- The trust must take action to improve safeguarding adults and safeguarding children level three training rates for doctors and nurses. (Regulation 18(1))

Furness General Hospital – Medical Care

Immediately after the inspection CQC took enforcement action using our urgent powers whereby we imposed conditions under section 31 on the trust's registration as people may or will be exposed to the risk of harm. These included: -

- The trust must implement an effective risk and governance system for the whole stroke pathway. (Regulation 17 (1)(2)(a)(b))
- The trust must operate an effective clinical escalation system to ensure stroke care and treatment is assessed and implemented in a timely way. (Regulation 12 (1) (2) (a)(b))
- The trust must implement an effective system to ensure that all clinical staff have the knowledge, competence, skills and experience to care for and provide treatment to patients presenting with symptoms of stroke. (Regulation 18 (2)(a))

Furness General Hospital – Surgery

- The trust must take actions to improve average length of patient stay for patients having trauma and orthopaedics surgery. (Regulation12 (1))
- The trust must take actions to improve referral to treatment waiting time performance in line with national standards. (Regualtion12 (1))

Furness General Hospital – Maternity

- The service must ensure there are sufficient maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. (Regulation 18 (1)(2)(a))

Our findings

- The service must ensure medical staff complete all required safeguarding level 3 training. (Regulation 18 (1)(2)(a))
- The service must ensure risk assessments are completed and are actions taken to minimise any risks identified (Regulation 12(1)(2)(a) (b))
- The service must ensure all women assessed as at risk of having sepsis receive care and treatment in line with national guidance and requirements. (regulation 12 (1))
- The service must ensure appropriate systems are used for maintaining accurate, complete and contemporaneous records for service users (Regulation 17(1)(2)(c))
- The service must ensure staff have access to up-to-date and evidence-based guidelines and policies. (Regulation 12 (1))
- The service must continue to develop a vision and strategy through engagement with staff, focused on sustainability and aligned to local plans within the wider health economy. (Regulation 17 (1) (2) (a) (e))
- The trust must ensure they establish and operate effective governance processes and systems, with robust action plans to monitor and improve the safety and quality of services and mitigate risks to women and families using the service. (Regulation 17 (1) (2) (a) (b))

Westmorland General Hospital - Maternity

- The service must ensure staff assess the risks to women during and after birth in order to identify women at risk of deterioration. (Regulation 12 (1) (2) (a))
- The service must ensure that women presenting in labour have immediate access to suitable qualified and skilled midwifery staff. (Regulation 18 (1))
- The service must ensure staff assess and mitigate the risks to women's health and safety in an emergency situation either during home birth or at the unit. They must ensure appropriate escalation and transfer takes place. (Regulation 12 (1) (2) (a) (b))
- The service must ensure staff have access to up-to-date and evidence-based guidelines and policies. (Regulation 12 (1))
- The service must ensure all equipment is properly maintained and that staff do not use equipment that is not safe nor used for its intended purpose. Specifically, they should not use a domestic bath to support water birth. All staff should be aware of the birthing pool emergency evacuation process and have access to the required equipment at all times. (Regulation 12 (1) (d) (e))
- The service must continue to develop a vision and strategy through engagement with staff, focused on sustainability and aligned to local plans within the wider health economy. (Regulation 17 (1) (2) (a) (e))
- The trust must ensure they establish and operate effective governance processes and systems, with robust action plans to monitor and improve the safety and quality of services and mitigate risks to women and families using the service. (Regulation 17 (1) (2) (a) (b))
- The service must ensure they deploy sufficient suitably competent and experienced staff and ensure all staff receive appropriate skills and drills training and professional development to enable them to maintain competency given the low numbers of deliveries. (Regulation 18 (1) (2) (a))

Action the trust SHOULD take to improve:

We told the trust that it should take action because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall.

Our findings

Trust wide

- The trust should ensure that Patient Group Directions oversight should be strengthened to ensure sure appropriate and timely review and implementation.
- The trust should ensure that the uptake of medicines management e-learning be prioritised to help improve medicines safety.
- The trust should ensure that Electronic Prescribing and Medicines Administration (EPMA) auditing be strengthened to proactively identify prescribing and administration errors.

Lancaster Royal Infirmary – Urgent and Emergency Care

- The trust should ensure that all staff follow infection control principles, including the use of personal protective equipment (PPE) at all times and receive refresher training in this where deemed necessary.
- The trust should consider whether they can build a separate paediatric treatment area to meet best practice guidelines.
- The trust should consider whether the triage service in the walk-in waiting area can be improved so that the triage nurse can observe patients in the waiting area more easily.
- The trust should consider ensuring that there is a doctor or consultant at all safety huddles so that clinical information is not omitted from being shared with nursing staff.
- The trust should ensure that patients waiting in corridors have formal assessments of skin integrity and pressure sores risk, if prompted by the Safe and seen document.
- The trust should consider giving emergency department managers access to view incidents that are graded no harm or low harm, in order that there is complete oversight of incidents in the department to ensure that they have been graded correctly or may meet the criteria for a serious incident.
- The trust should consider completing the urgent and emergency care plans that have been delayed so that these can feed into the medicine care group strategy.

Lancaster Royal Infirmary – Surgery

- The trust should take appropriate actions to improve staff mandatory training, including safeguarding training in line with trust compliance targets.
- The trust should take appropriate actions to improve staff appraisal completion in line with trust compliance targets.

Royal Lancaster Infirmary – Maternity

- The service should consider implementing a policy and schedule for changing the keypad code at ward entrances to maintain security.
- The service should ensure the policy for cleaning of the birthing pool is ratified and implemented to control the risk of spread of infection.
- The service should ensure that recommendations from external incident investigations are fully considered and appropriate, robust action plans put in place.
- The service should act to improve the assessment of women's pain in light of their clinical condition and ensure all women receive pain relief in a timely manner.

Our findings

- The service should continue to act to ensure women received continuity of care in line with national recommendations and targets.

Furness General Hospital - Urgent and Emergency Care

- The trust should consider what actions the service can take to improve safeguarding adults and safeguarding children level three training rates for doctors and nurses.
- The trust should ensure senior leaders of the department have oversight of paediatric activity and performance in the ED.

Furness General Hospital - Surgery

- The trust should ensure that wards are secured to maintain patient safety.
- The trust should ensure that fire doors are maintained and used correctly.
- The trust should ensure that systems and processes are established and operated effectively to identify, assess, monitor, escalate and take mitigating actions, particularly in relation to the safe storage of medicine and the checking of emergency resuscitation equipment.
- The trust should ensure patient records are stored securely.

Furness General Hospital - Maternity

- The service should act to improve the quality of safety information shared in situation, background, assessment and recommendation (SBAR) handover.
- The service should ensure the policy for cleaning of the birthing pool is ratified and implemented to control the risk of spread of infection.
- The service should act to improve the assessment of women's pain in light of their clinical condition.
- The service should progress actions to enable improved access within the birth centre, in context of the physical environment.
- The service should implement effective use of the whiteboard communication system on the birth centre.

Westmorland General Hospital – Urgent and Emergency Care

- The trust should ensure that visible information about requesting a chaperone is available to patients attending the centre.
- The trust should ensure that privacy and confidentiality is maintained for patients when sharing personal information.

Westmorland General Hospital - Maternity

- The service should consider protected time to allow for the completion of mandatory training.
- The service should ensure staff clean the birthing pool in line with the policy for cleaning of the birthing pool, which should be reviewed, ratified and implemented to control the risk of spread of infection.
- The service should work to engage the workforce and increase visibility of the executive team.

Our findings

Is this organisation well-led?

Our rating of well-led went down. We rated it as inadequate because:

- Not all senior leaders demonstrated the necessary experience, knowledge, and capacity to lead effectively. They did not always identify and manage priorities in an effective and timely way.
- The range and nature of the areas for improvement identified as part of this inspection indicated that there were significant and ongoing challenges in the capacity of the organisation to deliver and make sustained improvements at pace. This had resulted in the provision of additional external executive team support.
- Whilst the trust had a vision for what it wanted to achieve and a strategy, leaders and staff did not always understand or know how to apply and implement plans and monitor progress effectively.
- In the core services we inspected, we found that the culture was varied. In some services some staff felt respected, supported and valued, although this was not universal. There were some services where the culture was poor and had remained so for some time.
- The arrangements for governance were not clear and did not always operate effectively. Not all staff were clear about their roles and accountabilities. Processes were not always effective and completed in a timely manner.
- Risks, issues and poor performance were not always acted upon by leaders in an effective or timely manner, such as those we identified within stroke services, maternity and urgent and emergency care. Following the inspection, we formally wrote to the trust under our powers requesting evidence that key patient safety risks identified by CQC specifically in relation to the care of patients with a suspected or diagnosed stroke at the trust were being effectively managed and mitigated. There were systems to manage performance, although these were not used efficiently. The trust did not react sufficiently to risks identified through internal processes and had often relied on external parties to identify key risks before it started to address them.
- The trust did not always collect reliable data, analyse and use it to make improvements.
- We were concerned about the timely and effective management of incidents and learning from them. Incidents were not consistently identified and reported on. Not all incidents were dealt with appropriately or quickly enough and there was limited thematic learning across the organisation. We saw examples of incidents that should have been reported and had not been recognised or reported as such.
- The trust had a significant challenge in relation to managing the size of the financial deficit and how this was impacting on the operational performance and quality of the trust.

However;

- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. The chief executive was very visible to staff. The trust worked closely with the local community, other stakeholders and the integrated care system.
- We found that the Fit and Proper Person Procedure was fit for purpose and the files were predominantly in line with the requirements of the regulation.
- The trust promoted equality and diversity in daily work and provided opportunities for career development although there was still work to do in this regard.

Our findings

- The trust was working towards an open culture where patients, their families and staff could raise concerns without fear, this was not yet embedded.

Leadership

Not all senior leaders demonstrated the necessary experience, knowledge and capacity to lead effectively. They did not always identify and manage priorities in an effective and timely way. Although some executives were visible and approachable others were seen as remote and inaccessible with limited insight into service challenges.

The range and nature of the areas for improvement identified as part of this inspection indicated that there were significant and ongoing challenges in the capacity of the organisation to deliver and make sustained improvements at pace. This had resulted in the provision of additional external executive team support. As a consequence, this had increased the capacity of the leadership team with the potential to make improvements at pace.

The trust had a relatively stable leadership team. The chief executive (CEO) was appointed to the post three years ago having previously been the trust's director of finance and deputy chief executive from 2014. The role included key responsibilities working in partnership with the integrated care system (ICS) in the region. The CEO was also the ICS lead for stroke services. The Medical Director joined the trust in 2010; and had been deputy medical director from 2016 and was appointed in 2019. The executive nurse and deputy chief executive had been in post since 2013 and carried a wide portfolio. The chief operating officer (COO) joined the trust in 2013 and became the trust's deputy COO and interim COO from April 2020, before being appointed as a substantive COO in September 2020. The finance director was a recent external appointment commencing in February 2021. The director of people and organisational development started in post in July 2013.

For most of the executive team this was their first position at board level in their current role. Several of the executive team had worked in the trust in different roles prior to their executive appointments. There was limited breadth of executive leadership experience gained outside of the trust.

The chair was appointed in early 2020 and had a background in academia having worked in a variety of education and health roles for nearly 40 years. The non-executive directors (NED's) had a diverse range of experience. The most recent appointment was in February 2021 and this person brought experience of working within general practice. Other tenures began in 2015. The NED's chaired the trust committees which reported to the trust board. In May 2021 the trust had also appointed an advisor to the board to support with system reform and integrated care.

Many staff we spoke with were complimentary about the visibility and accessibility of the CEO, but less positive about the visibility and accessibility of other executive directors.

At the time of inspection, board development activity was limited. There had been some board development workshops in areas such as system reform and finance. We were told from interviews with the executive team, that plans were underway regarding board development; and that following an external governance review this was then formalised as an action to develop a board development programme. There had previously been a review, through an external company, to assess the 'Business Chemistry profile' for the Board.

Our findings

It was apparent from interviews that the Board discussed the trust's difficult issues and challenges. However, there was a lack constructive challenge to ensure there was both effective and timely holding to account for the actions required to improve and deliver sustainable services for patients. The board lacked curiosity, there was a general theme of accepting reassurance given, rather than seeking assurance.

It was evident that the leadership team faced a number of considerable challenges to deliver required improvements, although there were improvements planned many were still in progress and were not yet embedded. There was limited assurance as to the impact of the planned changes on service quality.

There was a distinct lack of pace and urgency. Not all improvements required had been made since the last inspection; although in a presentation to the inspection team we were told that all actions had been reviewed and had been agreed as completed by the trust board as of the 28 April 2021.

However the April Board paper stated remaining actions will be transferred from the CQC Improvement Plan into current operational and assurance work streams to enable greater focus and to prevent unnecessary reporting.

In addition, areas of concern, such as stroke care demonstrated a deteriorating picture, but limited action had been taken to address this. However, there had been improvements in the urology service following an external review and the implementation of the identified recommendations.

The trust was also in receipt of a significant element of external support to address the substantial challenges it faced; leaders were being supported to address these by a number of external experienced executives, organisations and stakeholders in addition to specific clinical reviews that were either ongoing or had recently been completed.

A council of governors was in place. We were told that the relationship between the governors and the board had developed positively over the past few years. Changes in processes had led to open and transparent ways of working.

The governors were aligned to the sub-committees and involved in activities from the beginning. The Head Governor attended both the public board and the private board meetings. There were joint meetings with the governors and the board members that included executives, the chair, and non-executives. The use of virtual technology, during the covid pandemic, had meant more opportunities to attend meetings. However; visiting restrictions had meant they were unable to visit patients on wards as they had done pre-covid.

Operationally the trust was run through five care groups; medicine; surgery and critical care; women's and children's; core clinical services; and integrated community. Each care group was led by a team made up of a clinical director, an associate director of nursing or equivalent role, and an associate director of operations who were supported by matrons and service managers

Local leadership of the core services we inspected varied. The main concerns related to the leadership of the maternity services and the medicine care group (which covered both medicine and emergency care). Not all concerns identified within the emergency departments at past inspections had been addressed. There were also significant concerns about the oversight and leadership of the stroke services across the trust which was under the leadership team

Although the local clinical team at Furness General hospital was working very hard to maintain patient safety at this site.

Our findings

Midwifery leadership was also of concern. Interim arrangements had been in place for several months. However, we were told of additional appointments planned to strengthen the leadership and oversight in maternity services in the near future. A new non-executive Board maternity safety had been appointed and trained; the previous non-executive maternity safety champion was the Chairman.

Fit and Proper Persons Requirement (FPPR)

We found that the Fit and Proper Person Procedure was fit for purpose and the files were predominantly in line with the requirements of the regulation.

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

We reviewed 13 executive and non-executive director files in total. Our review included checks for the newest executive, non-executive appointments and also the files for the chair, chief executive officer and Executive Chief Nurse / Deputy Chief Executive Officer. We did identify some assurance gaps, for example one file had only one reference on file for one executive and in another executive director file we found references pertaining to another individual.

We also looked at the trust's Fit and Proper Person Procedure and spoke to the company secretary who was responsible for oversight and compliance with the FPPR procedure.

We reviewed the six-monthly self-declarations, made by the directors, to confirm that they remained fit and proper. We found these were not always completed consistently and robustly in line with the trust's procedure. For example, we saw some of these were not signed, some were not completed in full and in one case one of the executive team had indicated they were not fit for their role.

We raised these concerns and lack of compliance with the procedure with the company secretary who addressed the issues within 24 hours. We were advised that some of the issues, for example where the forms were not fully completed were due to a printing error which was then rectified. However, we advised this had not been noted prior to the documents being added to the files. We were shown evidence of a second reference for the Executive previously identified and the self-declaration, which showed that the individual was not fit for their role, was sent out for amendment to the individual.

Vision and Strategy

The trust had a vision for what it wanted to achieve and a strategy, developed with relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff did not always understand or know how to apply and implement plans and monitor progress effectively.

The trust vision stated that:

"We will constantly provide the highest possible standards of compassionate care and the very best patient and staff experience. We will listen to and involve our patients, staff and partners."

Our findings

The strategy focused on the journey the trust had travelled by reflecting on their history, with a focus on stabilising the current situation and then looking at future long-term plans and transformation. We were told that the strategy was due to be refreshed; this had been agreed following an external review two years ago. Since August 2020 there was also ongoing support from another external organisation. The plan was to reset the strategy in 2021, especially in light of the national changes in relation to integrated care systems.

The trust had five clearly stated values; the five P's:

- Patients: Our patients will be treated with compassion, dignity and respect. Patient experience is our most important measure of achievement.
- People: Our colleagues (employees and volunteers) are the ones who make the difference. Colleagues understand and share our values, and this is reflected in everything they do.
- Progress: Our progress will be improved through innovation, education, research and technology to meet the challenges of the future.
- Partnership: Our partnerships make us stronger; by investing in them, we will deliver the best possible care to our communities.
- Performance: Our performance drives our organisation. Providing consistently safe, high quality patient-centred care is how we define ourselves and our success.

Although the trust had an overall vision and strategy, we found that this was not reflected in the core services and care groups' service plans.

In light of the Covid-19 pandemic the priorities for the leadership team were had been reduced to four in 2020/21. However, from most of our interviews with executives (other than the CEO), and senior managers they could not clearly articulate, what the priorities for the organisation were.

Going forward into 2021/22 there were three priorities agreed: colleague health and wellbeing; quality and safety of services; and finance and transformation. At the time of the inspection, the board had not yet discussed an improvement strategy. However, some groundwork had been completed in analysing existing data, such as Get It Right First Time (GIRFT), model hospital data and Patient Level Information and Costing System (PLICS).

The trust had a number of strategies that were aligned to the overall strategy including a clinical strategy and a financial strategy. There was an emphasis on the importance of integrated services throughout the region. The external governance review recommended that the trust needed to influence the development of the Integrated Care System (ICS) strategy. This was starting to happen, for example, the finance director had led a piece of work to develop an ICS financial improvement strategy.

The trust had strategies in place for meeting the needs of patients with a mental health, learning disability, autism or dementia diagnosis. We recognised that there had been improvements in supporting patients with a mental health concern particularly in the emergency departments.

The trust had reconfiguration plans that included an increase in elective activity at the Westmorland General Hospital (WGH) site. There was concerns from staff that this would impact on maternity services at WGH and the sustainability of the service due to the levels of activity. Areas that were part of the maternity provision had been re-purposed and were

part of surgical services. Longer term strategies included an ICS estate plan with the possibility of a new hospital to serve the wider population. The trust was part of the national new hospitals programme that included the possibility of a new hospital for RLI and significant refurbishment of FGH and WGH. However, this was in the early stages of consideration with no decisions made.

Culture

In the core services we inspected, we found that the culture was varied. In some services some staff felt respected, supported and valued, however; this was not universal. There were some services where the culture was poor and had remained so for some time.

Staff, in the main, were focused on the needs of patients receiving care despite the significant challenges in some services. The trust promoted equality and diversity in daily work and provided opportunities for career development although there was still work to do in this regard.

The trust was working towards an open culture where patients, their families and staff could raise concerns without fear, however, this was not yet embedded.

The trust recognised that there were challenges regarding its organisational culture. There were some clinical teams where the culture which was driven by the poor behaviours of some individuals. This needed targeted and focused action – some of which was underway but had not yet secured the cultural shift that was required or desirable. Bullying and harassment of colleagues remained a significant concern for staff, indicated by the most recent staff survey feedback (from 2020) although this had improved since the last survey.

The trust board were very attuned to how the reputation of the trust could affect the local communities view of the effectiveness of the trust in delivering patient care. This was following high profile media attention from well publicised cultural concerns in some areas of the trust. The trust had put in place a number of initiatives to address these cultural concerns. 'Effortlessly Inclusive' was how the trust explained their approach to equality and diversity.

The trust had introduced a behavioural standards framework that set out expectations for staff, patients and other stakeholders:

"*Our Behavioural Standards Framework has been developed by staff to ensure we have a set of core behaviours and attitudes that help us support each other to deliver our vision and values. The Framework applies to us all and is part of everyone's role.*"

The framework's expectations were displayed throughout the hospital as a visual reminder for all.

The trust had introduced their enhanced support programme, in 2020, that was available for areas identified as needing additional support. The programme is focused around diagnostic safety, action planning and cultural support; the aim of which was to be collaborative and not directive. These had included urology, maternity, paediatrics and trauma and orthopaedics. Urology was the first service that has progressed through the programme. Senior executives reported a positive impact on the service that included improved communication between clinicians.

Our findings

The clinical service manager for urology and urology medical staff told us there had been significant improvements made in relation to the leadership and culture within the urology services. These directly resulted from the board's Task and Finish group directly engaging with the clinical specialty; sponsoring improvement in quality and safety metrics and investing in a large-scale operational development investment that got to the core of the issues which were impacting upon patient safety.

We received a mixed response from the medical staff in the trauma and orthopaedic specialties and staff we spoke with felt previous concerns around culture and leadership within this service had not yet been fully addressed. The clinical director and associate director of nursing also told us that they were still in the process of implementing recommendations from the review of the service that was in progress at the time of the inspection.

The trust was exploring how to continue to support the service at the end of their enhanced programme of support. CQC acknowledged the significant positive changes within the urology service, however; trauma and orthopaedics were not as far along in the improvement journey and this was evident from our inspection findings.

For maternity services at FGH we heard mixed experiences of culture from staff we spoke with during the inspection. We found there were contrasting experiences in different parts of the service and some staff told us that "managers do not respect staff". We also heard from some others in the service who stated they did not respect managers, and that they did not demonstrate leadership of the service. Most staff we spoke with reported that there was a culture of openness in the service and that they would share confidential information with managers. We were told of recent whistleblowing concerns which had been raised, which included some issues in relation to equality and diversity. Staff frequently told us the continued pressures of staffing shortages were challenging, whilst in contrast, newer and junior staff generally appeared more optimistic and said they felt encouraged with a shared feeling of positive expectation in the service including the anticipated imminent recruitment of new staff.

In the staff survey (2020) 65.5% of respondents agreed or strongly agreed that they would recommend the trust as a place to work. This was similar to the England average of 66.9%. This had increased from 61.8% in 2019. There were 69.8% of respondents agreed or strongly agreed that they would be happy for a friend or relative to receive care at the trust. This had increased from 65.5% in 2019. This was worse than the England average which was 74.3%.

There was a clear commitment to the health and well-being of staff during the covid pandemic with a range of resources available to staff. They introduced 'the big five' as part of their flourish campaign:

- Make sure you have the right personal protective equipment
- Don't forget to take a break
- Remember – it's okay not to be okay
- Speak up
- Be kind

When asked about wellbeing, the 2020 survey results showed that 95% of respondents said 'yes' or 'definitely yes' when asked if the organisation took positive action on health and wellbeing. The trust had worked to support staff during the Covid pandemic. For example, at the time of the inspection, 87% of all staff (96% of staff in black and ethnic minority groups) had their first vaccination.

Freedom to speak up guardians (FTSU) were available. The service had been in place since 2015 with a speak up guardian; a second guardian was appointed in 2020. A third FTSU guardian was recruited specifically to support

colleagues in black and ethnic minority groups. They attended regional network meetings to share learning with other NHS trusts. The guardians reported to the medical director. Reports were presented to board. FTSU could be accessed either by email, phone or the application available through the trust's website. FTSU was part of the trust's big five campaign to support safety for patients and staff wellbeing. We were told that there may be differences in how staff respond to negative behaviours such as bullying and harassment. It was suggested that staff who had been employed for a number of years may be less likely to report any concerns, whereas staff employed more recently were more confident to speak up.

The guardian for safe working team supported doctors in their role. They attended doctor induction and other forums as well as liaising with educational supervisors. They encouraged doctors to submit exception reports and these were managed in a timely way. They reported their data to the workforce committee for review quarterly and annually to the board. The annual board report, presented in June 2020, provided assurance that junior doctors' training was safely rostered and their working hours compliant with the terms and conditions stipulated in the 2016 contract. They had identified themes; with most exception reports referring to hours and rest. The pandemic had meant that more meetings were able to be attended via a virtual platform rather than needing to take time out of busy work schedules to travel to face to face meetings.

CQC receives feedback form a number of sources that includes staff members. We have been contacted by and spoken with staff from a range of services regarding their concerns about culture in the organisation. Communication issues have been expressed as a concern including feeling that the trust had not been open or listened to their concerns. They have described a culture that has been based on blame rather than learning.

Inclusion and Diversity

The trust promoted equality and diversity in daily work and mainly provided opportunities for career development.

The Workforce Race Equality Standard (WRES) became compulsory for all NHS trusts in April 2015. Trusts have to show progress against nine measures of equality in the workforce. A gap analysis provided by the trust identified as part of the Workforce Race Equality Standards (WRES) a need to monitor and ensure equity in access to continuing professional development.

Data from WRES, was presented to the board of directors and governors in October 2020. Data showed that 40% of staff from a black and ethnic minority background had experienced harassment, bullying or abuse in the previous 12 months from other staff. The result was the same as in 2019. These figures were worse than the England average of 29.1%. For all other staff the figure was 27.4% and had decreased from 28.6% in 2019. This was worse than the England average of 24.4%. The WRES action plan clearly outlined a range of initiatives to address these results which included a listening project, introduction of an early resolution policy, 15 respect champions, a skills development portal and inclusive behaviours training.

The Trust has made some progress, delivering on action plans with results visible through a number of the WRES indicators, including board voting membership of 23% which was significantly higher than the England average consequently further improvements were needed. The diversity of the board members is outlined below:

- Of the executive board members, one was from a black and ethnic minority group and three were female.
- Of the non-executive board members, one was from a black and ethnic minority background and three were female.

Our findings

However, shifts in the staff survey metrics have not yet been made, and there have been deteriorations in some metrics in year. The Trust has recognised the need for a wider reaching improvement programme including investment in dedicated resource to transform the trust into an anti-racist organisation – thus addressing racism and racial inequalities.

The Workforce Disability Equality Standard (WDES) is a set of ten specific measures which enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. NHS trusts use the data to develop and publish an action plan. From the data presented to the board of directors and council of governors, it was noted that improvements had been made in this area, for example, in declaration rates, recruitment and application of reasonable adjustments. However, improvements in staff experiences were needed with regard to leadership roles and feeling valued.

It had been identified that staff groups within the trust were more diverse than the local community. This was mostly due to the overseas recruitment of registered nursing staff from the Philippines and international medical staff.

The black and ethnic minority group staff network won the North West regional 'wellbeing at work' category at the 2020 NHS Parliamentary Awards. The network produced their monthly 'round up' newsletter and promoted listening cafes through the pandemic. There was an anti-racism influencers group that had been established although this was in its infancy with pledges made in the group.

The trust produced a special edition of their inclusion and diversity newsletter in February 2021 to celebrate LGBT+ history month. The disability staff network had driven initiatives such as colleague health passports and improvements in estates accessibility. As a consequence of the covid pandemic, the trust's annual inclusion conference was organised as a virtual event with a range of awareness raising activities during disability history month. In December 2020, the trust was named the most inclusive employer in the United Kingdom (UK) in the inclusive top 50 UK employers list.

In the NHS staff survey, 2020, 88.2% of respondents said that they agreed or strongly agreed that the trust encouraged staff to report errors, near misses or incidents. This compared to 88% in 2019. The latest result was in line with the England average.

The five-year inclusion and diversity strategy, that included both patients and staff, was developed from 2016 and the trust were reviewing information for the next strategy. The trust employed a dedicated learning disability matron and a dementia matron to help ensure that the needs of these vulnerable groups were met. Examples included; a menu had been developed that was specifically 'dementia friendly'. The trust supported Johns campaign and the 'Forget me knot' schemes for dementia care.

The trust utilised data from the electronic patient records (EPR) system to monitor their equality objectives. Personalised passports were encouraged for patients with additional needs such as learning disabilities, autism or dementia. These had been reviewed, could be accessed on the trust website and uploaded via the website onto the EPR system. There were forms available for adults and children. The EPR system had indictors (starburst) to alert staff that there was specific information to review relating to a patient's individual needs.

There was an established safeguarding team who were available to support staff and monitored that care was appropriate for patients.

Our findings

A pager system had been introduced in the emergency departments for patients, such as those with autism, to use who may have challenges waiting in public waiting areas. Following a triage risk assessment, these patients could go and wait where they felt comfortable, for example in the car park, and return when alerted by the pager. The trust had linked with the local NHS ambulance service so that they could pre-alert the trust if a patient with autism or a learning disability was expected.

The trust had adopted the sunflower lanyard scheme to help support individuals with a hidden disability appropriately.

The trust had adopted an open and transparent approach with information shared on the public website regarding current activities or reviews. The trust website included a section dedicated to the accessible information standard with explanations and links to different formats. The website included a software system that allowed information to be accessible in a number of formats. This included text to speech, text highlighting to make fonts larger and translation for people whose first language was not English. The website included widget technology where pictures were connected with the text.

Interpreter services were available face to face and through a telephone system. There were hearing loops available for those identified with hearing impairments. Interpreters trained in basic sign language could be sourced for planned visits. For emergency visits, a video system could be accessed for deaf patients.

Patient information leaflets could be sourced according to individual need in alternate formats. Details of how to source them was included on the back of patient leaflets accessed at the hospitals or via the trust's website or social media sites.

The trust had installed changing places at Furness General Hospital and Westmorland General Hospital for patients with physical disabilities with plans for a similar facility at Royal Lancaster Infirmary.

Staff were supported to progress in the trust with a strong emphasis on 'grow your own'. During 2020 / 2021, the trust appointed 242 full-time nurses and were awaiting a further 45 to take up posts. The nurse vacancy rate was 3.2% at time of inspection. The trust had employed 22 new consultants and three long-term locums. There was a consultant vacancy rate of 10.8% and 8.1% vacancy rate for speciality and associate specialist (SAS) doctors. The trust had employed six radiologists on a global fellows' programme that included a three-year system of 'earn, learn and return'. Recruitment of medical staff was recognised as a concern particularly at FGH or certain specialities, such as radiology. Some services rotated staff across sites, but this was dependent on the speciality, such as respiratory and cardiology.

Governance

The arrangements for governance were not clear and did not always operate effectively. However, external support had been obtained to review and improve governance processes throughout the trust and with partner organisations. Not all staff were clear about their roles and accountabilities. Processes were not always effective and completed in a timely manner.

There was a significant level of external support within the trust from external stakeholders and individuals deemed as experts in their field of work to work with the trust to improve the governance. It was too early to judge whether the board had the capacity and processes to ensure that any changes made were maintained once the support ended.

The trust had undergone a number of external reviews that have required extensive resource to support.

Our findings

The trust had commissioned support from an external governance organisation in 2019 and another company 2020. The latest report was published, on the trust's website in February 2021 and had been shared with CQC. It included a number of recommendations to help improve and streamline processes and priorities. The previous report had highlighted there was duplication in some processes. An action plan had been produced that included how the trust planned to address the recommendations with target dates and a rag rated colour system to indicate if it was on target. At the time of inspection one recommendation was rated as amber with all others either on track or completed.

The external governance review, from 2020, highlighted a number of concerns regarding the board assurance framework (BAF) with a number of recommendations to support improvements.

These included the need to review the BAF to ensure it aligned with trust strategies, clarification of priorities for care groups and dedicating time at board meetings to review if the BAF risks had been covered appropriately. The recommendations also included the need for further improvements in terms of clarification about the use of performance data as well as linking the integrated performance report (IPR) to the BAF. The trust had been revising its BAF as a result of this.

At the time of the inspection, the existing processes were not always effective at identifying and managing patient safety issues. A significant example of this was the lack of governance and oversight of the stroke pathway within the trust. During the inspection of the core services, we identified concerns in the stroke pathway, particularly at the Royal Lancaster Infirmary. These concerns prompted focused inspections at both RLI and FGH.

Due to the concerns we found during this inspection, we used our powers under Section 31 of the Health and Social Care Act 2008 to take immediate urgent enforcement action and placed conditions on the provider's registration. This limited the rating of this key question to a rating of inadequate. We imposed conditions under section 31 of the Health and Social Care Act 2008 on the trust's registration as people may or will be exposed to the risk of harm. These included: -

1a. The registered provider must implement an effective system for managing and responding to patient risk for those presenting with symptoms of stroke and ensure that they are cared for in a safe and effective manner and in line with National guidance.

1b. The registered provider must operate an effective clinical escalation system to ensure stroke care and treatment is assessed and implemented in a timely way.

2. The registered provider must implement an effective risk and governance system for the whole stroke pathway which ensures that:

i. There is oversight at service, division and board level in the management of the stroke services;

ii. There are effective quality assurance systems in place to support the delivery of safe and quality care;

iii. Risk and occurrence of incidents are properly identified and managed, to include an effective system of recording actions taken and ensuring learning from any incidents;

iv. Incident grading is reviewed to ensure it is accurate and in line with national guidance.

v. Serious incidents are reflected and reported correctly in line with national guidance and adequately investigated.

vi. Ensuring learning is shared from the investigation.

3. The registered provider must implement an effective system throughout the whole stroke pathway to ensure that all clinical staff have the knowledge, competence, skills and experience to care for and provide treatment to patients presenting with symptoms of stroke. Training must include, but is not limited to; thrombolysis, dysphagia, nasogastric tube insertion and safety checks.

As part of these conditions, and following the inspection, the trust has provided information on the immediate actions it had taken to mitigate the risks we had identified at the inspection. The trust has since produced a detailed action plan, focusing on the conditions of registration and will be providing regular reports to CQC on the actions taken to improve the quality and safety of services. CQC will continue to monitor these actions through our routine engagement.

Following the historical concerns in maternity services as reported in the Kirkup report in 2015, the trust had commissioned a review of evidence to establish whether progress against the 18 Trust recommendations had been fully sustained, partially sustained or not sustained at all. The trust shared a draft copy of the review. Of the 18 recommendations, the trust reported that 15 had been sustained fully and three were sustained partially. CQC reviewed the draft report but were not assured that it was a robust review. The review was completed virtually with no onsite activity to observe day to day practice or culture. We were told that the review was presented at the private board meeting in May 2021 and was to be shared with the public board in June 2021. The trust was introducing a different electronic patient record (EPR) system for maternity services from June 2021 and there was external support for governance processes at the time of inspection. It was considered by the trust that all recommendations would be sustained fully following the current improvements in processes.

Our findings from the inspection did not provide assurance about the governance and oversight of risks or the long-term sustainability of the maternity services provided.

Following historical and ongoing concerns of the urology service an external review was commissioned where a large amount of documentation was looked at and staff spoken with. The outcome of the investigation had not been published at time of inspection.

The trauma and orthopaedic service had undergone an internal review in 2020 following concerns expressed by colleagues in the service. A current external review has been commissioned for the service and was underway at time of inspection.

We lacked assurance that the trust was effective in driving improvements through its governance systems. We reviewed a copy of the trust's audit plan that began in 2020. There were end dates of March and April 2021 set, however; during inspection of core services, we identified that some audit results were limited and not always completed. In the emergency departments, for example, the trust had not submitted the last set of data for the 2019/2020 Royal College of Emergency Medicine (RCEM) audits due to Covid and had been a delay in uploading the latest set of data. We were not provided with any action plans. Clinical audits were reviewed by the quality committee. There was limited routine benchmarking against other providers. We were told that the Covid pandemic had impacted on the programme with internal audit being refocused with the approval of the Audit Committee while staff were redeployed. Where the trust had recognised areas requiring improvement, it had developed a composite action plan (CAP) that included recommendations from different workstreams that could be overseen by the executive board and reported into the system improvement board (SIB).

Our findings

The latest draft report for internal audit was shared with CQC. This reported “moderate assurance can be given that there is an adequate system of internal control, however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some of the organisation’s objectives at risk.” The audit did recognise the unprecedented consequences of the Covid pandemic.

Controlled drugs recording had been identified as a risk and a trust wide alert was issued in February 2021, the impact of this was being monitored through auditing although we found continued recording errors during our inspection.

Patient group directions (A system for enabling medicines to be given to patients without a prescription) had been reviewed and updated but had not been implemented effectively in some locations. Compliance for medicines management training was 84.4% overall care groups.

Management of risk, issues and performance

Risks, issues and poor performance were not always dealt with appropriately or quickly enough. There were systems to manage performance, however, these were not used efficiently. The risk management approach was applied inconsistently or was not linked effectively into planning processes. Whilst services mainly identified risks, not all risks were escalated, prioritised or managed in a timely manner by senior leaders. The trust did not react sufficiently to risks identified through internal processes and had often relied on external parties to identify key risks before it started to address them. They had plans to cope with unexpected events.

Whilst the trust completed risk registers for the care groups and a corporate risk register, these did not always reflect the key risks or urgency of required actions to assure safe service provision. In addition, there was a lack of assurance that some of the risk identified were monitored effectively to provide assurance that actions had been taken. We identified a number of risks to safe service provision which were not on the risk registers we reviewed. For example, the need for a Paediatric emergency medicine consultant for urgent and emergency care services, concerns re the stroke pathway, especially regarding thrombolysis at RLI.

Although training was provided, and skills drills were undertaken for midwives at WGH; we were not assured that staff could maintain competencies and manage unexpected complications, due to the low numbers of births in this midwifery led service. In addition, the trust told us that the risks and breaches of regulation identified at the last inspection had all been addressed. However, on review of these during this inspection, we found some that had not been effectively addressed.

There were a number of estate concerns across the trust that had been identified on the risk registers including the infrastructure and fire hazards. During our inspection of core services, we found pieces of equipment that had labels indicating they were past their date for review. We escalated this to the estates team whilst on site. We were not assured that there was comprehensive oversight of equipment maintenance needs in the trust.

There was poor performance in terms of medicines reconciliation rates for the whole trust; these were at the time of the inspection, 35% of medicines reconciled within 24 hours which is well below National Institute for Health and Care Excellence (NICE) national guidelines of 80% within 24 hours. Due to maternity leave there was no dedicated antimicrobial pharmacist. Plans and investment in pharmacy workforce were in progress to help improve medicines reconciliation rates and manage the risk of no antimicrobial pharmacist. This was identified in the trust risk register.

Our findings

Medicines management e-learning targets were not being met within all care groups. The medicines safety group was monitoring the risks and taking actions to improve uptake. Risks of incorrect medicines discharge information due to a system fault had been managed over the last year and systems errors had now been resolved.

The trust monitored performance using balanced scorecards; these included metrics regarding quality and safety, people, performance and finance. The Covid pandemic had significantly impacted performance and plans were now progressing to mitigate risk and outcomes for patients. In February 2021, the referral to treatment times had shown an improving picture for the previous eight months and was reported as 62.03%. (In England patients 'have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible'. The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment).

Patients waiting for inpatient surgery were clinically validated and risk assessed to ascertain if they were able to wait until after the pandemic. The waiting list size was 20,621 in March 2020 (pre-pandemic); this figure rose to 23,950 in March 2021. Additional support from independent health providers was commissioned in targeted areas. Weekend and virtual clinics were introduced to help reduce numbers waiting. The number of patients who were past their date for review increased from 31,756 in March 2020 to 35,573 in March 2021. Patients requiring urgent follow-up were discussed at weekly performance meetings and additional clinical sessions were arranged. Patients waiting for 52 weeks for treatment increased in March 2021 to 2,496; compared to one patient last year. However, the trust's percentage of patients waiting more than 52 weeks was similar to the average for the trust's in the North-west. Alternate out-patient pathways had been explored including digital letters and booking systems as well as video calls with patients. A perioperative wellness scheme had been established to support patients with behaviour choices in order to keep well.

The 62-day performance for patients referred with suspected cancer was below the target of 85% throughout the pandemic. The performance for patients transferred to tertiary centres for treatment had deteriorated between January 2021 and March 2021. At the RLI the trust reported in the elective recovery plan that performance, in February 2021, was below the trust's Phase 3 Covid response plan targets. The trust reported there were 24 cancer patients waiting over 104 days, due to a combination of patient choice and delay in diagnostics. Cancer 62-day wait performance was 66% against the 85% national standard (with 24 breaches) and cancer 31-day wait performance was 96.2% (against the 96% standard).

At Furness General Hospital (FGH) the most recent trust data reported that there were 13 cancer patients waiting over 104 days, due to a combination of patient choice and delay in diagnostics, cancer 62-day wait performance was 54.8% against the 85% national standard and cancer 14-day wait performance was 58.6% against the 93% standard.

The trust had responded to manage the infection prevention and control (IPC) risks. The Covid pandemic had raised challenges for the IPC team; the service was increased to a seven-day services and two additional IPC staff were recruited. The team had increased engagement with frontline staff. The team were reporting to the quality committee prior to going to board. The trust recognised that the estates were a risk to IPC. Limited side rooms meant that patients were cohorted in bays. The annual IPC report included the Covid pandemic data as well as other reporting of infections. There were 2,420 cases of covid with 496 cases identified on day eight or more of admission. All hospital-acquired covid infections were incident reported and reviewed including weekly case review meetings. The IPC plan, for 2021 to 2022 was in the process of completion; it included actions and how these would be measured. However, not all staff were adhering to trust infection prevention and control policy in the use of personal protective equipment and maintain patient and staff safety through social distancing at all times and in all areas.

Our findings

The trust had a significant challenge in relation to managing the size of the financial deficit and how this was impacting on the operational performance and quality of the trust. There were additional financial pressures with the Covid pandemic operational issues.

The trust had met its financial control target for the last two years. In 2019/20 they delivered a £61.7m deficit against a £61.9m deficit control total. In 2020/21 they achieved a £0.7m surplus versus the breakeven target.

Information Management

The trust did not always collect reliable data, analyse and use it to make improvements. Staff accessed data on multiple electronic and paper platforms. This meant that, for some services, information was difficult to access promptly. The information systems were secure. Data or notifications were submitted to external organisations as required.

The trust had a number of electronic systems that included an electronic patient record (EPR), monitoring of early warning scores, medicines management and incident management systems. Some information was in paper format. This meant staff needed to navigate multiple systems to view information.

The external governance review had identified recommendations to support effective information systems. It was recommended that the trust review and clarify their requirements from performance data, and that this should be based on the trust's strategic priorities and key risks outlined in the revised board assurance framework. There was the need for the integrated performance report (IPR) to be reviewed in line with priorities.

There was a ward audit programme in place; the process had recently changed with a new quality assurance recording system at the time of our inspection. However, the new system did not give the trust full oversight of all areas. It did not include the maternity ward and therefore, managers on the maternity ward were unable to submit their ward-based audits through the quality assurance system. Manager told us they had escalated this to senior managers. The local managers told us they felt they got the information they needed at a local level to make improvements through the ward manager and matron audits.

Following the inspection we were informed that the maternity wards had access to the quality assurance recording system.

Electronic prescribing and medicines administration (EPMA) had been rolled out across the Trust which was overseen by the EPMA steering group; audit plans and ward dashboards were in the early stages to help proactively identify errors and required improvements.

Centrally there was a control centre, located at RLI, where real-time dynamic data could be viewed. Staff could monitor patient numbers at all three main hospital sites, such as in the emergency departments and capacity in other areas of the hospitals. The system had software that predicted the likely numbers of patients; this assisted with planning including staffing requirements. The control centre was utilised throughout the pandemic. During the day, from 8am, meetings were held four-hourly in the centre to review the flow and any arising issues; this was increased to two-hourly during busier times and when the additional surge beds were in use.

The trust has achieved awards for systems that included:

- Staff driving forward an analytical command centre at the health tech newspaper awards.

Our findings

- Westmorland General Hospital was honoured as National Joint Registry (NJR) 'Quality Data Provider' after successfully completing a national programme of orthopaedic data audits.
- The trust had won a global transformation award for their digital data systems.

Engagement

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

The system working across the Lancashire and Cumbria region was emphasised through many interviews.

Actions were put in place to support staff during the Covid pandemic. From the start of the pandemic there was a strong emphasis on staff well-being. Staff were encouraged to access support that was available including counselling and therapies as well as risk assessments. Occupational health services were available, and this included trauma risk management (TRiM).

Staff check-in appraisals developed in Covid were 80% completed. At the time of inspection 87% of the workforce had been vaccinated. This included 96% of staff from black and ethnic minority groups and 79% of other staff that had received their first dose. There were 5, 502 staff that had received their second dose. In addition, the trust vaccination services delivered 19,117 Covid vaccines to other health and social care colleagues. We were told that staff were all being rewarded for their hard work through this time with time off and a gift voucher.

Staff we spoke with during the core service inspections were positive about the visibility and approachability of the chief executive. The chief executive completed a blog as well as posting on social media platforms accessible for staff and patients. Staff we spoke with highlighted 'tea and talk' events with the chief executive. Events had been arranged for patients to attend, at community venues, prior to the Covid Pandemic.

During the pandemic the board executives took on the 'gold command' role where they were onsite at weekends. This provided an opportunity for staff to speak to senior staff.

There were a number of embedded staff workstreams for equality and diversity including the black and ethnic minority group, the lesbian, gay, bisexual, transgender (LGBT+) group, disability, veterans and gender equality groups. Each of the groups were supported by an executive sponsor. There was an emphasis on 'allyship' (supportive association with another person or group) in the trust. The trust supported the NHS rainbow badge scheme. Transgender guidance for patients had been developed as well as a policy for staff.

The patient experience team had been re-configured to cover all areas of patient feedback and engagement as well as oversight of volunteers. There was a clear reporting structure that included the executive team. The board received patient stories and there were plans to develop a library of the feedback from patients. The service was a point of contact for staff for support in the completion of equality impact assessments in the organisation. CQC were given examples of how the poor experience of a family member has been used to share learning and educate staff in a positive way. Following feedback from patients with hearing impairments, the trust was introducing an application that linked to the trust website for patients to access.

Our findings

Prior to the pandemic community events were organised. These included an event for patients with autism. The event was recorded meaning that patients could access remotely if reluctant to attend. The team had plans to arrange events for certain groups of patients such as homeless patients and veterans.

The trust had also consulted with patients for areas of particular concern and had involved them in some recruitment processes.

The latest published results for patient-led assessments of the care environment (PLACE), in 2019, showed that the trust scored higher than the national average for each of the measures.

- Cleaning – 99.98%
- Food score (menu range, hot and cold food choices) – 99.42%
- Organisation food (food strategy) – 97.68%
- Ward food (Actual taste, texture and temperature of food at ward level) – 100%
- Privacy, dignity and well-being – 97.69%
- Condition, appearance and maintenance – 95.55%
- Dementia – 94.82%
- Disability – 94.52%

During Covid changes were made to how feedback was collected for the NHS Friends and Family Test. Pre Covid information was gathered on paper, however; this information was not always current by time of collection and analysis. Information was collected electronically in Covid and the trust introduced a voice message option where certain individuals or teams could then receive feedback.

There was also learning from Covid to improve appointment accessibility. Some groups of patients have been challenged by technology; there were plans to work with a third-party charity to support these patients.

During the pandemic the trust worked with the local community on a number of projects. The trust approached a local school to design a visor and a national engineering company produced headwear to protect staff in areas with aerosol generating procedures. The result was the 'Morecambe Bay Hood.'

Information was shared, with the local community, on a public website with special interest news stories that may be useful to certain patient groups, such as highlighting a social media site for women receiving maternity services or people with symptoms of dementia. Information from external reviews published was available on the trust website for the public to view.

Learning, continuous improvement and innovation

Whilst the trust had systems in place to identify learning from incidents and complaints; these were not always effective or delivered in a timely way which delayed any required improvements to patient care. The mortality review process was clearly work in progress. Staff were committed to continually learning and improving services. They used quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Our findings

The patient safety unit was relaunched earlier in 2021. This included a patient representative as well as the governance team and senior executives. The role of this team included the reviewing of incidents alongside the mortality review group. The unit reported into the board's quality committee.

The mortality review process was clearly work in progress. The lead for mortality had a grasp of where the trust was at and what needed to be done to ensure this was effective. The mortality review process included different electronic systems and meetings that were site based. Reviews were completed weekly with a quarterly mortality report submission to the board. There was a recognition that coding needed to be accurate to monitor outcomes appropriately and understand reasons for any excess in numbers of deaths. This had identified a training need in the governance process. Structured judgement reviews (SJR) were completed by mortality reviewers. In the six months prior to inspection there were 909 mortality cases for review. Of these 66% were reviewed using a structured judgement review (SJR) format. Work was in progress to link in all care groups for wider sharing learning from deaths. The medical examiner process was in place with an emphasis on prioritising deaths that were identified as requiring further review. This process has reviewed 100% of eligible cases. There was a positive working relationship between the mortality reviewers and medical examiners. There were plans to review deaths in the community prior to 2022 depending on competing priorities.

As part of the inspection process we requested a sample of SJR's to review, however; we did not receive these during or post inspection, this was concerning as this information should have been readily available for review. We were therefore unable to confirm the effectiveness of this process. The mortality review process document for the women's and children's division, was past the date of review recorded as December 2020.

We were significantly concerned about the timely and effective management of incidents and learning from them. The Trust had recognised this and had put in place a number of improvements. We heard and received information about the systems and processes being put in place to manage incidents during the inspection. However, at this time it was too early to understand if these had led to a positive impact.

Following concerns regarding stroke services, we identified 152 incidents where there were potential concerns or delays and harms to patients. In our review of incidents relating to patients with strokes on the national incident reporting system (NRLS), there was evidence between 1 January 2019 and 1 April 2021 of poor patient care and outcomes where potentially the grading of incidents did not match the impact or potential impact to the patient or staff. Evidence of harm grading was felt to be inaccurate on at least 11 out of the 32 most concerning incidents identified. This suggested that the level of attributed potential harm for patients was lower than it was. There was no oversight of low or no harm incidents by managers at RLI to assess for trends or themes.

Following the inspection, the trust completed further analysis of these incidents. They identified some were duplicates so the number of incidents was 111. Five of these were relevant to the stroke pathway and were graded moderate or above. Learning had been identified and action plans were in progress.

During the inspection we were informed that there was a backlog of incidents requiring review. For quarter three 2020 there was a backlog of 5,062 incidents. Plans were in place for this to be completed by June 2021.

Following the inspection we were informed that the trust reported an average of 2,133 incidents per month and that there will always be a number of open incidents in line with the trusts policy. Training had been delivered for completing incident investigations as part of the streamlining of processes; we were told this would help with timeliness of the processes.

Our findings

It was not clear how serious incidents and any related immediate concerns were escalated to senior leaders. We were aware at the time of inspection work was ongoing to improve this. However, we asked senior leaders about the actions/ learning following a never event in February 2021; there was a lack of awareness about the event and any actions taken to prevent it from happening again. We also had an example from the FGH emergency department, when staff we spoke with were unaware of a never event that occurred in 2020. This suggested that any sharing from learning was not taking place effectively. However, learning bulletins were established for the sharing of learning and there were plans to introduce an 'incident room' where staff could access a library of learning.

Following the inspection we were informed there had been no further incidents of this type.

CQC reviewed a sample of serious incident reports, during and following the inspection, that included both initial reports (72-hour reviews) and completed investigations. The trust reported incidents on an electronic system and followed a root cause analysis (RCA) approach. In the sample we reviewed, we found the quality of reports was variable. They included detailed information, however; it was not always clear which hospital the incident related to and they did not always fully explore all the issues. Actions were identified although action plans were not always enclosed and therefore no record of when actions were closed.

This had been recognised by the trust and further training had been initiated. The trust had also strengthened the quality assurance process using a coaching methodology to ensure RCAs once completed were more robust; identified all issues and had measurable actions.

The timeliness of reports was a concern. Timeframes for RCA were not always met. Delays were seen in initiating the 72-hour reviews and these were not completed in a timely way. The trust acknowledged that they were not achieving the target time for completing 72- hour reports but had improved from 23 days to nine days.

We noted two versions of 72-hour review and noted that one version did not include a section to record when the incident review was commenced or when completed; this information was included in the other version. We were told that, as part of their changes in governance processes, 72-hour reports had been changed. Following the inspection we were told a new and revised 72-hour review template included when the incident review was commenced and completed.

Following the inspection, we were informed the current challenges pertained to the Covid pandemic. The Trust previously initiated 72-hour reviews for all moderate and above incidents. This was recognised to be disproportionate, not in line with the Serious Incident Framework and impacted on timeliness of reviews. The Trust reviewed the incident management process. We were told a daily triage had been put in place, and the trust has recently introduced a streamlined 72-hour review template.

Of the serious incidents reviewed, we found that duty of candour had been applied appropriately. (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).

Following the inspection the trust shared that when themes are identified at the serious incident panel a thematic review is undertaken. Ten thematic reviews were initiated in 2020, examples included; dementia and security and falls.

During the inspection, CQC reviewed a sample of complaints. We found the overall quality of the complaint responses were good and the tone of the letters were appropriate. An apology was included where necessary and needed. The

letters included advice on next steps and signposting both internally and externally if not satisfied with the outcome or response provided. However, the timeframes for a response were not timely and the examples reviewed had taken between six and 12 months to complete. The trusts 'Management Procedure for the Investigation and Resolution of Complaints' included the requirement of completion of complaints in 35 working days unless an extension has been agreed to the complex nature of a complaint.

The trust had developed a quality improvement programme, "The Hive" which brought together all improvement methods all under 'one roof'. The initial themes were; outpatients to achieve referral to treatment times and a 30% reduction; improvement of use of theatres and WGH utilisation; emergency care standard to be met and bed occupancy of 92% max. During Covid, the improvement team staff leading this work had been redeployed. At the time of the inspection the focus was returning, and the appointment of another team member had been made to move the programme on.

As part of the trust transformation projects, surgical services are being re-designed across the hospitals to support the prioritisation and restoration of services following the Covid pandemic. Outpatient services now included appointments that are either phone or video consultations as well as letters being received digitally on smart phones if preferred.

The trust was focusing on four key areas to drive improvement:

• Communication (between everyone)

• Documentation

• Escalation

• Variation (such as adherence to guidelines)

The trusts research teams supported trials of medicines and vaccines at the start of the pandemic as well as the development of point of care testing that received two financial awards.

During the first wave of the pandemic, the trust supported care homes in the local areas by providing training. Community district nurses provided training for care home staff to administer routine prescribed injections such as insulin for treating diabetes. This meant patients received their injection timely and reduced the risk of a Covid outbreak by reducing the number of people entering the home. For the district nurses, they were able to be redeployed to other patients elsewhere.

In the maternity services, staff were working with the national research project 'Born into Care'. They worked with external partners to provide memory boxes for women whose baby was being removed into care following birth.

A pilot 'think frailty' was carried out for a month. It included seven-day services of care involving consultants, specialist nurses, therapists and pharmacy, with in-reach to the emergency department. The pilot found a 25% reduction in admissions for this group of patients. In December 2020, the trust launched a frailty coordination hub that resulted in 199 admissions being avoided that equated to 1,592 bed days being saved and meant patients could be cared for at home.

Our findings

The trust had agreed to pilot the Magnet scheme. It is a framework that is used overseas and is an accredited scheme. It involves the reorganisation of how all registered clinicians and care support workers provide care and treatment. They had been developing plans to deliver care as outlined in this Magnet programme.

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

Month Year = Date last rating published

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ➔➔ Aug 2021	Requires Improvement ↓ Aug 2021	Good ➔➔ Aug 2021	Requires Improvement ➔➔ Aug 2021	Inadequate ↓ Aug 2021	Requires Improvement ➔➔ Aug 2021

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

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Royal Lancaster Infirmary	Requires Improvement → ← Aug 2021	Requires Improvement ↓ Aug 2021	Good → ← Aug 2021	Requires Improvement → ← Aug 2021	Requires Improvement ↓ Aug 2021	Requires Improvement → ← Aug 2021
Furness General Hospital	Requires Improvement ↓ Aug 2021	Requires Improvement ↓ Aug 2021	Good → ← Aug 2021	Good ↑ Aug 2021	Requires Improvement ↓ Aug 2021	Requires Improvement ↓ Aug 2021
Westmorland General Hospital	Requires Improvement ↓ Aug 2021	Good → ← Aug 2021	Good → ← Aug 2021	Requires Improvement → ← Aug 2021	Requires Improvement ↓ Aug 2021	Requires Improvement ↓ Aug 2021
Overall trust	Requires Improvement → ← Aug 2021	Requires Improvement ↓ Aug 2021	Good → ← Aug 2021	Requires Improvement → ← Aug 2021	Inadequate ↓ Aug 2021	Requires Improvement → ← Aug 2021

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

Rating for Royal Lancaster Infirmary

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Services for children & young people	Requires improvement Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
Critical care	Good Feb 2017	Good Feb 2017	Outstanding Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017
End of life care	Good Feb 2017	Good Feb 2017	Outstanding Feb 2017	Good Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017
Outpatients and diagnostic imaging	Good Feb 2017	Not rated	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017
Surgery	Good →← Aug 2021	Good →← Aug 2021	Good →← Aug 2021	Requires Improvement →← Aug 2021	Good →← Aug 2021	Good →← Aug 2021
Urgent and emergency services	Requires Improvement →← Aug 2021	Requires Improvement →← Aug 2021	Requires Improvement →← Aug 2021	Requires Improvement →← Aug 2021	Inadequate ↓ Aug 2021	Requires Improvement →← Aug 2021
Maternity	Good →← Aug 2021	Requires Improvement ↓ Aug 2021	Good →← Aug 2021	Good →← Aug 2021	Requires Improvement ↓ Aug 2021	Requires Improvement ↓ Aug 2021
Overall	Requires Improvement →← Aug 2021	Requires Improvement ↓ Aug 2021	Good →← Aug 2021	Requires Improvement →← Aug 2021	Requires Improvement ↓ Aug 2021	Requires Improvement →← Aug 2021

Rating for Furness General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Services for children & young people	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
Critical care	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017
End of life care	Good Feb 2017	Good Feb 2017	Outstanding Feb 2017	Good Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017
Outpatients and diagnostic imaging	Good Feb 2017	Not rated	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017
Surgery	Good → ← Aug 2021	Good → ← Aug 2021	Good → ← Aug 2021	Requires Improvement → ← Aug 2021	Good → ← Aug 2021	Good → ← Aug 2021
Urgent and emergency services	Requires Improvement → ← Aug 2021	Requires Improvement → ← Aug 2021	Good → ← Aug 2021	Good ↑ Aug 2021	Requires Improvement ↓ Aug 2021	Requires Improvement → ← Aug 2021
Maternity	Requires Improvement ↓ Aug 2021	Inadequate ↓↓ Aug 2021	Good → ← Aug 2021	Good → ← Aug 2021	Inadequate ↓↓ Aug 2021	Inadequate ↓↓ Aug 2021
Overall	Requires Improvement ↓ Aug 2021	Requires Improvement ↓ Aug 2021	Good → ← Aug 2021	Good ↑ Aug 2021	Requires Improvement ↓ Aug 2021	Requires Improvement ↓ Aug 2021

Rating for Westmorland General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity and gynaecology	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017
Outpatients and diagnostic imaging	Good Feb 2017	Not rated	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017
Surgery	Good May 2019	Good May 2019	Good May 2019	Requires improvement May 2019	Good May 2019	Good May 2019
Medical care (including older people's care)	Good May 2019	Good May 2019	Good May 2019	Good May 2019	Outstanding May 2019	Good May 2019
Urgent and emergency services	Good ↑ Aug 2021	Good ↑ Aug 2021	Good → ← Aug 2021	Good ↑ Aug 2021	Good ↑ Aug 2021	Good ↑ Aug 2021
Maternity	Inadequate Aug 2021	Requires Improvement Aug 2021	Not rated	Requires Improvement Aug 2021	Inadequate Aug 2021	Inadequate Aug 2021
Overall	Requires Improvement ↓ Aug 2021	Good → ← Aug 2021	Good → ← Aug 2021	Requires Improvement → ← Aug 2021	Requires Improvement ↓ Aug 2021	Requires Improvement ↓ Aug 2021

Royal Lancaster Infirmary

Ashton Road
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Description of this hospital

The Royal Lancaster Infirmary is a part of the University Hospitals of Morecambe Bay NHS Foundation Trust. It provides acute hospital services including urgent and emergency care, medical care, surgery, maternity, critical care, paediatrics and out-patients for people in the North Lancashire and South Cumbria areas.

We visited Royal Lancaster Infirmary as part of our unannounced inspection during 20 to 22 April 2021. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

We visited urgent and emergency care, surgery and maternity core services as part of the inspection.

Attendances at the emergency departments within the trust averaged around 10,000 per month.

The hospital had capacity for 203 medical beds and 106 inpatient surgical beds.

The hospital provides elective day case surgery for orthopaedic surgery, ophthalmology, ear, nose and throat (ENT), maxillofacial, urology and general surgery. Surgery at the trust includes all main surgical specialties with the exception of cardiothoracic, neurosurgery, plastics and vascular which are provided by other local NHS foundation trusts.

The trust had 2,397 elective surgical admissions, 10,124 emergency admissions and 13,114 day surgery admissions between January 2020 and December 2020.

Maternity services at Royal Lancaster Infirmary consist of a consultant and midwifery led day assessment unit, a delivery suite with seven beds, two dedicated obstetric theatres and a 24 bedded antenatal and postnatal ward. There are also a range of consulting rooms for antenatal and postnatal clinics and a bereavement suite.

Community midwifery services provide antenatal, intrapartum and postnatal care including birth at home and enhanced and specialist midwives provide care to vulnerable women.

From June 2020 to May 2021 there were 1643 babies delivered across the three maternity locations provided by the trust.

During the inspection we found areas of concern that led to a further unannounced focused inspection in medicine for the stroke care pathway.

Our findings

We did not inspect all of the key lines of enquiry as our concerns were related to specific risks around the stroke care pathway. We inspected against parts of the safe, effective, caring and well-led key questions.

Following this inspection, under Section 31 of the Health and Social Care Act 2008, we imposed urgent conditions on the registration of the provider in respect to the regulated activity; Treatment of disease, disorder and injury and diagnostic screen procedures. We took this urgent action as we believed a person would or may be exposed to the risk of harm if we had not done so. Imposing conditions means the provider must manage regulated activity in a way which complies with the conditions we set. The conditions related to the stroke pathway at the Royal Lancaster Hospital and the Furness General Hospital. In light of this, we suspended the ratings for Medical care including care for older people.

Since the conditions were imposed, the trust responded immediately and put actions in place to improve the service. These were ongoing at the time of publication of the report.

Our rating of this location stayed the same. We rated it as requires improvement because:

Urgent and emergency Care

- In the urgent and emergency care service there were not always enough staff with the right qualifications, skills, training and experience to provide care and treatment to children and staffing of children's nurses was not in line with national guidance.
- The urgent and emergency care service did not ensure that there was always safe management, storage and administration of medicines.
- The urgent and emergency care and maternity service did not always provide care and treatment based on national guidance and evidence-based practice. There was a lack of clear information to evidence how the service monitored the effectiveness of care and treatment. The services could not always demonstrate how they used findings to make improvements and achieve good outcomes for patients.
- Patients in the emergency department did not always have their privacy and dignity maintained.
- Within urgent and emergency care, there was not an effective governance process, some specific risks had not been identified on the risk register and other risks remained the same as they were when we last inspected the service. Staff did not always feel respected, supported and valued by senior leaders.

Medical care

- Following this inspection, under Section 31 of the Health and Social Care Act 2008, we imposed urgent conditions on the registration of the provider in respect to the regulated activities; Diagnostics and Screening and Treatment of Disorder, disease and Injury. We took this urgent action as we believed a person would or may be exposed to the risk of harm if we had not done so. Imposing conditions means the provider must manage regulated activities in a way which complies with the conditions we set. The conditions related to the stroke services at Royal Lancaster Infirmary and Furness General Hospital. In light of this, we suspended the ratings for Medical care including care for older people.
- The trust did not have an effective risk and governance system for the whole stroke pathway.
- The trust did not operate an effective clinical escalation system to ensure stroke care and treatment was assessed and implemented in a timely way.

Our findings

- The did not have an effective system to ensure that all clinical staff had the knowledge, competence, skills and experience to care for and provide treatment to patients presenting with symptoms of stroke.
- Patients who had experienced a stroke were not always cared for in the most appropriate environment.
- Staff in the medical service did not always assess swallowing abilities in a timely manner. They did not always use special feeding and hydration techniques when necessary.

Surgery

- Most clinical audit outcomes were comparable to expected national standards within surgery. However, the service performed worse than expected for patient length of stay in the national hip fracture audit 2019 and the national bowel cancer audit 2020.
- Within surgery, the service performed worse than national standards for waiting times from referral to treatment. The average length of stay for patients having trauma and orthopaedics surgery was worse than national average. Whilst the services had plans in place to improve this, these measures had not been fully implemented and had not yet led to any significant improvement in the services.

However,

- Staff treated patients with compassion and kindness and took account of their individual needs and helped them understand their conditions. They provided emotional support to patients, families and carers.
- There was enough staff to care for patients and women and keep them safe.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The trust engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Maternity care

- Outcomes for women within the maternity service were not always positive, consistent nor met expectations, such as national standards.
- The maternity service did not always assess and monitor women to see if they were in pain, nor give pain relief in a timely way. Staff in the emergency department did not always reassess pain scores.
- In the maternity service leaders did not consistently use reliable information systems to enable them to run services well. The service did not have effective governance processes and systems to manage risk, issues and performance. There was no clear vision and values for the service that was understood by staff.

However:

- Staff treated patients with compassion and kindness and took account of their individual needs and helped them understand their conditions. They provided emotional support to patients, families and carers.
- There was enough staff to care for patients and women and keep them safe.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The trust engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Across this location:

Our findings

- Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well.
- Staff provided good care and treatment, gave patients enough to eat and drink. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- The trust planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.

Urgent and emergency services

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

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

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff and made sure everyone completed it.

All staff received and kept up to date with their mandatory training.

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

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

Managers monitored mandatory training and alerted staff when they needed to update their training.

We reviewed the mandatory training figures for nursing staff on site and saw that in 10 of the 13 mandatory training courses, 100% of staff had completed the training. In the other three courses, the completion rate was over 90%.

Safeguarding

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

Nursing staff received training specific for their role on how to recognise and report abuse.

All nursing staff undertook safeguarding children and adults – levels one and two. The completion rates for these courses was 100%. Staff of band four and above also undertook safeguarding children and adults – level three. The completion rate for this course for eligible staff was 95.9% which was above the trust target of 95%.

Medical staff received training specific for their role on how to recognise and report abuse.

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

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

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

Reception staff had access to a child protection information sharing system. The Child Protection Information Sharing Project is an NHS England sponsored work programme, dedicated to providing an information sharing solution that will deliver a higher level of protection to children who visit unscheduled care settings such as accident and emergency departments, minor injury units, paediatric assessments and walk-in centres. Reception staff were alerted when booking in a child as to whether that child was on the child protection register, a "looked after child" or whether concerns had been flagged by social services staff.

Safeguarding alerts for adults were flagged on patient records and were also picked up by reception staff.

Safeguarding training also included PREVENT, part of the government anti-terrorism strategy about safeguarding vulnerable people from being radicalised; child sexual exploitation and female genital mutilation.

There was clear referral guidance available for staff called "Who do I tell?". This was a red, amber or green rating (RAG) dependent on the circumstances of the presentation. Green presentations did not meet a safeguarding referral, amber called for a safeguarding incident report to be completed and red called for a full social work safeguarding referral.

Staff had a strong working relationship with the safeguarding team. We spoke with a clinical nurse specialist from the safeguarding team who told us that staff made lots of referrals and felt comfortable and empowered to make referrals and question child safety, for example, when an adult drug user had been admitted. Considering safeguarding in all cases was well embedded in the department. The safeguarding team reported that the quality of referrals was very good and they used examples of referrals that could have been better as learning tools for staff.

A paediatric nurse in the department was the lead on safeguarding and delivered training to colleagues.

The safeguarding team had a duty line that was staffed from 9am-5pm, Monday to Friday and staff could call for advice. The safeguarding intranet site had been refreshed and we saw that it contained clear guidance to enable staff to make a decision on making a referral and questions that could be asked.

Cleanliness, infection control and hygiene

The service controlled infection risk well and kept equipment and the premises visibly clean. Most staff used equipment and control measures to protect patients, themselves and others from infection however, we did observe two staff members using PPE inappropriately or not wearing PPE.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). We observed a staff nurse who was wearing surgical gloves return to a bed area to clean it after moving a patient without changing their gloves. When a new patient arrived in the cubicle, the nurse applied alcohol gel on top of the same gloves and continued to assess the new patient. We later observed a doctor who was examining patients and not wearing PPE apart from a facemask.

We saw that 100% of nursing staff in the department had undertaken infection prevention and control training and hand hygiene training. All staff we observed were compliant with arms bare below the elbow.

There were defined Covid-19 negative and positive areas within the department. In majors, doors had been added to the Covid-19 positive cubicles to reduce the spread of infection. There was a separate, walled Covid-19 positive bay in the resus area. There was quick point of care testing in place for those patients who may be presenting with Covid-19 symptoms with a turnaround time of around 10 minutes to obtain the test results.

All areas were clean and had suitable furnishings which were clean and well-maintained.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. There was a cleaning checklist in place to ensure that all areas of patient bays were thoroughly cleaned after each patient had left.

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

There was a domestic team in the department to deep clean Covid-19 or suspected Covid-19 positive areas after each patient had left. They were present until 2pm every day and then on-call thereafter.

Environment and equipment

The maintenance and use of facilities, and equipment kept people safe. Staff were trained to use equipment. Staff managed clinical waste well.

However, the design of the premises and lack of paediatric equipment presented a potential risk to children and patients in the waiting area. At busy periods it was often necessary to care for patients in the corridor whilst cubicles in the majors area became available.

The department pre-dated national guidance for compliance with Health Building Notice 15-01 Accident and Emergency Departments.

The Facing the Future: Standards for Children in Emergency Care Settings (RCPCH 2018) states that children should be provided with waiting areas that are separate from adult waiting areas. We saw that a separate, enclosed waiting room for paediatric patients was being built and due to open in the coming month in the minors area. At the time of our inspection, child and adult patients shared a small waiting area with very few seats due to social distancing.

We saw that the double doors to the main corridor of the hospital were constantly kept open, despite the fact that these were fire doors. They were close to the waiting area for paediatric patients in minors and posed the risk of a child leaving the department or potentially being abducted. We raised these concerns with the trust during our inspection and following the inspection the trust completed a risk assessment. This detailed current mitigation in terms of staff training and oversight of paediatric patients by staff.

The department did not yet have a separate paediatric treatment area. Paediatric cubicles were within the minors area and one cubicle in the resuscitation area.

The design of the waiting area for walk-in patients presented a possible risk to patients who may deteriorate whilst waiting to be seen. Walk-in patients arrived and checked in at reception but because of social distancing, at busy periods, some patients had to wait outside the department. These patients could not be seen by staff at reception. Similarly, the triage nurse in the waiting area performed the triage through a window of the reception office and had no direct access to the patient. We observed that, after each triage, they closed the window and there was no direct observation of patients waiting in the waiting room.

Urgent and emergency services

There were 10 cubicles in use in the majors area of the department and a further five cubicles, all with doors in a separate Covid-19 area. There was an additional room in this area being used as a Covid-19 resus room. We saw that, when the department got busy, that patients had to be kept on the corridor of the unit, until a cubicle became available.

There were two cubicles in the majors area that could be used for patients with mental health needs; within these rooms the ligature points had been removed. There was also a separate mental health area called The Annexe where there were two rooms that were ligature free and had furniture in line with mental health guidelines. There was the ability to put a bed in the room, instead of a chair or trolley, when needed. This was an improvement to the department since our last inspection. This area was staffed by mental health liaison nurses from the local mental health trust with support from the trust emergency department mental health nurses. However, the annexe could not be used for unstable patients.

Staff carried out daily safety checks of specialist equipment.

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

There were resuscitation trolleys for adult and paediatric patients in each area of the emergency department. We saw that daily checks of the trolleys had been completed. Defibrillators and other equipment had undergone electrical safety testing to ensure that they were safe for use.

The service had major incident equipment stored within the department and a decontamination unit external to the department. We saw that the equipment was well-ordered, clean and labelled and was in date. Equipment was checked regularly.

Staff disposed of clinical waste safely. We saw waste management systems were in place to ensure waste was appropriately disposed of. Clinical and non-clinical waste was sorted into colour coded bags. All the sharps containers we saw were free from protruding needles and stored safely. Once sharps dispensers were full, they were sealed, signed and dated accurately. This was in accordance to NICE clinical guidelines CG139 February 2017 standards.

Assessing and responding to patient risk

We found concerns in relation to stroke care and some delays in treatment for patients when the department was busy. Staff did not always complete mental health risk assessments for each patient. However, staff identified and quickly acted upon adult patients at risk of deterioration but we were not confident that the resuscitation of a deteriorating child in a cubicle could be arranged in the timeliest way.

Stroke patients arriving in the department did not always receive treatment in a timely way and in accordance with the trust's stroke pathway and best practice guidance.

Patients with a suspected stroke require a CT scan to identify whether the stroke was caused by a bleed. If no bleed is detected, they then require a CT angiogram to check whether there is a blood clot. This should be treated by thrombolysis, using a clot-busting drug to disperse the clot and return the blood supply to the brain. Thrombolysis needs to be given within four and a half hours of the onset of the stroke. Doctors reported that it was not always possible to get a CT angiogram scan in a timely way following the CT scan. on occasions, the scanner was being used for less urgent patients.

The CT department was available 24 hours a day, 365 days a year. CT head angiograms were not routinely undertaken for patients who were being investigated for a suspected stroke between 16:00–03:00 as there was no thrombectomy service at the trust. However, they could still be undertaken during these hours if required by the referring doctor.

We reviewed the trust's incident data, from 2019 up to the time of our inspection, and this supported our concerns.

We were not assured that doctors in the emergency department had received relevant training and had the competencies to carry out thrombolysis. There was no competency element for doctors giving thrombolysis and this was not assessed or monitored. The National Institute of Health Stroke Scale/Scores is a tool used by healthcare providers to objectively quantify the impairment caused by a stroke. This training was mandatory every two years for doctors working in the department and there was only 15% compliance with the training though doctors were still thrombolising patients. There was nothing within the training about delivering thrombolysis.

Between 5pm and 8am Monday to Friday and all weekend, the stroke consultancy was delivered by Telestroke whereby a stroke consultant should be contacted for advice from a rota shared between eight hospitals. The stroke consultant was required to stay on the call until the bolus of the clot-busting drug had been administered. We were told that emergency department consultants did not always contact the Telestroke service and this was outside the stroke pathway and Telestroke guidelines.

The trust had a stroke action plan, which was provided after the inspection. We were not assured on how this would ensure necessary changes would be implemented and several actions had long timescales for completion.

The service had 24-hour access to mental health liaison and specialist mental health support, if staff were concerned about a patient's mental health needs. There were two mental health nurses working for the trust in the department.

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

Shift changes and handovers included all necessary key information to keep patients safe. However, there were safety huddles in the department every two hours that should have been attended by doctors and nurses from the team to share information about numbers of patients within the department and their ongoing care needs. We saw that on 20 April 2021 there were 10 safety huddles between 07:00 and 19:45. A consultant or doctor was only present at four of these meetings. This meant that the team was potentially not receiving full information about the need and acuity of patients within the department.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The department used a national early warning (NEWS2) system for adults and a paediatric early warning score (PEWS) system for children to identify deteriorating patients. These systems scored a set of observations and prompted an appropriate response dependent on the score or whether the score was increasing.

Staff knew about and dealt with any specific risk issues. Sepsis screening tools were in place and assessments for risk of falls or venous thromboembolisms. There was a sepsis trolley in the department so that sepsis treatment could be initiated quickly. The department had its own blood gas machine to support a prompt diagnosis.

The Royal College of Emergency Medicine guidance on the initial assessment of emergency patients (2017) states face to face contact with the patient should be performed in an environment that has sufficient privacy to allow the exchange of confidential information and that the assessment should be carried out by a clinician within 15 minutes of arrival. The

median time from arrival to initial assessment was below (better than) the overall England median between April 2020 and January 2021. This meant on average patients were triaged in a timely manner, this was an improvement from the last inspection. However, triage of patients was carried out by a nurse through a hatch from the reception office and we were concerned that this was not a fully effective way of triaging a patient.

The median time to treatment in the department before April 2020 was close to the national target of 60 minutes but this improved from April 2020 when numbers attending the emergency department reduced and has been consistently better than the England average since April 2019.

Ambulance handover records showed that patients were being handed over and clinically assessed within 15 minutes of arrival and ambulances were able to clear the department to attend another call. Ambulance crews told us that there were few delays in handing over patients when they arrived at the department.

Risk assessments were used to record and act on risks of reduced skin integrity, falls, venous thromboembolism (blood clots), safeguarding vulnerability or delirium (confusion). The patient record system prompted staff to consider these risks and provided instructions should the risk be present.

There was always a nurse in the department with European paediatric life support or advance paediatric life support training, even if this was not one of the paediatric nurses. There was always a consultant in the hospital with advanced paediatric life support training who was either in the department or on call where this was not available.

Nurse staffing

The service had enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, the service did not always have enough staff with the right qualifications, skills, training and experience to provide care and treatment to children. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep adult patients safe.

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

The department manager could adjust staffing levels daily according to the needs of patients.

The number of nurses and healthcare assistants matched the planned numbers.

At the time of our inspection the department had no vacancies for band seven, band six and band two nursing staff. There had been over-recruitment of nine band five nurses; 0.6 band four nurses and eight band three nursing staff. These figures did not include paediatric nurses.

The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency settings (2012) states that there should always be two registered children's nurse in the emergency department.

The department was not able to fully achieve this, however the trust tried to ensure there was always one fulltime band 6 paediatric nurse on shift covering the children's emergency department between 9am – 9pm seven days a week. In November 2020 there were six days when there were no paediatric nurses on duty but this was an improving picture and in April 2021 there was only one day where there was no paediatric nurse on duty.

In addition, the department planned to have had a paediatric nurse on a twilight shift from 5pm-2am. This would provide two paediatric nurses on duty from 5pm to 9pm to cover the peak time for paediatric admissions. This was not always achieved, for example, in April 2021, this shift was only covered on 12 occasions.

The service had five band six paediatric nurses at the time of our inspection, although one of these was on maternity leave. They had recruited a further band five nurse who was due to start work in the department at the beginning of May.

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

Managers made sure all bank and agency staff had a full induction and understood the service.

Medical staffing

The service had medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment but there were some vacant positions and some permanent locum staff. However, the service did not have enough staff with the right qualifications, skills, training and experience to provide care and treatment to children. Managers gave locum staff a full induction.

The department had eight consultants, three of which were permanent locum consultants. For a department of this size, the Royal college of emergency medicine guidance indicates that there should be a minimum of 10 consultants. They covered the department from 8am until 11pm and there was an on-call consultant after this time. One consultant shift was from 8am-4pm; one from 8am-5pm and one from 3pm-11pm. This meant that there was only one consultant in the department from 5pm until 11pm when the department was usually at its busiest.

There was no evidence of active recruitment of more consultants for the department.

There were 14 middle grade doctors working in the department but to fulfil the rota there should have been 16. The department was covered by two middle grade doctors and one junior doctor overnight. There were eight junior doctors working in the department.

The service had no paediatric emergency medicine specialists or paediatric consultant and relied on the paediatric unit in the women and children's division to provide medical support when a child required medical assessment and clinical decisions to be made.

The service had low turnover rates for medical staff.

The service had low and/or reducing rates of bank and locum staff.

Managers could access locums when they needed additional medical staff.

Managers made sure locums had a full induction to the service before they started work.

The service always had a consultant on call during evenings and weekends.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

The department used an electronic records system.

There was also a separate paper record called "safe and seen" for recording visual observations about those patients who were still waiting to be seen, for example, waiting in a corridor. This document was used for those patients who may have been on a trolley in a corridor for a number of hours, to assess the risk of pressure sores but a visual "safe and seen" observation only was recorded rather than using a recognised pressure sore assessment system, such as Waterlow.

Patient notes were comprehensive, and all staff could access them easily. We reviewed 10 sets of adult patient records and found them to be generally well completed, in line with trust and professional standards with falls assessments and allergies well recorded.

We reviewed 10 sets of paediatric records and found these to be comprehensive and well completed.

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

Records were stored securely.

Information governance training was mandatory. Information seen on site for nursing staff showed that compliance for nursing staff was 100%.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines. There were particular issues around the administration of controlled drugs and patient group directions.

Patient Group Directions (A system for enabling medicines to be given to patients without a prescription) had been reviewed and updated but had not been implemented effectively. We reviewed 30 paper copies of patient group directions that had been signed by nursing staff, all of which were out of date. We were told that they had not been renewed due to the pandemic. Staff, including managers, did not know if up-to-date patient group directions were held electronically.

Nurses only signed the patient group directions where they were comfortable and felt competent in administering the drug in question. We did not see any formal competencies for staff to administer the drugs.

Staff did not always follow systems and processes when safely prescribing, administering, recording and storing medicines, particularly around controlled drugs. They did not always store and manage medicines and prescribing documents in line with the provider's policy around controlled drugs.

We checked the controlled drugs cupboards in resus, majors and the Covid-19 area. We found that the registers in all three areas were kept on the worksurface and were not locked away with the drugs. This mirrored the same findings that we reported on during our last inspection. We also saw that the daily checklist was a loose sheet of paper kept in the front of the controlled drug register.

We found a number of omissions when we checked the registers, such as, doses administered not recorded (five occasions in resus and four in majors), no time of dose administered recorded (One in resus) and no name of patient recorded (One in resus).

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure people’s behaviour was not controlled by excessive and inappropriate use of medicines.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. However, managers did not have oversight of incidents that were recorded as low or no harm. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

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

Staff raised concerns and reported incidents and near misses in line with trust/provider policy.

The service had no never events during the last year. Never events are serious, largely preventable safety incidents that should not occur if the available preventative measures are implemented.

Managers shared learning with their staff about never events that happened elsewhere.

Staff reported serious incidents clearly and in line with trust policy. Managers debriefed and supported staff after any serious incident.

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

Staff received feedback from investigation of incidents, both internal and external to the service but we were concerned that if managers did not have sight of incidents recorded as low and no harm on the incident system, that they could not identify themes and instigate changes to avoid these incident from happening again.

Urgent and emergency services

Managers investigated incidents thoroughly. Patients and their families were involved in investigations where appropriate. However, managers in the department only had access to review incidents that were classed as causing moderate harm or above. It was not clear who reviewed incidents that were classed as no or low harm to ensure that they had been graded correctly or whether they were reviewed for themes and trends. We reviewed a number of incidents relating to stroke patients and saw that a number of these had not had the level of harm identified in line with trust policy.

Is the service effective?

Requires Improvement 

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

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients subject to the Mental Health Act, but mental health risk and capacity assessments were not always carried out in line with the trust policy in a timely way.

Staff did not always follow up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We were concerned that the stroke pathway was not being followed effectively and our concerns are detailed elsewhere in this report and the medicine core service report.

Pathways and policies were based on guidelines and standards set by organisations such as the National Institute of Health and Care Excellence (NICE) and the Royal College of Emergency Medicine (RCEM). The documents were easily accessible to all staff on the intranet. There was a clear list of common emergency presentations and comprehensive guidelines and pathways to manage these conditions.

Staff protected the rights of patients subject to the Mental Health Act but did not always carry out mental health assessments and mental capacity assessments in a timely way to ensure that the right level of support was put in place.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. The department provided sandwiches and hot and cold refreshments for patients.

Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

Pain relief

Staff made an initial assessment of patients so see if they were in pain and gave initial pain relief in a timely way. However, they were not reassessing pain scores for patients. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool. However, in nine out of the ten records checked, pain scores had not been re-assessed within 60 minutes of the initial assessment.

Staff prescribed, administered and recorded pain relief accurately.

Adult patients received initial pain relief soon after it was identified they needed it, or they requested it.

We found pain was not appropriately assessed in children, the last paediatric RCEM pain audit reported of the 50 paediatric records reviewed, 11% of children did not receive a pain assessment within 15 minutes, furthermore 50% of children with moderate and severe pain did not receive analgesia within 20 minutes.

We discussed pain assessments with senior leaders, who were unable to provide actions to improve pain assessments and documentation in the department for both adults and children.

Patient outcomes

Staff did not always monitor the effectiveness of care and treatment. As a result, they were unable to benchmark their effectiveness of clinical practice and patient outcomes against similar departments.

The trust did not submit data for the three Royal College of Emergency Medicine (RCEM) audits they were eligible to participate in for 2019/2020 due to the pandemic. They did not participate in all the RCEM audits for 2020/2021 as there was a delay in uploading the data. Local data was being collected and was going to be uploaded to the national portal to allow comparison of national data. Department leads were unable to evidence clinical outcomes against clinical standards to which all emergency departments should aspire to achieve.

Where compliance was low in previous audits, we saw that the department put forward recommendations as a result of the audits. However, senior leaders were unable to provide an explanation to how these actions had been implemented and the changes seen in the department as a result.

The trust's SSNAP data showed poor patient outcomes, data showed a deteriorating score between June and December 2020. Consultants told us the pandemic impacted the stroke service and which was reflected in the data. They performed worse than the national average on a number of standards including percentage of patients scanned within one hour of clock start, percentage of all stroke patients given thrombolysis and percentage of patients who were thrombolysed within one hour.

There was limited local audit activity; it was unclear what action had been taken as a result and how this information was shared with staff to improve performance. For example, there had been an audit about women of child-bearing age presenting with abdominal pain and the audit found that less than 50% of these women had been given an HCG pregnancy test.

Urgent and emergency services

We found no evidence of the department collecting performance data for national audits that was used to improve services locally and to benchmark performance nationally.

Competent staff

The service generally made sure staff were competent for their roles but there were gaps in the training and competencies of medical staff giving thrombolysis treatment to stroke patients. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were generally experienced, qualified and had the right skills and knowledge to meet the needs of patients. However, we were not assured that doctors in the emergency department had received relevant training and had the competencies to carry out thrombolysis for stroke patients. There was no competency element for doctors giving thrombolysis and this was not assessed or monitored.

Managers gave all new staff a full induction tailored to their role before they started work. Nurses spoke highly of the induction process which had been developed based on staff suggestions for improvement. They told us that it was very thorough, and they were given time to settle into the department and work a supernumerary period before being counted in the nurse staffing figures with suitable supervision and a buddy system in operation.

Managers supported staff to develop through yearly, constructive appraisals of their work.

The clinical educators supported the learning and development needs of staff. There was a practice nurse educator to support nurses to maintain and further develop their professional skills and experience.

Many of the nurses working in the department had chosen to be link nurses and studied subjects in which they were interested in so that they could train other nurses in that subject or assist other nurses in caring for patients. There were link nurses for dementia; stroke; diabetic ketoacidosis (DKA); mental health; thrombolitis; respiratory; alcohol; trauma and others.

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

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

The trust had a process in place to support nursing and medical staff in revalidation procedures. Revalidation is the process that all nurses and medical staff in the UK need to follow to maintain their registration with the Nursing and Midwifery Council (NMC) and General Medical Council (GMC).

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

Managers made sure staff received any specialist training for their role. Medical staff told us that they received additional specialist training and had dedicated learning time within their rotas.

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

Multidisciplinary working

Urgent and emergency services

Doctors, nurses and other healthcare professionals in the department worked together as a team to benefit patients. They supported each other to provide good care. However, staff from the emergency department did not always work well with medical staff from specialities and assessment units to achieve best outcomes for patients.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Handovers took place with nursing and medical staff three times a day to share information about the status of the department and address any issues. Staff were allocated to different areas of the department but supported each other and moved if one area was particularly busy.

However, there was a reluctance by speciality teams to accept admissions in a timely way from the emergency department and the insistence of specialists to assess patients in the emergency department which blocked cubicles for much longer than acceptable. We also saw that there were delays in treatment being started for some patients who were to be admitted because they were not seen by a medical consultant until they transferred to the acute medical unit and a treatment plan was made.

Staff worked across health care disciplines and with other agencies when required to care for patients. The frailty team was based next to the emergency department and assessed patients, gave advice and put measures in place to keep patients safe whilst in hospital and when they were discharged from hospital.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. Staff worked closely with the mental health liaison team who were based next to the emergency department.

We spoke with ambulance staff who told us they had good working relationships with staff in the department.

Seven-day services

Key services were not always available seven days a week to support timely patient care.

Staff could call for support from doctors and other disciplines, including mental health services, 24 hours a day, seven days a week but CT angiogram scans were not always available for stroke patients and thrombectomy services had to be carried out at another NHS trust, with patients being transferred there. This service was also not available 24 hours a day, seven days a week.

A pharmacist visited the department seven days a week and were contactable ‘out of hours.

The trust bereavement team were available to provide specialist support for families and loved ones. They operated from 9am to 5pm between Monday and Friday and on and on call basis outside of these times.

Health Promotion

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

The service had relevant information promoting healthy lifestyles and support in the department. We saw that there were leaflets available in the department on health promotion and lots of advice sheets for parents and carers of children on common injuries and conditions.

Urgent and emergency services

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

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health, but capacity and mental health risk assessments were not being undertaken in a timely way, in line with trust policy. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. However, we saw that mental capacity assessments were not always carried out for patients presenting with mental health conditions.

Trust policy stated that an initial mental health risk assessment and mental capacity assessment should be carried out within 15 minutes of a patient with mental health needs arriving in the department. However, we found mental health patients arriving in the department did not always have risk assessments completed in a timely way. We checked patient notes for six mental health patients who had attended the department on 20 and 21 April 2021 and did not see any completed capacity assessments. There were completed mental health triage risk assessments in only two of the six records we reviewed and neither had been completed within 15 minutes.

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

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available. Doctors and nurses obtained verbal consent from patients before providing care and treatment. We heard staff explaining treatments and diagnoses to patients, checking their understanding, and asking permission to undertake examination and perform tests.

Staff clearly recorded consent in the patients' records.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. The 'Gillick Test' assists clinicians to ascertain if a child under 16 years of age has the legal capacity to consent to medical examination and treatment. The child must be able to demonstrate sufficient maturity to understand the nature and implications of the proposed treatment options, including the risks. Fraser guidelines are used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment.

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

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Mental health liaison staff from the mental health trust worked in the department 24 hours a day, seven days a week and there were two mental health nurses employed by the trust. They were available to give advice when needed.

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

Urgent and emergency services

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation.

Is the service caring?

Requires Improvement 

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

Compassionate care

Staff treated patients with compassion and kindness and took account of their individual needs, but privacy and dignity of patients was not always respected.

Staff were discreet and responsive when caring for patients in cubicles. Staff took time to interact with patients and those close to them in a respectful and considerate way. However, we observed that, when patients were being triaged in the reception area, that it was possible to overhear what was being said to the patient by the triage nurse who was carrying out the assessment through a hatch in the reception office.

We spoke with three patients. They all said that staff treated them well and with kindness.

Staff mainly followed policy to keep patient care and treatment confidential. However, we saw that when patients were being examined in the corridor, they were very close together and there was no privacy or dignity afforded to those patients when they were being examined by a doctor. We observed patients being examined and saw that there was no attempt by the doctor to screen the patients or move them to a vacant room whilst they were being examined. This was an issue that had been raised at our last inspection and staff told us that it was a regular occurrence.

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

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

Emotional support

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

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

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

Urgent and emergency services

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

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

Understanding and involvement of patients and those close to them

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

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

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

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

Staff supported patients to make informed decisions about their care.

The feedback from the Emergency department survey test was positive. The latest CQC urgent and emergency care survey results were still embargoed at the time of our inspection but showed a high level of positive responses from participants about the care and treatment they received in the department.

Is the service responsive?

Requires Improvement 

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

Service delivery to meet the needs of local people

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

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

The department was adequately signposted so that patients could easily find it from outside or within the hospital.

At the time of our inspection, waiting areas had seats blocked out to maintain social distancing so this presented a problem at busy times when some patients may have to stand or wait in temporary waiting areas.

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

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

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

There was discussion around moving the entire department to what is now the education department which would offer a bigger space, but we saw no firm plans for this to happen as it was unclear whether this could be financed.

Meeting people's individual needs

The service was inclusive, but they could not always take account of patients' individual needs and preferences because of the size of the department. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

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

A cubicle in the majors area was being designed specifically for patients with dementia, with input from the lead dementia nurse in the hospital. There was a door on the cubicle to make this a quieter area and there would be sensory elements in the room to keep patients calm.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports.

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

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

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

Staff had access to communication aids to help patients become partners in their care and treatment.

However, facilities and premises provided a challenge for the services being delivered. The clinical strategy referred to the constraints of the geography and estate which were being addressed through the estates strategy.

The department was becoming unable to facilitate increasing numbers of patients and there was no separate paediatric unit to treat children although a separate paediatric waiting area was under construction at the time of our inspection. There was no play specialist to support paediatric nurses in the department.

The department was also under pressure from growing numbers of mental health patients attending, many of which were frequent attenders. This had an impact on mental health staff working in the department and keeping the patients safe until they could be signposted or transferred to a more suitable service for appropriate treatment. The mental health annex was a good additional facility in the department but was under utilised because unstable patients could not be cared for in there and there were problems in staffing it with nurses from the local mental health trust.

Access and flow

Urgent and emergency services

People could access the service when they needed it. However, waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards. The service was not meeting national standards to admit, treat, transfer or discharge patients within four hours. There was a declining picture, consistent with increasing numbers of patients coming into the service although the numbers of patients attending the department had not reached the same number as were attending each day prior to the pandemic. Patients were not discharged from the department or admitted to the ward in a timely way.

At our last inspection of the department we saw that patient flow through the department was real concern with patients being held in the corridor during busy periods and delays in discharging and admitting patients. We saw that this situation had not improved. Patients were still being held on corridors and delays in admitting and discharging patients remained.

Managers and staff cited numerous obstacles to the flow through the department, these being:

Assessment units such as the acute medical unit; surgical assessment unit and gynaecology assessment unit used too much in-reach into the emergency department and insisted on assessing patients within the emergency department rather than accepting them onto their own unit for assessment. This blocked cubicles in the emergency department. Managers told us that they would push back and advise the assessment units that they would send the patient to them, but it appears that not all staff were comfortable in doing this.

Managers told us that there were not enough on-call doctors in the hospital to carry out clerking of patients to speciality units and that this could take up to six hours.

We were told of other delays to admitting patients; there were not enough cleaners in the hospital overnight to carry out deep cleans of bed spaces for admitted patients and there were also delays caused by having to flip bays from male to female or vice versa.

Staff told us that bed meetings were not effective as they did not identify beds that were not available to emergency department patients, for example, it was stated in one of the bed meetings that we attended that there were 21 beds available in the hospital but, in fact, only five of these beds were available to emergency department patients. There were “super green” (deep cleaned) bed spaces within the hospital that were for elective surgery patients only, but these were not being separated out at bed meetings.

We were concerned, that, despite similar issues being cited at our last inspection, that senior managers still did not have an overarching action plan to improve and manage the flow of patients through the department and manage cultural issues between emergency department staff and speciality teams and there was a lack of pace in trying to resolve this.

Patient access to treatment for walk-in patients had improved since our last inspection. However, the department did not have the relevant software to support 111 First where patients telephone 111 and are given an appointment time to attend the emergency department if this is deemed to be the most appropriate action during the call to the 111 service. We saw that patients were attending the department and expecting to be seen at the allotted time but were just added to the queue of patients waiting to be seen when they arrived.

The Royal College of Emergency Medicine recommends that the time patients should wait to be assessed upon arrival is 15 minutes. The trust achieved 85% compliance rate during the week of the inspection.

Urgent and emergency services

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 achieved 89.7% compliance rate at the time of inspection.

There was a triage nurse for walk-in patients in the reception area and another triage nurse in the ambulance triage area where there were two assessment cubicles. The triage nurses supported each other during busy periods in each area.

During our last inspection, we reported that tests and monitoring were not always initiated on triage and that patients had to wait to see a doctor before these could be ordered. We saw that this situation had improved as there was now a consultant in the waiting area, assisting the triage nurse who could order blood tests and ECG tests and they were supported by a clinical support worker who would facilitate the tests and they were now happening in a much more timely way.

The number of patients leaving the service before being seen for treatments was low although it appeared that mental health patients regularly left the department. Two had left the department during our inspection but both had returned the following day.

Managers and staff worked to make sure that they started discharge planning as early as possible. Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. However, there were often long waits for an appropriate bed in a mental health facility to become available for mental health patients. At the time of our inspection, there were two patients with mental health conditions in the department who had been there since the previous day waiting for a suitable bed to become available.

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

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas. It was easy for people to give feedback and raise concerns about care received. We saw posters and leaflets in patient areas on how patients could make a complaint. Patients raised complaints via the Patient Advocacy and Liaison Service (PALS).

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

Managers investigated complaints and identified themes. We reviewed four complaints and found that these were reviewed and responded to in detail. Apologies were given to patients and families appropriately and there was learning from complaints

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

Urgent and emergency services

Managers shared feedback from complaints with staff and learning was used to improve the service. We saw that there was a file in the staff room where compliments and complaint letters and responses were held and that learning from complaints was shared with staff.

Staff could give examples of how they used patient feedback to improve daily practice.

Is the service well-led?

Inadequate  

Our rating of well-led went down. We rated it as inadequate.

Leadership

Local leaders had the skills and abilities to run the service, however there had been a lack of pace from care group leaders in managing the priorities and issues the service faced, such as the shortages in medical and nursing paediatric staffing and the flow of patients through the department. Care group and executive leaders were not always visible and approachable in the service for patients and staff. Departmental leaders supported staff to develop their skills and take on more senior roles.

The emergency department was part of the medicine care group.

There was a triumvirate leadership team for the medicine care group, this being a clinical director, associate director of nursing and associate director of operations. They were supported by a governance business partner and two deputy associate directors of nursing. The associate director of operations, governance business partner and one of the deputy associate directors of nursing had only been in post for a short time.

At departmental level, the emergency department was led by a clinical lead, a matron and a service manager. They were supported by a ward manager and a lead consultant for governance.

The associate director of nursing met with ward managers once a month and with matrons twice a week.

The deputy associate director of nursing visited the service twice a week and the matron reported that they were very approachable and supportive but more senior leaders were not described by staff as regularly visible in the service.

Staff described the departmental leadership team as visible and approachable and both the ward manager and matron undertook clinical shifts

The departmental clinical lead was well-sighted on the issues facing the department and had worked in the department for a number of years. However, staff reported that they were frustrated in mitigating risks to patients by a lack of support from the speciality teams and the executive leadership team for the care group.

Staff told us that there was a difficulty in referring patients to speciality teams and the executive team was not being supportive in managing corridor patients. It was reported that there was no robust implementation of the escalation

plan when the department was crowded. The corridor escalation plan states that when there are more than six patients being cared for in the corridor, that extra staff should be sought to assist in their care and an incident report should be submitted. However, we saw an example whilst carrying out the inspection where there were seven patients being cared for on the corridor and the escalation plan was not followed and no incident report was submitted.

Although the care group executive leads had an overview of some of the issues facing the department there were no overarching action plans for the department to mitigate the risks and manage the priorities. For example, the service had worked with the acute medical unit (AMU) to try to improve flow through the department but when asked for the action plan arising from this, we were told that there was none and it had just been a coaching/relationship building exercise.

We had particular concerns that managers were not sighted on the risks around stroke care.

Similarly, managers were aware that incident reports were not always submitted when the numbers of patients in the corridor reached maximum escalation level but there was no evidence of actions to ensure that this happened.

Vision and Strategy

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

The trust vision was: *"We will consistently provide the highest possible standards of compassionate care and the very best patient and colleague experience. We will listen to and involve our patients, service users, colleagues and partners."*

There were five core values, known as the five P's, these being, patients; people; partnerships; progress and performance.

These were outlined in the trust strategy 2019-2024 that was aligned with the Better Care Together health economy transformation programme.

We saw that the five core values were embedded and governance meeting agendas were based on these five topics.

The vision was displayed on notices around the hospital site.

As well as an overall trust strategy for 2019-2024 there was also a clinical strategy 2019-2024; patient experience strategy; governance and assurance strategy 2018-2021; food and drink strategy; inclusion and diversity strategy 2016-2021; infection prevention and control strategy 2019-2024; patient and public involvement strategy; quality improvement strategy 2019-2022; risk management strategy; security management strategy and staff health and wellbeing strategy.

The clinical strategy contained a number of objectives under the emergency and urgent care model. These objectives were:

- To continue with improvement work in accident and emergency departments with oversight from the A & E Delivery Board.

- To work with Bay Health and Care partners to ensure a comprehensive streaming model is in place to ensure that only those patients who require emergency services attend accident and emergency departments while continuing to deliver the urgent care service at Westmorland General Hospital.
- Moving to providing a comprehensive model of same day emergency care (SDEC) which has been evidenced to increase the proportion of acute admissions on day of attendance from one fifth to one third.
- Ensuring an enhanced frailty assessment service was in place so that those who do present to the department are assessed, treated and supported by skilled multidisciplinary teams delivering comprehensive geriatric assessments with a focus of returning the patient back to their place of residence as a preference to admission.

The objectives for the department were spread across a number of strategies. When asked about a strategy for the urgent and emergency care departments, senior managers told us that there a wider strategy for the medicine care group to identify priorities over the next 12 months was being developed. Each department was to develop a "plan on a page" that fed into this. We were told that this had been delayed since January 2021.

Senior managers told us that the main priorities would be to link into the integrated care system recovery strategy and to meet key performance indicators for emergency departments, such as four hour wait standards and ambulance turnaround times.

Culture

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

Consultants, doctors and other staff that we spoke to cited cultural differences with the speciality teams and did not feel supported by the executive team so that the issues could be resolved. Issues raised, were the reluctance of speciality teams to accept admissions in a timely way from the emergency department and the insistence of specialists to assess patients in the emergency department which blocked cubicles for much longer than acceptable and severely hindered the flow of patients through the department.

Senior managers told us that the culture and working relationship between the emergency department and wards and the acute medical unit was now far from where it had been, was more mature and with respect shown to colleagues and a higher quality of conversation between departments. However, this was not echoed by staff in the department.

Doctors were able to cite examples where speciality teams had initially accepted a patient and then later a speciality doctor would call to say the referral had not been accepted and that they would assess the patient in the emergency department.

Referrals were made to speciality teams by an electronic referral system rather than speaking to a speciality doctor and this was evidently not working well. We were told that the Emergency Care Admission Standard Operating Procedure, that had been signed off by the Medical Director, did not have full buy in from the specialities.

Doctors that we spoke to all said that they were very worried about patients being cared for on the corridor in the department.

Staff within the department reported that working through the pandemic had brought everyone closer and they had been well supported through a difficult time.

Doctors reported and we saw that they had a good working relationship with nursing staff and that managers in the department had an “open door” policy.

The trust had started a wellbeing ambassadors programme to have staff around the trust who could support staff wellbeing and offer coaching. There were 24 staff on the programme which included two staff from the Royal Lancaster Infirmary emergency department and one from Furness General Hospital emergency department.

Governance

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

There was no clear governance channel into the wider organisational management structure that oversaw the paediatric provision in the emergency department. At the triumvirate meeting we were not assured senior leaders had oversight of paediatric activity and performance in the emergency department. Senior leaders confirmed they did not attend any meetings relating to the paediatric provision and did not review any data activity. This meant they were unable to provide clarity of actions taken to address the paediatric RCEM audit results and the lack of paediatric emergency medicine consultant cover.

Similarly, there was a lack of oversight and effective risk and governance system for the stroke pathway.

Within the emergency department there was a weekly patient safety meeting to review incidents that were rated moderate or above to agree any requirements to record them as serious incidents and whether a root cause analysis investigation was required.

There was a monthly medicine care group governance and assurance group meeting attended by the matron, clinical lead and service manager from each department. This meeting covered a standard agenda following the assurance slide deck from each department. This included; incidents (numbers, types, trends, root causes and lessons learned); NICE guidance; cancer targets; risk registers and learning to improve.

Managers reported that it was often a challenge to get full attendance at these meetings.

Key messages from the governance meeting were reported to the care group board and in turn to the trust’s quality committee from which key message were reported to the trust board.

There were weekly medical leads meetings and a senior nursing group meeting where key messages were delivered from executive and board level and these were cascaded down to staff in the department through the learning to improve bulletin and daily huddles.

Immediately after the inspection CQC took enforcement action using our urgent powers whereby we imposed conditions under section 31 on the trust’s registration as people may or will be exposed to the risk of harm. These included: -

- the provider must implement an effective risk and governance system for the whole stroke pathway.
- the provider must operate an effective clinical escalation system to ensure stroke care and treatment is assessed and implemented in a timely way.
- the registered provider must implement an effective system to ensure that all clinical staff have the knowledge, competence, skills and experience to care for and provide treatment to patients presenting with symptoms of stroke.

The trust responded and has provided information on the immediate actions they had taken to mitigate the risks we had identified at the inspection. The trust has since produced a detailed action plan, focusing on the conditions of registration and will be providing regular reports to CQC on the actions taken to improve the quality and safety of services. CQC will continue to monitor these actions through our routine engagement.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. However, recent performance based on the outcomes of the Royal College of Emergency Medicine (RCEM) audits had not been measured as the trust had not submitted data for the last set of audit reports. They identified and escalated risks and issues and identified actions to reduce their impact though some specific risks had not been identified on the risk register and other risks remained the same as they were when we last inspected the service.

The medicine care group had a risk register. This was held on an electronic system and each risk was allocated to a named lead. There were some departmental level risks that had been amalgamated into a single risk for the care group where the risk was present in a number of departments or wards.

The risk matrix was based on the likelihood of the risk occurring and the severity of impact to give a red, amber or green rating. Controls and actions to mitigate the risk were also on each risk report.

There were two specific risks on the risk register relating to the emergency departments. These were: the urgent care access standards which identified that there was a significant impact on patient flow because of increased demand, acuity, including mental health, and wider pressure across the system in community, primary care and local authority.

The second identified risk was around mental health patients in acute settings where the concern was around insufficient service provision from the mental health trusts meaning that mental health patients were often cared for, for prolonged periods whilst awaiting transfer to an appropriate mental health setting and the significant impact on the operation of the department.

These two risks were on the risk register at the time of our last inspection in November 2018 with similar actions stated to mitigate the risks. There was little evidence of progress to mitigate the risks following the actions and controls identified, despite the risks being regularly reviewed.

We also identified at our last inspection that specific risks, such as the holding of patients in corridor areas had not been identified on the risk register, although managers were aware of the risk and it was of particular concern to medical staff in the department. The issue of holding patients in corridors remained in the department and it was still not specifically identified as a risk on the register and there appeared to be no mitigating action plan to reduce the number of times this was happening and the risks to patients. Similarly, the shortage of paediatric medical staffing was not identified as a risk.

The ward manager and matron completed a monthly ward assurance slide deck template that followed the subject headings of the "the five P's", patients; people; partnerships; progress and performance. The matron met with the associate director of nursing to review the document and agree actions for the following month.

Due to the pandemic the emergency departments had not submitted data for the 2019/2020 Royal College of Emergency Medicine (RCEM) national audits and there was a delay in uploading the data for the 2020/2021 audits. They had no measure of effectiveness in improving outcomes for these audits. FY1 doctors had recently been tasked to audit all standards for RCEM audits but this was only just underway.

Managers told us that there was now a consultant lead for audits in the emergency department and that they and the head of post-graduate training had delivered training to medical staff in paediatric resuscitation following on from the RCEM audit in paediatric resuscitation.

There was limited local audit activity; it was unclear what action had been taken as a result and how this information was shared with staff to improve performance. For example, there had been an audit into women of child-bearing age presenting with abdominal pain and the audit found that less than 50% of these women had been given an HCG pregnancy test.

Information Management

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

Data was collected to measure performance using several IT systems. Included in this were the time from arrival to treatment, overall time in the unit and outcome such as discharge, transferred or left without being seen and x-ray results.

The department had an electronic dashboard showing waiting times to be seen in the department on the trust internet site and outside the department, although the board outside was not working at the time of our inspection.

There was a secure electronic incident reporting system in place that could be used to analyse themes and trends in reported incidents to enable reviews and appropriate mitigating actions to be taken.

Staff had access to policies and procedures via the trust secure intranet although this was extremely slow in some locations.

Patient records were stored securely on an electronic patient record system.

Engagement

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

Urgent and emergency services

The department participated in the friends and family test and CQC urgent and emergency care patient experience surveys bi-annually. The latest CQC urgent and emergency care survey results were still embargoed at the time of our inspection but showed a high level of positive responses from participants about the care and treatment they received in the department. There were no questions where the results had significantly worsened since the last survey and three questions where the results had significantly improved.

Patients were able to leave a patient story voicemail about their experience on a dedicated line, though it is not clear how widely this was used.

A patient's daughter had helped the trust with an improvement campaign called "Imagine this was your mum" following a poor experience.

The trust had worked with John's Campaign to support carers to be able to attend the department with patients during the pandemic. Similarly, the family liaison team had supported the department to provide relevant information to families when they were unable to attend with patients.

The trust had been working with charities to improve support to veterans, many of whom suffer from mental health and MSK conditions.

The chief executive held forums for staff called "Tea and Talk" where any issues or concerns could be raised.

Some staff delivered a "topic of the month" and delivered training to colleagues and had notice boards dedicated to the topic in the staff room.

There was a range of communications to staff to advise them of changes and improvements, such as emails, staff huddles, an improvement newsletter and ward meetings for each grade.

Staff had also been involved in the proposed improvements to the department such as the dementia cubicle and paediatric waiting room.

There was a closed social media group for staff to share ideas for improvements.

Learning, continuous improvement and innovation

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

Staff in the department were committed to improving the facilities and environment for patients with dementia, mental health conditions and children.

Leaders were able to cite innovation and participation in research that the emergency departments had been involved in and of which they were proud.

These included:

Urgent and emergency services

The introduction of a pager system for patients with learning disabilities or autism so that they were able to remain in a car rather than in a busy waiting room before being seen.

Work in the department by the alcohol liaison team which was soon to expand to include drug liaison.

The frequent attenders team (HEAT) who had worked with mental health services, the ambulance service and CCG to ensure that care plans were in place for mental health patients who attended the service regularly to reduce the number of visits to the department and ensure these patients had support from more appropriate services put in place.

Doctors in the department had participated in Covid-19 research and screened patients into appropriate research trials. They were one of the lead recruiters into these clinical trials. This resulted in the trust getting an early vaccine trial and were one of only three centres to achieve this. They were also one of only two centres to recruit to the Remdesivir trial at the beginning of the pandemic.

Doctors had also been involved in developing Covid-19 testing in collaboration with the local university and had received two external funding awards to support this work.

Medical care (including older people's care)

Inspected but not rated

Is the service safe?

Inspected but not rated

Environment and equipment

The use of facilities, premises and equipment did not always keep people safe.

Since the last inspection, the acute stroke unit and stroke rehabilitation ward had combined to form Huggett Suite in the main hospital building. This had been beneficial for patients requiring repeated CT scans. The Huggett Suite had a rehabilitation area with specialist stroke and rehabilitation equipment.

However, there was no dedicated area on the ward to treat acute stroke patients who have been thrombolysed. Acute stroke patients were placed where there was space on the ward. Patients were not always admitted directly to a stroke unit; which was not in line with guidelines and best practice. There was no 'ring fencing' of stroke beds – using beds only for stroke patients.

We observed seven patients who had experienced a stroke not being cared for on Huggett Suite. Senior doctors stated the presence of stroke patients in outlying areas of the hospital meant that the consultants time was spread too thinly and thus the care was diluted putting patient care at risk.

The Sentinel Stoke National Audit Programme (SSNAP) data found the percentage of patients directly admitted to a stroke unit within four hours was 18% in January 2020 to March 2020. This was worse than the national average of 49%. Between October 2020 and December 2020 this had further deteriorated to 10%.

After our inspection the trust said two beds would be 'ring fenced' by 14 June 2021.

The service did not have enough suitable equipment to help staff to safely care for patients. The Huggett Suite was set up to provide care for six acute stroke patients who need continuous monitoring for 72 hours after thrombolysis. However, the monitoring equipment was limited to two units, this was insufficient in the event of having six acute stroke patients.

Assessing and responding to patient risk

Staff did not always manage and respond to patient risk to ensure patients experiencing symptoms of stroke are cared for in a safe and effective manner in line with National Guidance. Staff did not always identify and quickly act upon patients experiencing a stroke in a timely way.

Thrombolysis treatment should only be given where staff are thoroughly trained and experienced in the stroke thrombolysis. Trust guidance stated a final decision on stroke thrombolysis should be made by a stroke consultant. However, specific to this site the policy stated, 'the stroke nurse and the ED consultant make the decision unless the care is complex and the stroke consultant is contacted.'

Medical care (including older people's care)

Medical staff in the emergency department told us the stroke consultants would only be contacted if the stroke and thrombolysis was complicated. No guidance was provided on what would be classified as a complicated stroke.

Medical clinicians confirmed that medical staff in the emergency department (ED) were thrombolising independently and stroke consultants were often not contacted. We were also told that registrars were also thrombolising patients at night, again this was not always done with input from the stroke consultant.

We reviewed trust National Reporting and Learning System (NRLS) data for incidents between April 2020 and April 2021. This showed that there were 14 incidents resulting in harm due to delays in starting or giving thrombolysis.

Following the inspection, the trust completed further analysis of these incidents. They identified five of the incidents graded moderate or above were relevant to the stroke pathway and in two of these the patients died.

Stroke treatment is time critical and for this reason, ambulance staff pre alerted the hospital of incoming patients experiencing stroke symptoms so that the hospital was ready to receive and assess the patient in a timely manner. The Stroke specialist nurse would be called to attend the emergency department within the hours of 9am and 5pm seven days a week.

Triage for stroke patients was done by the ED consultant. During the hours of 5pm until 11pm there was one consultant in the department. Out of hours and in the evening, triage was undertaken by a registrar.

A key diagnostic procedure in the stroke pathway is an urgent CT scan to check for either a bleed or a blood clot in the brain. If a CT scan shows no evidence of a bleed, patients undergo further testing by way of a CT angiogram.

The Sentinel Stroke National Audit Programme (SSNAP) found the median time between arrival and having a CT scan was one hour and 27 minutes between October and December 2020. This was much worse than the national average of 51 minutes.

Trust NRLS data from April 2020 to April 2021 highlighted five delays in patients receiving CT scans to check for a bleed. A further seven patients had delays in CT Angiograms to check for a clot. Four of these led to delayed referrals to a thrombectomy service and some missed the thrombectomy window. There was a potential for patient harm due to these delays.

Further analysis by the trust of these incidents was provided following the inspection. This showed that for some of the patients thrombectomy was not indicated and that the outcomes for the patients was not affected. However, other incidents found the outcome could have been improved; other incidents were still being fully investigated.

A thrombectomy is a procedure to remove a blood clot. This is a specialist service and is not provided at every hospital. The procedure must be undertaken within six hours of a person experiencing a stroke. A thrombectomy service was not provided at this trust, patients identified as suitable for this treatment were transferred to another trust in the North West.

Staff did not always share all key information to identify and act in a timely way to diagnose stroke patients safely in line with national guidance. Radiographers stated the CT request forms did not always identify if the patient was for the thrombectomy or thrombolysis pathway. This would be an indicator to radiographers to perform an urgent CT and proceed to a CT Angiogram if no bleed was seen.

Emergency Department clinicians stated there were problems in getting referrals for CT angiogram, if there was no evidence of a bleed on the CT scan. After the Inspection, we were provided with an improvement plan, but it was unclear how delays in diagnostics would be improved.

Remote medical staff could not easily access patient records causing delays in decision making. The Telestroke system consisted of a two-way video and audio conference facility. Telestroke allows specialist on call stroke consultants to remotely access patients and view CT brain scan images across the network sites. The Telestroke consultant would be available to remotely assess the patient and provide decision making around thrombolysis.

The National Reporting and Learning System (NRLS) data for incidents between 2019 and 2021 included three incidents relating to delays in the Telestroke consultants receiving and reviewing CT Scans. This delayed decision making for patients requiring thrombolysis. Thrombolysis is a time limited treatment so delays in decision making could to cause harm to patients or prevent them getting the treatment in time.

Staff used a recognised tool in assessing and responding to patient deterioration in line with guidelines and best practice. In addition, the trust used a Stroke Thrombolysis Observation Complication Chart and NIHSS score assess stroke patients.

We reviewed four patient records and found that the relevant risk assessments, NIHSS Scores were found in three of the four records. NEWS scores were not completed fully in the first 24 hours in four out of four records. This meant that there was a risk that deteriorating patients would not be identified.

As part of our onsite inspection, we reviewed patient records and found delays in giving treatment for medications due to delays in completing the Dysphagia (difficulty swallowing) Screening Tests.

Nurse staffing

The service did not always have enough nursing and support staff with the right knowledge, competence, skills, and experience to keep stroke patients safe from avoidable harm and to provide the right care and treatment. Managers did not always adjust the numbers and skill mix of staff to match patients' needs.

The number of qualified nurses on Huggett Suite did not meet the British Association of Stroke Physicians (BASP) guidelines. In the first 72 hours following a stroke the nurse to patient ratio of 1:2 is recommended. The stroke service included provision for six acute beds and 14 rehab beds.

During the day the ward had four nurses and one sister in charge co-ordinating the ward (1:5 staff to patient ratio). At night there were three nurses. There were plans to change this to one sister in charge at night with two nurses to care for the patients (1:10 staff to patient ratio). This would not be sufficient to meet the guidelines and care for all 20 patients safely.

The ward used a staffing acuity tool (safe care acuity tool) in which the patients acuity scoring was measured against the safer nursing care evidence-based tool, reportable through "Safecare". The online Safecare highlighted any concerns around staffing levels. The clinical site manager and matron had the responsibility to ensure the ward had the correct numbers of staffing. However, we were unsure how this worked to reflect the additional staffing needed to care for acute stroke patients.

Medical care (including older people's care)

During the inspection staff told us they felt there were insufficient band six nursing sisters on the stroke unit to support more junior staff.

Mangers did not always adjust the numbers and skill mix to match the patients' needs. The ward manager and co-ordinator were used to help care for patients on the ward when acuity levels were high.

Medical staffing

The service did not have enough medical staff with the right knowledge, competence, skills, and experience to keep patients presenting with a stroke safe from avoidable harm and to provide the right care and treatment.

The service did not have enough Stroke Consultants to keep patients safe. The service had vacancy rates for two whole time equivalent stroke consultants.

The stroke service had one permanent stoke consultant and one locum consultant. The consultants led ward rounds five days a week as per the Royal College of Physicians Stroke Guidance (2016). However, this meant that if a consultant was on leave or sick, there may not be consultant cover even during weekdays.

Senior doctors did not always review patients in a timely way. The SSNAP data found, that between January 2020 and March 2020, 50% of patients were assessed by a stroke specialist consultant physician within 24 hours. This was worse than the national target of 84%. This further deteriorated to 36% between October 2020 and December 2020.

Nursing staff on the Acute Medical Unit stated there had been a recent incident regarding delays in stroke consultants reviewing stroke patients on the ward.

Trust NRLS data for incidents between April 2020 and April 2021 included five incidents related to delays in being seen by a stroke consultant which had the potential to cause harm to patients.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were not always clear and not always easily available to all staff providing care.

Patient notes were not always comprehensive and staff could not access them easily.

The provider had an electronic record system in place. The electronic records system included prescription charts, observation charts using the National Early Warning Score 2 (NEWS2), and nursing and medical documentation. The Acute Stroke – Medical and Emergency Guidelines (GEM/GUID/016) states stroke pathway should be commenced on the electronic patient record.

During inspection the patient records reviewed did not have evidence of observations and thorough documentation of the stroke patient in the first 24 hours.

We asked to see the observation charts to check if blood pressure management was being considered. The electronic patient records seen did not show the observations for the first 24 hours. Nursing staff stated the paper stroke pathway was started in the emergency department, instead of the electronic system. These paper notes were not always scanned into the electronic records.

Medical care (including older people's care)

Incidents

The service did not always manage patient safety incidents well. Staff recognised and reported incidents and near misses. Managers did not always ensure that actions from patient safety alerts were implemented and monitored.

Staff did not always rate reported incidents and near misses accurately in line with trust policy. From incidents reviewed between April 2020 and April 2021 we lacked assurance that incidents were always graded appropriately. An example being that a patient had a delay of 88 minutes between doing CT head and CT angiogram. This delay to imaging meant the patient missed the thrombectomy window. This incident was graded as no harm.

Following the inspection further details was provided in relation to this incident from the trust investigation. This stated the patient was not suitable for thrombectomy.

Staff met to discuss incidents and look at improvements to patient care.

The managers for stroke care met and discussed incidents and improvements plans for the SSNAP Meetings every month. The stroke consultant told us they were looking into delays in CT scans and ensuring stroke patients came to stroke beds. They were having a meeting with bed management the afternoon of the inspection to discuss stroke beds. There was an email trail discussing delays in CT scans but no formal action plan.

The stroke consultant informed us that mortality reviews for stroke were above average. Royal Lancaster Infirmary (RLI) worked cross site to review Furness General Hospital's (FGH) mortalities and provided feedback. FGH reviewed RLI's mortality reviews with feedback and shared learning cross site.

Between 1 April 2020 and 1 April 2021, we found evidence in the National Reporting and Learning System (NRLS) of 152 incidents related to stoke services. This evidence showed that patients were exposed to the risk of harm. However, the NRLS data examined did not always specify which hospital site the incidents related to.

Following the inspection, the trust completed further analysis of these incidents. They identified some were duplicates so the number of incidents was 111. Five of these were relevant to the stroke pathway and were graded moderate or above. Learning had been identified and action plans were in progress.

The NRLS data reviewed from April 2020 to April 2021 showed evidence of inappropriate treatment. There were six examples resulting in harm that had impacted the outcomes for the patient. Examples included an 'NG Tube, for feeding, inserted within 24hrs of receiving thrombolysis treatment. Also had catheter inserted due to retention. Both of these procedures and contra - indicated within 24 hours of thrombolysis treatment due to a risk of bleeding'. Inserting NG tubes and catheters within 24 hours of thrombolysis is not reflected in the local policy, but it is in national guidance

Is the service effective?

Inspected but not rated

Evidence-based care and treatment

Medical care (including older people's care)

The service did not always provide care and treatment based on national and local guidance and evidence-based practice. Managers did not check to make sure staff followed guidance and local policy did not always reflect best practice guidance.

The trust guidance, Acute Stroke Medical and Emergency Guidelines (GEM/GUID/016) stated; “final decision on stroke thrombolysis is made by a stroke consultant”.

The Operational Policy for Cumbria and Lancashire Telestroke Network (STROKE/POL/003) stated; “If decision to thrombolise, on-call Telestroke consultant, in consultation with local site clinician, will agree the dose and the “on call Telestroke consultant MUST stay on the video link until the bolus has been delivered and time recorded”.

Information provided to the onsite inspection team was that this policy was not always followed. Emergency department medical staff felt confident to thrombolise independently.

However, from reviewing documents we found that national guidance was not always reflected in local policy. For example, inserting nasogastric tubes and catheters within 24 hours of thrombolysis was not reflected in the trusts local policy, but is included in national guidance.

Nutrition and hydration

Staff did not always give patients enough food and drink to meet their needs and improve their health. Staff did not always assess swallowing abilities in a timely manner. They did not always use special feeding and hydration techniques when necessary.

The service had three whole time equivalent speech and language therapists dedicated to the Huggett’s Suite and stroke patients. Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. But the advice given was not always followed.

During inspection we found three incidents reported on the incident reporting system of patients being given wrongly prescribed thickness of food and fluid, no harm came to these patients. However, one similar incident reported on NRLS led to the patient having surgery to have the food bolus removed but was recorded as no harm.

Managers did not always share learning from incidents with their staff in a timely manner. We spoke with the ward manager, and they were unable to provide information on immediate actions taken to prevent these incidents happening again. However, we were told that monthly training would be implemented in June 2021. We were told one of the months would include training from speech and language therapists.

Staff were not always timely in starting artificial feeding when required for patients. The service did consider mental capacity assessment (MCA) and deprivation of liberty (DoLS) when artificial feeding was required. At inspection we observed a board round where MCA and DoLS was discussed regards feeding. NRLS data reviewed between April 2020 and April 2021 showed evidence of delays in artificial feeding which caused significant harm.

On the Huggett Suite, shift changes and handovers included necessary key information to keep patients safe. The multidisciplinary team discussed problems feeding patients which involved considering the Mental Capacity Act, Deprivation of Liberty Safeguards and best interests’ decisions.

The SSNAP data found between January and March 2020, that 50% of patients were given a swallow screen within four hours. This was worse than the national average of 73% nationally.

There were four incidents on the National Reporting and Learning System reviewed that included delays in assessing the stroke patients swallowing abilities. Two patients waited for over eight hours for a dysphagia screening test. One of the incidents stated the patient required a swallow assessment when they got to the Huggett Suite.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They did not always use the findings to make improvements and did not always achieve good outcomes for patients.

The service participated in relevant national clinical audits - the Sentinel Stroke National Audits Programme (SSNAP). The SSNAP is a major national healthcare quality improvement programme that measures the quality and organisation of stroke care in the NHS.

Outcomes for patients were poor, inconsistent and did not meet expectations, such as national standards. Audit data from SSNAP between January 2020 and March 2020 showed the trust were performing worse than the National average on 23 of the 44 key indicators (8 of the 10 domains). They were performing better on 6 of the key indicators compared to the national average. The remaining 15 key indicators were close to the national averages.

We reviewed data between and October 2020 and December 2020 which showed a further deterioration in 31 of the 44 key standards (8 of the 10 domains). The domains consist of;

1. Scanning
2. Stroke Unit
3. Thrombolysis
4. Special assessment
5. Occupational therapy
6. Physiotherapy
7. Speech and Language Therapy
8. Multidisciplinary Working
9. Standards by discharge
10. Discharge Processes

Therapy outcome measure were not always being measured effectively. Therapy staff on inspection stated that they have concerns around the recording of data.

Therapy staff stated that there was significant deconditioning for stroke patients when they were not cared for on Huggett Suite.

We lacked assurance that actions were being taken in a timely way to audit data. We were provided with an action plan, but this did not provide assurance that the required actions to improve would be implemented in a timely manner.

Medical care (including older people's care)

Competent staff

The service did not always make sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff across the provider were not always experienced, qualified and had the right skills and knowledge to meet the needs of the stroke patients.

Not all staff had the right qualifications, skills, and experience to care for stroke patients safely. This was particularly relevant for stroke patients not cared for on the stroke ward.

On the Huggett Suite, managers gave all new nursing staff an amended stroke competency workbook which consisted of 20 stroke specific competencies. However, managers could not provide compliance figures for specialist stroke nursing competence and skills.

Managers, on Huggett Suite, identified training needs for their nursing staff and had improvement projects taking place to provide opportunities to develop nursing staff skills and knowledge.

Managers supported nursing staff to develop through yearly appraisals of their work.

The ward manager of the Huggett Suite carried out yearly appraisals for nursing staff, these were at 79%. The manager had a structured plan in place to achieve 100% compliance.

There was a lack of clarity regarding formal training and assessment of competency to undertake thrombolysis.

The National Institutes of Health Stroke Scale (NIHSS) is a systematic assessment tool that provides a quantitative measure of stroke-related neurologic deficit. This assessment tool was part of the trust's electronic record system in the emergency department.

Training on this tool is mandatory, to be completed every two years, for;

- Band six nursing sisters on the stroke ward
- Stroke specialist nurses,
- Stroke consultants
- Emergency department consultants.

Information provided at the time of inspection showed that NIHSS training compliance for consultants and registrars in the emergency department was only 15%. It is not a mandatory requirement for associate specialists or registrars to undertake the training.

Managers did not always give all new staff and locum staff a full induction which included stroke management before they started work, this was particularly important as they were potentially managing thrombolysis independently.

We found variation in the competency assessment for medical staff in the insertion of nasogastric tubes. We also found a lack of training for nursing staff in the emergency department and the acute medical unit for the insertion of nasogastric tubes (NG) and dysphagia screening tests. This meant there were potential treatment delays for patients.

Medical care (including older people's care)

Not all junior doctors were trained in checking NG tube and fine bore feeding tube placement. However, there was evidence that nursing staff were confident in questioning the doctor's competency.

Multidisciplinary working

Doctors, nurses and other healthcare professionals on the Huggett suite worked well together as a team to benefit the patients on the ward but this was not always the case when considering the stroke outlier patients.

Nursing and medical staff said merging the wards had produced a closer-knit unit of staff.

Staff held regular multidisciplinary meetings to discuss stroke patients on the Huggett Suite.

Staff did not always discuss the specialist stroke care needs of outlier patients at multidisciplinary team meetings. This meant that stroke patients needing specialist stroke input may be missed or overlooked.

Managers and staff worked to make sure that they started discharge planning as early as possible. This was seen on the Huggett suite; the discharge coordinator attended the board rounds in the morning Mondays to Fridays where each patient was discussed including their discharge needs.

Seven-day services

Key services were not always available seven days a week to support timely patient care.

The service did not have the provision for thrombectomy services on site, if required they needed to refer to another NHS provider in the region. Thrombectomy services were only available between 8am and 5pm on a Monday to Friday. Due to the travel distance patients could only be referred up until 4pm. The treatment window for a thrombectomy is six hours from the time of the known onset of stroke symptoms.

Telestroke services were available overnight during weekdays, from 5pm until 8am, and 24 hours a day at the weekends. The service covered six trusts across Lancashire and Cumbria. Each Telestroke stroke consultant was expected to do on call cover roughly every 16 days.

The Acute Stroke – Medical and Emergency Guidelines (GEM/GUID/016) stated to only perform CT Angiogram if patient presents during hours when clot retrieval service is available at the other NHS provider. Patients that arrived overnight during the week, within the hours of 4pm and 2am, and over the weekends would not receive a CT Angiogram immediately. There was no provision for treatment for removal of clots, thrombectomy, during these hours.

The National Reporting and Learning System (NRLS) data for incidents in 2019 to 2021 included one patient that could not receive thrombectomy services at the weekend and caused significant harm.

Access to thrombectomy services is a known national problem. Stroke guidance states there are currently not enough trained doctors to be able to provide a 24 hour a day seven-day service. Specialist neuroscience centres, where thrombectomy procedures usually happen, are not evenly spread out across the UK.

Medical care (including older people's care)

The occupational therapy target for stroke patients is to receive 45 minutes of occupational therapy each day. SSNAP measures the compliance against an average of 26 minutes of occupational therapy. The service was averaging 48% of all patients receiving 26 minutes of occupational therapy. This was worse than the national average of 94%, from data between January 2020 and March 2020. In October 2020 and December 2020, this further deteriorated to 40%.

The service had a full requirement of staff for occupational therapy staff employed at the service.

The physiotherapy target is for stroke patients to receive 45 mins physiotherapy each day. SSNAP measures the compliance against an average of 27 minutes of physiotherapy. The service was averaging 43% of all patients receiving 27 minutes of physiotherapy, compared to 89% nationally during January 2020 and March 2020. In October 2020 and December 2020, this further deteriorated to 37%.

There were significant shortages in physiotherapy staff for the Huggett Suite, the service only had half the required number of physiotherapists in the stroke services. Physiotherapy could not always be provided for the required time and when there were significant outliers.

Speech and Language therapy target is for stroke patients to receive 45 mins speech and language therapy each day. SSNAP measures the compliance against an average of 16 minutes of Speech and Language therapy. The service was averaging 34% of all patients receiving 16 minutes of speech and language therapy, compared to 58% nationally during January 2020 and March 2020. In October 2020 and December 2020, this further deteriorated to 14%. There were no shortages in speech and language therapy staff for the Huggett Suite.

Is the service caring?

Insufficient evidence to rate

Is the service responsive?

Inspected but not rated

Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets for Transient Ischaemic Attack (TIA) clinics.

During the pandemic the service managed to review their waiting list for the TIA clinic and had no waiting list for outpatient TIA clinics. This ensured patient were seen in a timely manner.

The referral system was through the online electronic record used throughout the hospital, so it was quick and easy to refer patients.

Medical care (including older people's care)

The service moved patients off the stroke ward without a clear medical reason.

Managers did not have arrangements to minimise stroke patients on non-stroke wards and for medical staff to always review these stroke patients in a timely manner. We highlighted this to the trust at the time of inspection.

Is the service well-led?

Inspected but not rated

Leadership

Leaders within the stroke service had the skills and abilities to run the service. They understood but did not always have the support from senior leaders to manage the priorities and issues the service faced.

The stroke service did have clinical oversight and management within the team at Royal Lancaster Infirmary. The stroke services staff at local operational levels were aware of the challenges and were working hard, with limited resources and support from senior management, to make the service safe for patients.

Vision and Strategy

The vision and strategy for stroke care was not aligned across the trust.

We were told that the strategy for stroke care was dependent on wider discussions and decisions within the health economy and the Lancashire and South Cumbria Integrated Care system (ICS). The trust's CEO was the ICS lead for stroke services across the geographical area.

At the time of inspection, the stroke services at Furness General Hospital and the Royal Lancaster Infirmary operated independently and care pathways were not aligned. The actions on the stroke improvement plan were site specific and did not appear to be focused on aligning the services.

Governance

Leaders did not operate effective governance processes throughout the service and with partner organisations to ensure effective care and treatment of stroke patients. Staff at the local operational level were clear about their roles and accountabilities, however it was not shared with the senior management team. The local operational team had regular opportunities to meet and discuss the service but did not always share learning from the performance.

We found there was a lack of robust governance systems and processes for the stroke pathway.

When asked Senior leaders could not clearly articulate how risks were being managed.

It was not clear from the evidence reviewed and staff interviewed that there was a clear communication channel from the clinical teams involved in stroke care to the board. Staff including senior leaders, could not clearly articulate the governance framework for this.

Medical care (including older people's care)

Audit data from the Sentinel Stroke National Audit Programme (SSNAP) from January 2019 to December 2020 showed the trust were performing worse than the National average on a number of standards. The overall rating for this site, during this time period, had deteriorated from C to E. The domains related to thrombolysis and therapy input all had deteriorated to an E rating.

After the inspection, we requested the trust action plan in relation to the SSNAP audit data. We were provided with an improvement plan. This contained 167 'tasks' however it was unclear how these would be implemented, who had responsibility and what would evidence their impact. Several of the tasks also had long time frames for implementation. For example, ensure Thrombolysis pathway is utilised completed by 30 September 2021.

Immediately after the inspection CQC took enforcement action using our urgent powers whereby we imposed conditions under section 31 on the trust's registration as people may or will be exposed to the risk of harm. These included: -

- the provider must implement an effective risk and governance system for the whole stroke pathway.
- the provider must operate an effective clinical escalation system to ensure stroke care and treatment is assessed and implemented in a timely way.
- the registered provider must implement an effective system to ensure that all clinical staff have the knowledge, competence, skills and experience to care for and provide treatment to patients presenting with symptoms of stroke.

The trust responded and has provided information on the immediate actions they had taken to mitigate the risks we had identified at the inspection. The trust has since produced a detailed action plan, focusing on the conditions of registration and will be providing regular reports to CQC on the actions taken to improve the quality and safety of services. CQC will continue to monitor these actions through our routine engagement.

Management of issues, risk and performance

Leaders and teams did not use systems to manage performance effectively. They did not identify and escalate relevant risks and issues and did not identify actions to reduce their impact. They did not have plans to cope with unexpected events. They did not always grade incidents accurately.

Senior leaders could not clearly articulate how risks were being managed and identified; risks to patients on the stroke pathway were not recorded on the risk resister. The risk register supplied did not identify the risk, delays and potential harm to patients requiring care and treatment for stroke symptoms.

These concerns are further supported by information from the trust mortality review meetings for 2019/2020 which state "2% could have prevented death however we have concerns regarding true insight into incidents for 2019/2020. We have reviewed several incidents that are listed as no harm/low/moderate harm but have resulted in death".

From reviewing trust board papers between September 2020 and March 2021, there is little mention of stroke services and no information related to any risks associated with the service or incidences of patient harm or treatment delays. We were concerned that at a more senior level the stroke pathway and outcomes were not being addressed in a meaningful and timely way.

The local service leads were aware of the risks to the service and the actions required to mitigate and make improvements.

Surgery

Good

Is the service safe?

Good

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

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. However, mandatory training compliance was slightly below trust targets across all the training modules.

Mandatory training was delivered through e-learning modules with some face to face training modules. Training compliance was monitored on a monthly basis and line managers and individual staff members were notified when mandatory training was due or had expired.

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

The surgical services at this hospital had achieved the trust-wide training completion target of 95% for a range of topics, including conflict resolution, information governance, infection prevention and control, fire safety, health and safety, manual handling, hand hygiene. However, training compliance was slightly below the trust's 95% target for a number of topics, including medical gases awareness (85%), medicines management (89%), adults basic life support (86%) and paediatric basic life support (91%).

This showed most staff within the surgical services at this hospital had completed their mandatory training but the hospital's internal target of 95% training completion had not been achieved across all the training modules.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. However, the number of staff that had completed the higher level of children's safeguarding training did not meet trust targets.

The majority of staff in the surgical services at this hospital had completed mandatory training in the safeguarding of vulnerable adults and children. Records showed 100% of staff had completed children and adult safeguarding training (level 1) and 97% had completed children and adult safeguarding training (level 2). Staff compliance in adults safeguarding training (level 3) was 98%; however, the proportion of staff that had completed children's safeguarding training (level 3) was 77% and below the trust target of 95%.

The associate director of nursing reported level three training compliance was mainly below target because of low compliance among medical staff. Safeguarding training compliance was monitored at speciality level and care group level on a monthly basis and there was a plan in place for medical staff to complete their outstanding training over the next few months.

Surgery

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Information on how to report adult and children's safeguarding concerns was displayed on notice boards in the areas we inspected.

The trust had safeguarding policies available to support staff and these could be accessed on the trust intranet. Staff were aware of how they could seek advice and support from the trust-wide safeguarding team.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Staff worked effectively to prevent, identify and treat surgical site infections. There had been only one surgical site infection reported by the surgical services at this hospital during the past 12 months. Patients underwent infection screening (such as Covid-19 and MRSA) prior to admission to the wards.

The wards and theatres we inspected were clean and safe. Staff were aware of current infection prevention and control guidelines. Cleaning schedules were in place, and there were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.

There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. There were enough hand wash sinks and hand gels. We observed staff following hand hygiene and 'bare below the elbow' guidance. Staff and visitors were encouraged to wash their hands.

There was clear guidance displayed on how to minimises risk of spread of Covid-19 and we saw staff and patients adhere to social distancing guidelines across the ward and theatre areas. Staff were observed wearing personal protective equipment, such as gloves, aprons and visors while delivering care. Gowning procedures were adhered to in the theatre areas.

Patients identified with an infection were isolated in side rooms. We saw that appropriate signage was used to protect staff and patients. There were no patients identified with Covid-19 on the surgical wards during the inspection.

Staff told us cleanliness of the environment and equipment and hand hygiene compliance was monitored as part of routine monthly ward audits and the monthly matron's assurance audits. Staff also told us they could also seek advice and support from the trust-wide infection prevention and control team if required.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

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

Surgery

We found that whilst the patient areas in the surgical assessment unit were clean and well maintained, the treatment room was worn, aged and appeared untidy with scuff marks on the walls and visible mould around the hand wash sink. We raised this with ward staff during the inspection and the associate director of nursing reported the treatment room had undergone a deep clean and repainting of walls following the inspection.

Access to most surgical wards was secure and the theatre areas required key code access. The associate director of nursing reported the main doors in surgical assessment unit could not be locked. This had been identified as a security risk and there were plans to implement key-code access locks in the unit within the next two months.

The environment and equipment in the theatre areas was well maintained; however, we found the storage areas were cluttered. Staff reported there was a shortage of storage space; however, there was a suitable system in place for safe storage of consumables and surgical implants.

All the ward areas had sufficient shower and bathing facilities. The majority of side rooms had ensuite toilet facilities. The ward areas were free from clutter and we saw that equipment and consumable items were stored appropriately.

Staff told us equipment was routinely checked and cleaned in between use. The majority of equipment (such as hoists and blood pressure monitoring machines) we saw were visibly clean and had service stickers displayed and these were within date. Single-use, sterile instruments and consumable items were stored appropriately and were within their expiry dates.

Staff told us equipment needed for care and treatment was readily available and any faulty equipment could be replaced promptly. Ward staff also told us they did not have any difficulty obtaining specialist equipment, such as for pressure care or equipment for larger patients. Equipment was serviced by the trust's maintenance team under a planned preventive maintenance schedule. Staff told us they received good and timely support if a fault was reported.

Emergency resuscitation equipment was available in all the areas we inspected and this was checked on a daily basis by staff. We saw that daily and weekly equipment check logs were complete and up to date in the areas we inspected.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

On admission to the surgical wards and before surgery, staff carried out risk assessments to identify patients at risk of harm. Patient records included risk assessments such as for venous thromboembolism (VTE – blood clots), pressure ulcers, nutritional needs, risk of falls and infection control risks.

Patients at high risk were placed on care pathways and care plans were put in place so they received the right level of care. Staff carried out 'intentional rounding' observations at least every four hours so any changes to the patient's medical condition could be promptly identified. Patient records we looked at showed that patients were reviewed regularly and escalated appropriately when required.

Staff used national early warning score systems (NEWS2) and carried out routine monitoring based on patients' individual needs to ensure any changes to their medical condition could be promptly identified.

Surgery

A monthly early warning score audit was completed across the surgical specialties to assess compliance against trust policies and National Institute for Health and Care Excellence (NICE) standard CG50 (Acutely ill adults in hospital: recognising and responding to deterioration). The audit showed the general surgery directorate achieved overall compliance of 95% between May 2020 and April 2021, based on a sample of 45 patient records.

Staff followed appropriate guidelines, pathways and screening tools, based on national guidelines for the management of patients with sepsis. Staff we spoke with understood how to identify the signs of sepsis and management of sepsis in line with national guidelines. There was a monthly audit of all patients screened for sepsis to monitor outcomes and staff compliance. There had been 14 patients identified with sepsis in the surgical wards at this hospital during February 2021 and March 2021. The sepsis audit showed these patients received appropriate care and treatment. Patient records we looked at also showed clinical pathways were followed by staff in the identification and treatment of patients identified with sepsis.

The surgical wards had a similar layout with three bay areas in each ward that allowed clear lines of sight to patients. Staff told us high risk patients could be placed in bays close to the nurse's station to aid observation. A number of wards had also introduced 'bay tagging' where a dedicated nurse was allocated to a bay area with cover from another nurse or healthcare assistant during their breaks.

We observed three theatre teams undertaking the 'five steps to safer surgery' procedures, including the use of the World Health Organization (WHO) checklist. The theatre staff completed safety checks before, during and after surgery and demonstrated a good understanding of the 'five steps to safer surgery' procedures.

There was a monthly audit to check staff compliance against the safer surgery checklist across the theatre areas. This included an observational audit to observe staff practice based on 10 audit standards (including staff participation in the brief, sign in, time out phases). The monthly audit results for the period between May 2020 and April 2021 showed high levels of staff compliance in the use of the checklist and the theatre teams at this hospital consistently achieved 100% compliance throughout this period.

Nurse Staffing

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

The service had enough nursing and support staff to keep patients safe. The ward manager could adjust staffing levels daily according to the needs of patients. The number of nurses and healthcare assistants matched the planned numbers.

We reported nurse staffing fill rates were below establishment during our previous inspection in November 2018. We found improvement shad been made during this inspection.

The nurse and care staff levels on the wards were either at or near to full establishment. There were minimal vacancies across the wards we inspected. Staff told us they did not routinely use agency staff and cover for sickness or unplanned absence was provided by bank staff or through the existing staff working additional hours.

Surgery

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Ward managers told us staffing levels were based on the dependency of patients and this was reviewed daily. We saw that additional care support staff could be allocated to patients with greater dependency following their surgery to allow 1:1 care across the surgical wards.

The theatre staff at this hospital were overseen by the matron for theatres. The theatre staffing was to full establishment with no vacant posts. Operating theatres were staffed with sufficient numbers of staff, in line with national guidelines, such as the association of perioperative practice (AfPP).

The surgical services also had a number of advanced nurse practitioners in place to support the surgical specialties such as for urology.

Nursing staff handovers took place during daily shift changes and these included discussions about patient needs and any staffing or capacity issues. Ward staff used the situation-background-assessment-recommendation (SBAR) tool during handovers.

The associate director of nursing told us they had recently started to review the current nursing staff establishment to determine whether this was sufficient for the surgical services going forward, in line with the trust's nursing recruitment strategy 2021 and workforce plan 2021/22.

Medical Staffing

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

The service had enough medical staff to keep patients safe. The medical staff matched the planned number. There were separate medical rotas in place to cover specific specialties, such as for colorectal surgery, urology and trauma and orthopaedics. There was at least on junior doctor, middle grade and consultant on call for each specialty 24 hours per day.

We reported medical staffing fill rates were below establishment during our previous inspection in November 2018. We found improvement shad been made during this inspection.

There was sufficient on-site and on-call consultant cover over a 24-hour period including cover outside of normal working hours and at weekends. Consultants operated a 24 hour on-call rota during weekdays and a separate on-call rota for weekends. This allowed for onsite consultant presence during normal working hours across seven days and daily consultant-led ward rounds took place across the surgical wards seven days per week. The same consultant provided on site and on call cover during weekdays to provide continuity of care.

The trauma and orthopaedic wards were also supported by an ortho-geriatrician during weekdays. The ortho-geriatrician also carried out daily reviews of patients. The ward staff and junior doctors spoke positively about the support they received from the ortho-geriatrician.

Junior doctors were based on wards depending on their surgical specialty areas. The hospital operated a number of mixed-specialty wards. The medical staff had daily access to patient lists and ward staff told us patients were seen by their specialty consultants and doctors on a daily basis, including on weekends.

Surgery

The proportion of junior and middle grade doctors was either at or near full establishment at the time of the inspection. There were three whole time equivalent surgical consultant vacancies in the colorectal and urology specialties and these posts were covered by local consultants.

Where locum doctors were used, they underwent recruitment checks and induction training to ensure they understood the hospital's policies and procedures. The clinical director told us that the majority of locum doctors had worked at the hospital on extended contracts so they were familiar with the hospital's policies and procedures.

The junior doctors we spoke with told us they received good support and could easily access middle grade or consultant support if needed. The medical staff we spoke with told us the workload was manageable and they were able to provide timely care and treatment during busy periods. The ward and theatre staff told us they received good support from the consultants and ward-based doctors.

Daily medical handovers took place during shift changes and these included discussions about specific patient needs.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive and all staff could access them easily. Records were stored securely. Staff used electronic patient records for recording risk assessments, care plans and for medical and nursing notes, care plans and patient assessments. When patients transferred to a new team, there were no delays in staff accessing their records.

Paper patient records were used for standardised nursing activities, such as daily observations and nutritional care and these were kept at each patient's bed side. Observations were well recorded and the observation times were dependent on the level of care needed by the patient.

We looked at the records for 33 patients. These were structured, legible, complete and up to date. Patient records showed that nursing and clinical assessments were carried out before; during and after surgery and that these were documented correctly. Patient risk assessments were reviewed and updated on a regular basis. We found that patient's care plans were person-centred and were completed to a good standard. Multidisciplinary staff interventions were recorded in daily notes and these were up to date.

Patient records were checked for accuracy and completeness as part of routine audits, such as the matron's assurance monthly audit.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Staff carried out daily checks on controlled drugs and medicine stocks to ensure that medicines were reconciled correctly. We looked at a sample of controlled drugs and found the stock levels were correct, and the controlled drug registers were completed correctly.

Surgery

We saw that medicines that required storage at temperatures between 2ºC and 8ºC were appropriately stored in medicine fridges. Fridge temperature logs showed that these were checked daily and the medicines we checked were stored at the correct temperatures. Log sheets also showed that staff monitored the temperature of the clinic rooms in the surgical wards and theatres on a daily basis.

There was a system in place for staff to notify the maintenance team and the pharmacy department where medicine fridge or treatment room temperatures exceeded the maximum temperature range.

The Trust used an electronic prescribing and medicines administration recording system. We looked at the medicine administration records for seven patients. These showed patients were given their medicines in a timely way, as prescribed, and records were completed appropriately with few errors or omissions. The electronic records included allergies information and entries where patients refused their medicines. The medicine records also flagged when medicines were due to be given and showed oxygen was prescribed and appropriately documented.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Staff followed current national practice to check patients had the correct medicines. A pharmacist reviewed all medical prescriptions, including antimicrobial prescriptions, to identify and minimise the incidence of prescribing errors. The ward staff we spoke with confirmed a pharmacist carried out daily reviews either on the wards or remotely by reviewing the electronic records.

The surgical wards were supported by two medicine administration pharmacy assessments during weekdays. Their role was to support nursing staff by administering patient medicines (excluding injectables and controlled drugs), checking medicine stocks and maintaining cleanliness of medicine storage and treatment rooms. There were two pharmacy technicians in post supporting the surgical wards with two vacant posts that were currently being recruited to. The nursing staff carried out these duties on the weekends and on the wards with no pharmacy technician support.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff were aware of the process for reporting any identified risks to staff, patients and visitors. All incidents, accidents and near misses were logged on the trust-wide electronic incident reporting system.

Routine incidents logged on the system were reviewed and investigated by ward managers to look for improvements to the service. Serious incidents were investigated by a multidisciplinary team of trained staff with the appropriate level of seniority, such as the senior nurses, clinical leads and matrons.

Staff carried out weekly and monthly reviews of incidents at specialty level and care group level to look for trends and to improve practice and the service to patients. Staff told us they received verbal feedback about incidents reported. Incidents were discussed during daily ‘safety huddles’ and routine staff meetings so shared learning could take place. Learning from incidents was also shared through hospital-wide alerts and newsletters.

Surgery

There had been one never event in relation to the surgical services at this hospital during the past 12 months. Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each Never Event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event.

The never event occurred in January 2021, in relation to wrong site surgery where a patient was consented for a right sided bone anchoring hearing aid (BAHA) attract was placed on the wrong ear.

The patient underwent revision surgery to rectify the error and the root cause investigation was on-going at the time of the inspection. The incident had been shared with theatre staff to raise awareness and aid their learning and we saw there was an increased focus from the theatre teams around compliance with the five steps to safer surgery. The services had also launched the '10,000 feet' initiative in April 2021 that aimed to improve team efficiency and imbed a patient safety culture.

The governance business partner reported there had been 39 serious incidents reported by the critical care and surgery care group across the trust during the past 12 months. This included 12 surgical incidents, 12 diagnostic incidents, seven treatment delays, four slips, trips and falls, two instances of suboptimal care of the deteriorating patient, one medicines incident and one pressure ulcer incident.

Staff across all disciplines were aware of their responsibilities regarding duty of candour legislation. Staff compliance against duty of candour standards was reported by each surgical specialty on a monthly basis and records for March 2021 showed 100% compliance had been reported. 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.

Patient deaths were reviewed by individual consultants within their specialty area. These were also presented and reviewed at monthly audit and mortality meetings within each specialty department. We looked recent meeting minutes for the urology and trauma and orthopaedics specialties. These showed patient deaths were reviewed and discussed to identify good practice learning through improvement actions. Complex patient death cases were also escalated to the trust-wide Mortality Review Group (MRG) for review.

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Information relating to patient safety, such as pressure ulcers and infections was displayed in notice boards in the ward and theatre areas we inspected.

Patient safety incidents were monitored and reviewed as part of monthly surgical speciality level meetings and surgical care group meetings.

Is the service effective?

Good 

Surgery

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

Evidence-based care and treatment

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

Staff followed clinical guidelines and pathways that were based on national guidance, such as from The National Institute for Health and Care Excellence (*NICE*) and the Royal Colleges' standards.

We reviewed care pathways for a number of surgical procedures, including colorectal surgery, general (gastro-intestinal) surgery, knee replacement and neck of femur (hip) surgery and found these were based on best practice guidance. The services also used a number of enhanced care and recover pathways in areas such as elective orthopaedic surgery. Enhanced recovery is an evidence-based approach to delivering care in a way that promotes a better surgical journey for the patient and delivers a quicker recovery.

The surgical services participated in both national and local clinical audits. The surgical specialties at this hospital were involved in 44 national and local clinical audits during the past 12 months and 15 of these had been completed to date, with the remaining audits at various stages of progress.

Findings from clinical audits were reviewed during monthly surgical specialty group audit meetings and any changes to guidance and the impact that it would have on their practice was discussed.

Staff told us policies and procedures reflected current guidelines and were easily accessible through the trust's intranet. We looked at a selection of the policies, procedures and care pathways and these were up to date and based on current national guidelines.

Staff used specific care plans when providing care and treatment for patients with mental ill health, which included additional measures such as enhanced monitoring and supervision. Staff could also seek support and advice from the trust-wide safeguarding team and mental health liaison teams when providing care for these patients.

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff used the *Malnutrition* Universal Screening Tool (*MUST*).Where patients were identified as at risk, staff fully and accurately completed patients' fluid and nutrition charts where needed.

Specialist support from staff such as dietitians was available for patients who needed it. The records we looked at showed that there was regular dietitian involvement with patients that were identified as being at risk. Patients with specific dietary needs (such as diabetic patients) were identified and routinely monitored by staff.

Patients with difficulties eating and drinking were placed on special diets and staff told us patients could also be provided with finger foods and snacks. Patients told us they were offered a choice of food and drink and spoke positively about the quality of the food offered. Patients ordered their meals electronically and optional menus were available for patients with specific requirements. We observed that protected meal times were in place and saw patients being supported to eat and drink. Drinks were readily available and were in easy reach of patients.

A monthly MUST compliance audit was carried out across the surgical wards. The audit results for October 2020 to March 2021 showed high levels of staff compliance.

Staff compliance against nutrition and hydration standards was also monitored as part of the monthly matron's assurance audit. The monthly surgery fluid balance audit results for October 2020 to March 2021 showed overall staff compliance of 91% across the surgical wards at this hospital. We looked at fluid balance charts for five patients and found staff had completed fluid input, output and cumulative totals correctly.

Pain Relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff assessed patient's pain using either a universal pain assessment tool for patients that were able to communicate or the Abbey Pain Score for patients who were unable to clearly articulate their needs. Acute pain symptoms were managed by the surgical consultants.

Pain scores were recorded electronically. Staff prescribed, administered and recorded pain relief accurately. The patient records we looked at showed that patients received the required pain relief and that they were treated in a way that met their needs and reduced discomfort.

Patients received pain relief soon after requesting it. Patients told us staff gave them pain relief medicines when needed and their pain symptoms were managed appropriately.

Patient Outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for most patients. Whilst most clinical audit outcomes were comparable to expected national standards, the service performed worse than expected for patient length of stay in the national hip fracture audit 2019 and the national bowel cancer audit 2020.

Hospital episode statistics (HES) data showed urology and general surgery patients at this hospital had a lower than expected risk of readmission for elective and non-elective admissions when compared to the England average between November 2019 and October 2020. However, the elective colorectal surgery and non-elective trauma and orthopaedics patients had a higher than expected risk of readmission for elective admissions when compared to the England average.

Surgery

The clinical director and surgical speciality audit leads told us they did not have any specific concerns in relation to patient readmissions and the untoward readmission rates may be due to data quality or coding issues in relation to the reporting of patient readmission rates due to the inclusion of planned re-attendances being included in the data (such as patients attending the surgical ambulatory unit for routine follow-up appointments after discharge.

The national hip fracture audit 2019 showed this hospital performed worse than the England and Wales average for five of the six indicators. The clinical audit lead for trauma and orthopaedics told us most patients undergoing hip fracture surgery experienced positive outcomes but the hospital's audit performance was impacted by access and flow issues that impacted on the audit indicators relating to time to surgery and post-operative patient length of stay.

The national bowel cancer audit of 2020 showed that the trust performed worse than the national average for post-operative length of stay greater than five days after major resection. The trust performed within the expected range for the audit indicators relating to operative mortality rate, unplanned readmission rate and temporary stoma rate.

The national emergency laparotomy audit (NELA) 2018 showed this hospital achieved the national standard (85%) and performed within the expected range for all six audit indicators. The national oesophago-gastric cancer audit 2018 also showed the trust performed within the expected range for all eligible audit indicators.

The clinical audit leads told us audit outcomes were monitored as part of the monthly surgical speciality audit meetings to look for improvements to the service.

Competent Staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. However, the number of staff that had completed their appraisals did not meet trust targets.

Staff told us they routinely received regular supervision and annual appraisals. Appraisal completion rates at this hospital were 73% for the ward and theatre staff and 68% for medical staff. This showed most staff had completed their appraisals but the trust target of 95% for staff appraisal completion had not been achieved.

Newly appointed staff had an induction and their competency was assessed before working unsupervised. Bank and locum staff also had inductions before starting work.

Most staff we spoke with told us they routinely received competency-based training in their specialty area and felt confident to do their role. Junior nursing and medical staff we spoke with were positive about on-the-job learning and development opportunities and told us they were supported well by their line management. Staff told us they had routine weekly training sessions and were supported to attend these.

Ward staff received competency based training and assessments (such as use of equipment, taking bloods, cannulation, and line insertion) through a central hospital-wide team. The surgical wards did not have a practice based educator in place at the time of the inspection. The post was vacant at this hospital due to long-term sickness and a senior nurse had recently been appointed to fulfil this role on a part-time basis.

Junior nursing and medical staff we spoke with were positive about on-the-job learning and development opportunities and told us they were supported well by their line management.

Surgery

The surgical services had recently recruited a number of newly qualified and international nurses on the surgical wards. This had an impact on the skill mix across the wards as not all newly recruited staff had fully completed their competency based training. The ward managers or other senior ward staff provided additional support for newly recruited staff.

The surgical wards had moved to mixed-specialty wards during the Covid-19 pandemic, most staff we spoke with told us they were comfortable working within mixed-specialty patient wards and had received additional ward-based training (such as for urology patients). They told us they also received sufficient support from staff from other surgical wards with the relevant experience in that specialty area when required.

Multidisciplinary working

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

There was effective daily communication between multidisciplinary teams within the surgical wards and theatres. Staff handover meetings took place during shift changes and 'safety huddles' were carried out on a daily basis to ensure all staff had up-to-date information about risks and concerns.

The ward staff told us they had a good relationship with consultants and ward-based doctors. We saw there was effective team working and communication between the theatre teams.

Staff worked across health care disciplines and with other agencies when required to care for patients. Specialty multidisciplinary (MDT) meetings took place on a weekly basis with input from medical and nursing staff as well as staff from other hospitals within the trust or external hospitals where patients received care and treatment from more than one healthcare organisation.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. The patient records we looked at showed there was routine input from nursing and medical staff and allied health professionals.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression.

The ward and theatre staff told us they received good support from pharmacists, dietitians, physiotherapists, occupational therapists as well as diagnostic support such as for x-rays and scans.

Seven-day services

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

Staff rotas showed that nursing staff levels were sufficiently maintained outside normal working hours and at weekends.

There was sufficient out-of-hours medical cover provided to patients in the surgical wards by junior and middle grade doctors as well as on-site and on-call consultant cover. There was on-site consultant presence across most surgical specialties on weekends along with on-call cover and consultant-led ward rounds took place seven days per week.

There was a 24-hour service with dedicated emergency and trauma theatres so any patients admitted over the weekend that required emergency surgery could be operated on promptly.

Microbiology, physiotherapy, occupational therapy and pharmacy support was available on call outside of normal working hours and at weekends. Imaging (such as x-rays) was available 24 hours, 7 days a week.

The trust pharmacy was open for supply of medicines from 9am to 5pm on Saturday and Sunday.

The ward and theatre staff told us they received good support outside normal working hours and at weekends.

Health Promotion

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

The surgical wards had health promotion information displayed on notice boards and in information leaflets that were readily available for patients. There was signage and posters in place promoting safe hand hygiene practices and side rooms had appropriate signage to make staff and patients aware of any potential risks.

Health promotion was included as part of the pre-operative admission and ward admission. Patients identified with weight concerns were referred to dietitians for advice and support. Patients with addiction to alcohol and drugs were offered treatment and provided with support from specialist hospital-wide liaison teams.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty. Whilst best interest decision meetings routinely took place and were documented, staff did not always record who had been involved in the best interest decisions.

Staff understood how to obtain informed verbal and written consent from patients before providing care or treatment. Patient records we looked at showed that patient consent had been obtained and that planned care was delivered with their agreement. Staff told us the risks and benefits of the specified surgical procedure were documented and explained to the patient.

Staff understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Mental Capacity Act and Deprivation of Liberty training was incorporated into the adult safeguarding (level 3) training.

A range of multidisciplinary staff were trained to carry mental capacity assessments (such as nurses and medical staff), in order to determine if a patient had the capacity to make their own decisions. The patient records we looked at showed capacity assessments were completed, up to date and were repeated if further clinical decisions were required during the patient's stay.

We looked at four patient records where a Deprivation of Liberty Safeguards (DoLS) application had been made and the records for this had been completed correctly. Staff told us they periodically reassessed patients under DoLS (such as when an urgent DoLS authorisation had gone beyond seven days) to determine whether they were still valid and relevant for that patient.

Surgery

If patients lacked the capacity to make their own decisions, staff told us they sought consent from an appropriate person that could legally make decisions on the patient's behalf. Where this was not possible, staff told us they made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals.

We saw evidence of best interest meetings and decisions documented in four patient records. The best interest decision records we looked at clearly documented who had completed the meeting record and the outcome decision. However, staff did not always record who had been involved in the best interest meeting, such as other staff or patients and their representatives.

There was a trust-wide safeguarding team that provided support and guidance for staff for mental capacity assessments, best interest meetings and Deprivation of Liberty Safeguards applications.

Is the service caring?

Good 

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

Compassionate Care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw that patients were treated with dignity, compassion and empathy.

Staff followed policy to keep patient care and treatment confidential. Patients' bed curtains were drawn when providing care and treatment and we saw nursing and surgical staff spoke with patients in private to maintain confidentiality. Patients could also be transferred to side rooms to provide privacy and to respect their dignity.

Patients transferred between the ward and theatre areas were given dressing gowns and their dignity was maintained. Patients calling for assistance and call bells were answered in a timely manner across the wards we visited.

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

Patients said staff treated them well and with kindness. We spoke with 12 patients during the inspection. They all told us they thought staff were friendly and caring and gave us positive feedback about ways in which staff showed them respect and ensured that their dignity was maintained. The comments received included: "'staff are nice, come quickly when I need them, 'staff have been very good, very friendly' and 'the staff have been excellent, extremely caring both day and night'.

Surgery

The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. The test data between October 2020 and April 2021 showed the surgical wards at this hospital achieved an overall satisfaction score of 94% (based on a response rate of 24%). This indicated the majority of patients were positive about recommending the hospital's surgical wards to friends and family.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. We observed staff providing reassurance and comfort to patients.

Patients told us they were supported with their emotional needs and were able to voice any concerns or anxieties. Patients told us the staff were calm and reassuring. Two of the patients we spoke told us they expressed anxiety when they were admitted to the surgical wards and the nurses and consultants had been reassuring and helped to calm them.

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

Patients or their relatives could be referred for access to counselling and psychological support if required. A multi-faith chaplaincy service was available for spiritual or religious support to patients of all faiths and beliefs. Staff told us they could contact the hospital's palliative (end of life care) team for support and advice during bereavement.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. We observed staff speaking with patients clearly in a way they could understand.

Staff supported patients to make informed decisions about their care. Patients told us the nursing and medical staff fully explained the care and treatment options to them and allowed them to make informed decisions. Patient comments included "I was kept informed while awaiting blood test results' and 'everything has been fully explained, communication has been very good'.

The trust had restricted visiting due to the Covid-19 pandemic; however staff told us they routinely discussed patients' care with their relatives. Patients could keep in contact with their relatives through the use of bedside phone and entertainment units and staff told us they could provide tablet computers for patients who wished to carry out video calls with their relatives.

Surgery

Is the service responsive?

Requires Improvement ➔➔

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

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care. The average length of stay for patients having trauma and orthopaedics surgery was worse than national averages.

Managers planned and organised services so they met the needs of the local population. There were daily meetings with the bed management team so patient flow could be monitored and maintained and to identify and resolve any issues relating to the admission or discharge of patients. Staff were aware of how to escalate key risks that could affect staffing and bed capacity constraints and there was daily involvement by the matron and ward managers to address these risks.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The areas we inspected were compliant with same-sex accommodation guidelines: we observed that male patients were cared for in separate areas to female patients.

The hospital provided a range of elective and unplanned surgical services for the communities it served. This included, trauma and orthopaedics, maxilla-facial surgery, ear, nose and throat (ENT) surgery, ophthalmology, urology and general surgery. There were arrangements in place with neighbouring hospitals to allow the transfer of patients for surgical specialties not provided by the hospital, such as cardiothoracic surgery and vascular surgery.

The surgical emergency ambulatory care (*SEAC*) unit was located in the acute surgical unit (ASU). The SEAC had 19 chairs with 12 available due to social distancing and was staffed by a care support worker supported by a nurse. The ambulatory care unit operated during routine hours on weekdays and patients were transferred to an inpatient ward if they required overnight stay. The unit accepted 'fit to sit' designated patients through direct GP referral as well as patients attending follow ups, scans and blood results. Staff on the SEAC felt the unit was effective in reducing unnecessary admissions.

The surgical wards operated a colour-coded Covid-19 designation. Ward 33 (elective surgery ward) was designated as a green (Covid-19 free) ward. Patients underwent Covid-19 screening and testing prior to admission to this ward. The remaining wards were designated as amber wards, which meant patient with Covid-19 could be admitted. The associate director of operations told us the Covid-19 ward designation was routinely reviewed and ward designations could be changed depending on patient admissions with Covid-19.

The surgical wards had moved to mixed-specialty wards during the Covid-19 pandemic, which meant staff on a ward provided care and treatment for patients from other surgical specialties (such as general surgery and urology patients on the trauma and orthopaedic ward).

The associate director of operations told us they planned to undertake a review of the surgical wards as part of the post-pandemic recovery plan to determine the most appropriate use of the surgical wards going forward.

Surgery

The hospital had five operating theatres for surgery that were located in the main theatre areas and in the same building as the surgical wards. The hospital previously had two additional day case theatres located at another part of the hospital, but these had been transferred to one of the trust's other hospitals.

There was an emergency general surgery and trauma theatre that was staffed 24-hours, seven day per week so that patients requiring emergency surgery during out of hours and weekends could be operated on promptly.

Meeting people's individual needs

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

The service had information leaflets available in languages spoken by the patients and local community. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Staff could access appropriate equipment, such as specialist commodes, beds or chairs to support the moving and handling of bariatric patients (patients with obesity) admitted to the surgical wards and theatres.

Staff used specific care plans when providing care and treatment for patients with a learning disability or those living with dementia. We saw evidence of these care plans in use in the records we looked at and they included reasonable adjustments and additional support and advice for patients and their carers.

Staff also used a 'traffic light' passport document for patients admitted to the hospital with dementia or a learning disability. Staff could contact the trust-wide safeguarding team for advice and support for caring for patients living with dementia or a learning disability.

Access and Flow

People could not always access the service when they needed it or receive the right care promptly. The service performed worse than national standards for waiting times from referral to treatment. The average length of stay for patients having trauma and orthopaedics surgery was worse than national average. Whilst the services had plans in place to improve this, these measures had not been fully implemented and had not yet led to any significant improvement in the services.

Patients could be admitted for surgical treatments through a number of routes, such as pre-planned day surgery, through accident and emergency or through GP referral. Patient records showed that patients were assessed upon admission to the wards or prior to undergoing surgery.

During the inspection, we did not observe any significant concerns relating to patient access and flow. The environment in the wards and theatres appeared calm and relaxed and we found a number of beds were empty during the days of the inspection. However, we saw some patients on the trauma and orthopaedic ward had experienced extensive length of stay, for example there was one patient that had been on this ward for over a month.

From December 2019 to November 2020, the average length of stay for patients having elective and non-elective surgery at this hospital was better than the England average across all surgical specialties except trauma and orthopaedics.

Surgery

The average length of stay for patients having non-elective trauma and orthopaedics surgery at this hospital was 8.9 days. The average for England was 7.7 days. The average length of stay for patients having elective Trauma and orthopaedics surgery at this hospital was 4.7 days. The average for England was 3.4 days.

Staff on the trauma and orthopaedic wards told us the patient length of stay was impacted by elderly hip fracture patients that were awaiting a community or nursing home care placement. The surgical wards had length of stay meetings twice a week to review patient discharge arrangements and ward staff were supported by the complex discharge team.

A report submitted to the trust wide Quality Committee in February 2021 in relation to trauma and orthopaedics length of stay identified planned remedial actions such a review of the clinical operating model and care pathways to identify areas for improvement and to work with physiotherapy leads, trauma leads and trauma co-ordinators to explore areas for further improvement.

The trauma and orthopaedic wards were supported by an ortho-geriatrician during weekdays but this was resourced by the medical wards. A business case to support the recruitment of an ortho-geriatrician within the surgery and critical care group was also in development.

The trauma and orthopaedics service improvement plan was also in progress and included a number of actions to improve patient length of stay. The planned improvements to patient length of stay had not yet been fully implemented so the impact of these measures on improving patient length of stay could not be verified at the time of inspection.

The proportion of patients whose operations were cancelled and were not treated within the 28 days across the trust was better than the England average between October 2017 and September 2018. There were 26 patients whose operations were cancelled and were not treated within the 28 days during this period. However, this included 14 patients for the period between January 2018 and March 2018. There had only been seven instances reported in the following six months which indicated an improving trend.

From February 2020 to January 2021 the trust's referral to treatment time (RTT) for admitted pathways for surgery was worse than the England average. During this period, one specialty (oral surgery) was above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery and five specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

Referral to treatment time performance for ophthalmology (31.1% compared to England average of 50.5%) and trauma and orthopaedics (23.2% compared to England average of 41.2%) was significantly worse than the England average.

NHS England data showed the total number of patients on the waiting list was 49,196. The largest number of patients on the waiting list were for trauma and orthopaedics (8,718), followed by general surgery (6,714) and ear, nose and throat surgery (6,014).

The elective recovery plan 2021/22 outlined the trusts proposals to reduce waiting times. The trust submitted baseline elective capacity plans for 2021/22 to inform recovery plans for the NHSE/I North West regional team.

The trust reported in the elective recovery plan that current performance (February 2021) was below the trust's Phase 3 Covid response plan targets. The trust reported there were 24 cancer patients waiting over 104 days, due to a combination of patient choice and delay in diagnostics. Cancer 62-day wait performance was 66% against the 85% standard (with 24 breaches) and cancer 31-day wait performance was 96.2% (against the 96% standard).

Surgery

The trust reported day case activity was 75% and elective activity was 38% (compared with target of 90% of pre-pandemic activity levels). This was due to Impact of using theatre and recovery space for critical care surge capacity. There were 2,365 patients waiting over 52 weeks, compared with target of zero patients by end of the year.

The elective recovery plan 2021/22 included proposed trajectories for reducing waiting lists for cancer patients, elective inpatient and day case patients and those waiting over 52 weeks.

The recovery plan trajectories from April 2021 to March 2021 The plan trajectories showed the trust could achieve zero (waiting list prioritisation 2) patients waiting over 28 days by March 2022 with additional funding. The recovery plan showed that without additional capacity, the number of patients waiting over 52 weeks would increase to 4,178 by March 2022 and even with additional capacity and funding, there would still be 210 patients waiting over 52 weeks by March 2022.

The recovery plan also showed that without significant additional capacity and funding, the elective and day case performance would equate to 888% to 89% of 2019/20 activity levels.

The director of operations for the critical care and surgery group told us the trust had agreed to fund additional capacity for April to June 2021 through outsourcing (patients treated by independent sector) and insourcing models (use of trust theatre space by independent providers) elective and day case patients.

There was an agreement in place with an external health provider to utilise the trust's existing theatre space during weekends to provide surgery for elective and day case ear, nose and throat (ENT) surgery patients. The trust also had arrangements with a number of independent health providers to support breast surgery, elective orthopaedic surgery and ophthalmology (cataract procedures).

The trust reported the recovery plan to utilise the independent sector and additional theatre activity sessions for elective and day case patients would mean the trust could achieve over 100% of 2019/20 activity levels by July 2021.

There was a theatres improvement programme in place aimed to improve theatre utilisation, reduce late start times for theatre lists and to reduce cancellations. The programme was in progress and the March 2021 progress update showed the plan was on track with progression of identified workstreams.

The theatres improvement plan showed the theatre teams at this hospital achieved 74%-75% theatre utilisation between January 2021 and March 2021, which was below the target of 85%. The percentage of theatre sessions with late starts at this hospital ranged between 29% and 44% between January 2021 and March 2021, which was below the target of 30%. The percentage of patients cancelled across the trust also ranged between 9% and 12% during this period, which was below the target of 0.8%.

NHS England data over the past two years showed the percentage of patients whose operation was cancelled and were not treated within 28 days at the trust was better than the England average. During this period, the percentage of cancelled operations as a percentage of elective admissions at the trust were similar to the England average. (Cancelled operations as a percentage of elective admissions only includes short notice cancellations.)

The surgical services had introduced a clinical review of all operations cancelled on the day to identify reasons and look for improvements. A review was also under way around data quality and coding issues due to cancellations identified as reported in error or duplicated.

Surgery

We identified concerns around patient length of stay and performance against referral to treatment waiting times as part of our previous inspection in November 2018. We found during this inspection that no significant improvements had been made in relation to waiting times and length of stay. The Covid-19 pandemic also had an adverse impact on the hospital's performance measures such as length of stay and referral to treatment wait times.

The services had put in place a number of measures and plans to improve waiting time performance and patient length of stay; however, these had not yet been implemented and had not led to a significant improvement at the time of the inspection.

Learning from complaints and concerns

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

The ward and theatre areas had information leaflets displayed showing how to raise complaints. This included information about the Patient Advice and Liaison Service (PALS). The patients we spoke with were aware of the process for raising their concerns with the staff.

The ward and theatre managers were responsible for investigating complaints in their areas. The timeliness of complaint responses was monitored by a centralised complaints team, who notified individual managers when complaints were overdue.

Staff told us that information about complaints was discussed during daily 'safety huddles' and at routine team meetings to aid future learning. We saw evidence of this in the meeting minutes we looked at.

The trust complaints policy stated that complaints would be acknowledged and responded to within 35 working days for routine formal complaints.

From April 2020 to March 2021 there were 52 complaints about the surgical services at this hospital and the trust reported these were responded to within the timescales specified in the trust complaints policy.

Is the service well-led?

Good 

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

Leadership

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

Surgery

The surgical services at the hospital formed part of the critical care and surgery care group. The care group was led by a clinical director, who was supported by a triumvirate leadership team made up of the associate director of operations and the associate director of nursing along with the governance business partner. The clinical director had been in post for two years. The remaining triumvirate team had been in place less than 12 months but had a clear understanding of the risks to the surgical services and how to address these.

The surgical specialties were spilt into six specialty care groups and each specialty was led by a clinical lead and clinical manager with a surgical matron supporting across a number of specialties. Each surgical ward was managed by a ward manager with support from senior nurses. There was a theatre matron responsible for overseeing the services. A number of new ward managers, matrons and senior nurses had been appointed in the last 12 months, so the leadership team was fairly new across the surgical services.

The ward-based nursing staff were overseen by the matron for surgical wards at this hospital. The matron had been newly appointed and had been in post for a number of weeks at the time of the inspection. The matron for surgery received support from the associate director of nursing and matrons from the trust's other hospital. There was a vacant post for an additional matron for the surgical services at this hospital and recruitment for this was ongoing.

The majority of staff spoke positively about the leadership and organisation structure. The theatres and ward based staff told us they understood their departmental reporting structures clearly and described their line managers as approachable, visible and who provided them with good support.

Vision and Strategy

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

The trust's brand statement was 'better care together'. The trust's vision was 'We will consistently provide the highest possible standards of compassionate care and the very best patient and colleague experience. We will listen to and involve our patients, service users, colleagues and partners.' These were underpinned by a set of five priorities; patients, partnerships progress and performance.

The vision and values had been cascaded to staff across the surgical services and staff had a good understanding of these.

The strategy for the critical care and surgery care group was outlined in the care group business plan 2021/22, which was based on the overall trust vision and priorities.

The business plan included a number of objectives for the year, including the improvement of cancer pathways and referral to treatment waiting time performance, focus on positive working cultures, staff recruitment and developing extended roles, such as trained advanced nurse specialists and surgical care practitioners, participation and collaborative working in a range of integrated care systems (ICS) programmes, use of digital technology to support new models of care (such as virtual clinics) and to utilise 'get it right first time (GIRFT) right care and model hospital data to drive cost improvements.

Progress against the business plan priorities and objectives was monitored as part of monthly surgical management board meetings.

Culture

Most staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an improved culture and was working towards embedding an open culture where patients, their families and staff could raise concerns without fear. The improvements identified following an external review around culture within the trauma and orthopaedic specialty had not yet been fully implemented.

The staff we spoke with were highly motivated, patient-focussed and spoke positively about the care they delivered. Staff told us there was a friendly and open culture. The medical and ward staff we spoke with told us they received regular feedback to aid future learning and that they were supported with their training needs by their line managers. Junior doctors and newly recruited nurses told us they received good training and learning opportunities.

Most staff felt confident to raise issues with line managers and felt managers responded positively when concerns were shared. All staff we spoke with were aware of the whistleblowing policy and understood how to contact the freedom to speak up guardian if needed.

The medical teams in the urology and trauma and orthopaedics specialties underwent external reviews during 2020. These highlighted a number of areas for improvement in relation to leadership, culture and clinical practice.

The clinical service manager for urology and urology medical staff told us there had been significant improvements made in relation to the leadership and culture within the urology services. This included regular engagement and input from staff around how to improve the services. The introduction of a separate on-call consultant during weekdays at this hospital and Furness General Hospital was also received positively.

We received a mixed response from the medical staff in the trauma and orthopaedic specialties and staff we spoke with felt previous concerns around culture and leadership within this service had not yet been fully addressed. The clinical director and associate director of nursing also told us that they were still in the process of implementing recommendations from an external review of the service during 2020 and this was in progress at the time of the inspection.

Governance

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

The surgical services at the hospital had clear governance structures in place that provided assurance of oversight and performance against safety measures. There were monthly specialty level and care group level governance meetings in place to discuss governance and risk. Each surgical specialty had routine monthly governance meetings and governance and operational performance was reviewed at monthly surgery governance and assurance group and surgery management board meetings.

Surgery

We reviewed the minutes of recent monthly speciality meetings, group level surgery governance and assurance group and surgery management board meetings. These included key discussions around workforce, current risks, clinical effectiveness and performance issues in relation to each speciality area.

The trust had an existing ward accreditation programme to assess the quality of care delivered in the surgical wards. This programme had been suspended during the Covid-19 pandemic. The ward accreditation programme had restarted recently with a plan to assess each surgical ward by July 2021. The acute surgical and Ward 31 (colorectal surgery ward) underwent ward accreditation visits during November and December 2020 and achieved amber status, indicating further improvements were required to achieve the trust's green or exemplar status.

Management of risk, issues and performance

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

The trust used an electronic risk register system to record and manage key risks. The critical care and surgery care group maintained a risk register to document key risks relating to the overall surgical services across the trust and also incorporated the individual departmental / ward risks.

The governance business partner told us key risks were identified and control measures were put in place to mitigate risks. Identified risks had a review date and an accountable staff member responsible for managing that risk.

Staff were aware of how to record and escalate key risks on the risk register. A risk scoring system was used to identify and escalate key risks to care group and trust level.

Staff were supported by governance leads within each specialty to review open risks and identify mitigations / controls to reduce or eliminate risks. Meeting minutes showed key risks were reviewed at routine specialty level meetings and at the monthly care group level surgery governance and assurance group meetings.

In each area we inspected, there were routine staff meetings to discuss day-to-day issues and to share information on complaints, incidents and audit results.

We saw that routine audit and monitoring of key processes took place to monitor performance against objectives. Information relating to performance against key quality, safety and performance objectives was monitored and cascaded to staff through team meetings, safety huddles, performance dashboards and newsletters.

The surgical specialty leads produced a monthly 'safer today' report which included performance indicators around patient safety, staffing, operational performance and finances. This was presented at monthly surgery governance and assurance group meetings.

The matron for surgery carried out a monthly matron's assurance audit, which included indicators such as handover records, harm free care, medicines management, patient safety and documentation and safe environment. The average assurance audit scores across the critical care and surgery care group between June 2020 and March 2021 ranged between 89% and 96% for these indicators.

Information Management

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

Staff completed information governance training as part of their core skills mandatory training. The surgical services had achieved the trust target of 95% of staff to have completed this training.

We did not identify any concerns in relation to the security of patient records during the inspection. The majority of patient records were electronic. We saw that paper-based patient records (such as patient bed side notes) were kept securely. Staff files and other records (such as audit records, staff rotas, files) held electronically.

Computers were available across the wards and theatre areas and staff access was password protected. Electronic patient records were also password protected. The staff we spoke did not identify any concerns relating to accessing IT systems or any connectivity issues.

Each ward had a visual display screen with live patient information such as admission, length of stay, current status and whether observations were due. The ward and theatre areas also had a number of notice boards that displayed information such as staffing levels, patient safety and infection control.

Staff could access policies, procedures and clinical guidelines through the trust intranet site. Staff told us they could access patient information and up to date national best practice guidelines and prescribing formularies when needed.

Engagement

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

Staff told us they received good support and regular communication from their line managers. Staff routinely participated in team meetings across the areas we inspected. The trust also engaged with staff through newsletters and through other general information and correspondence that was displayed on notice boards and in staff rooms.

The associate director of operations and associate director of nursing told us the findings from the NHS staff survey 2020 had been reviewed and draft action plans were currently being developed to cascade across the surgical teams.

Staff were provided with emotional support. For example, clinical supervision and debrief support was put in place to support staff. The medical and nursing staff participated in specific events and training days that included engagement, training and discussions around improvements to clinical processes. The care group leads told us they carried out regular walk rounds to engage with staff across the surgical ward and theatre areas.

The trust had developed a staff booklet detailing the support available during the covid-19 pandemic. This included guidance for staff and details of support available for staff in relation to emotional health and well-being.

Staff across the surgical services told us they routinely engaged with patients to gain feedback from them. This was done informally and formally through participation in the NHS Friends and Family. Feedback from NHS Friends and family survey was mostly positive across the surgical wards.

Surgery

Public engagement had been impacted due to the Covid-19 pandemic; however staff told us there was still engagement through patient focus groups and general engagement through the trust's website.

Learning, continuous improvement and innovation

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

A number of senior managers, matrons and clinical leads had been appointed in the last 12 months following the creation of the new trust and the majority of staff felt positively about sharing ideas and best practice from the trust's other hospitals.

The culture across the services was based on quality improvement. There were a number of quality improvement projects and work streams in place across the surgical services, such as theatre improvement and elective surgery quality improvement programmes.

Staff across the services were involved in research, innovation and clinical trials to improve patient care and treatment; for example, new funding applications and collaborative working with an external university for new surgery imaging for orthopaedics. Staff participated in local clinical audits to improve the services; for example, local audits for clinical note taking and anaesthetic record documentation had led to improvements in staff compliance.

As part of the peri-operative wellness programme, the surgical services developed the patient charter with involvement from patients, staff and other stakeholders. The patient charter aimed to support patients to be fit for surgery, help patients decide is surgery is the right option for them and to offer alternative treatments such as physiotherapy or pain management to manage their health condition.

Maternity

Requires Improvement ↓

Is the service safe?

Good →←

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

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up-to-date with their mandatory training. We saw compliance with the NHS 10 core skills ranged between 91 and 100%. For example, 98% of staff had completed information governance training. Staff told us they attended three mandatory training days each year one of which was for PROMPT training. PROMPT stands for Practical Obstetric Multi-Professional Training and is training for professionals across disciplines in maternity services on responding to obstetric emergencies. During the pandemic this training was moved to online modules to ensure staff could continue to keep up-to-date with training.

The mandatory training was comprehensive and met the needs of women and staff. As well as the NHS 10 core skills, staff completed training in incident reporting and fetal monitoring. Midwives on preceptorship were given protected time to attend a monthly training day.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff we spoke with told us they were encouraged to attend the mandatory training days and given three days protected time to attend mandatory training each year. Matrons audited compliance with mandatory training as part of the matron audits. Managers told us that during the COVID-19 pandemic compliance with mandatory training had been reviewed at each 'SITREP' call between matrons, ward managers and senior managers and these were held three times a week.

Safeguarding

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

Nursing and midwifery staff received training specific for their role on how to recognise and report abuse. Staff compliance with level three safeguarding adults and children training was 94%. Staff told us prior to the COVID-19 pandemic they had been given protected safeguarding training time as part of mandatory training days. During the pandemic this had been provided online to ensure all inpatient staff received training annually. Safeguarding training included training on female genital mutilation (FGM).

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act. Some staff were appointed as safeguarding champions and given protected time to review women's records and ensure individual birth plans were in place and any safeguarding issues were raised.

Community staff told us they had received additional training on recognising and reporting FGM and worked with medical staff to devise personalised care plans for women affected by this.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. We spoke with the specialist midwives for safeguarding who covered all three maternity locations including Royal Lancaster Infirmary. They worked as part of the trust-wide safeguarding team and attended daily safeguarding safety huddles. They maintained a log of all safeguarding referrals and vulnerable families the service worked with. Specialist safeguarding midwives delivered safeguarding supervision to maternity staff

The electronic patient record system included a 'flag' for safeguarding so staff could easily identify where there was a known safeguarding issue with a woman and staff had access to the national child protection information sharing system

Staff described good working relationships with external safeguarding authorities attending monthly meetings to discuss difficult cases and share information.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with told us they received excellent support from the lead safeguarding midwifes and trust safeguarding team and said they felt confident approaching them for advice and support.

Staff followed safe procedures for children visiting the ward, only children of the woman on the ward were allowed to visit.

Staff followed the baby abduction policy. A copy of the baby abduction policy was available for all staff in the ward manager's office. The policy was reviewed in October 2020 and included a clear one-page flow chart for staff follow in the event of a suspected baby abduction. Access to the ward and delivery suite was by a numerical keypad and there was an emergency button which could be used by staff to override the use of the keypad in an emergency situation.

However, there was not a schedule for changing the keypad code to maintain security and staff we spoke to told us they did not feel the system was fully secure as they could potentially be overlooked when inputting a code. We were told baby abduction drills had been suspended during the COVID-19 pandemic.

Cleanliness, infection control and hygiene

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

The maternity ward, delivery suite and other areas we visited were visibly clean and had suitable furnishings which were clean and well-maintained. However, the flooring on the maternity ward and delivery suite was in disrepair in some places, with a temporary fix. This meant it posed a trip hazard and could not easily be cleaned. Managers were aware of the issue and told us this had been reported to estates.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We reviewed cleaning records for the week of our inspection on the maternity ward and saw they were fully completed. We also saw records of water running and curtain changes were kept up to date. Risk assessments had been completed for all substances hazardous to health. Internal estates service audited the cleanliness of the environment and equipment every six months alongside the manager.

Staff followed infection control principles including the use of personal protective equipment (PPE). Hand washing facilities and hand gel were available at the entrance to the maternity ward and delivery suite. Staff washed their hands before and after providing care using the World Health Organisation five moments for hand hygiene. We observed staff followed 'bare below the elbows' guidance. PPE equipment was available at ward and unit entrances and at the entrance to each individual room. We observed staff donning and doffing PPE as appropriate when entering single rooms. Staff observed social distancing in communal areas with the handover being held in a large bay to facilitate this.

Staff cleaned equipment after patient contact and labelled equipment with green 'I am clean' stickers to show when it was last cleaned. The service employed its own domestic staff and they were visible across the service throughout our inspection.

The service had systems for testing and screening women and partners for COVID-19 on admission through various pathways. The inpatient ward used side rooms and cohorted women in specific bays until their COVID-19 status had been established.

However, the service did not have a specific policy for cleaning of the birthing pool. The service provided information that showed they had a water birth policy which included how to clean the pool. This referred to the water safety standard policy which was not provided by the trust but was not specific to the cleaning of birthing pools. The service told us the birthing pool cleaning policy was waiting to be ratified and implemented during our inspection. The service told us the birthing pool cleaning policy was waiting to be ratified and implemented during our inspection.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Women could reach call bells and staff responded quickly when called. We saw call bells were available at the side of or on every bed.

The design of the environment followed national guidance. The service had access to a second obstetric theatre for any obstetric emergencies which was directly accessible from the delivery suite. The recovery area had recently been refurbished to allow women to be separated dependent on COVID-19 status.

Staff carried out daily safety checks of specialist equipment. We reviewed the adult and neonatal resuscitation trolleys on delivery suite and saw they were stored in line with Resuscitation Council (UK) guidelines with the drawers sealed with a tamper evident tag. All daily and weekly checks were completed and signed.

The service had suitable facilities to meet the needs of women's families.

The service had enough suitable equipment to help them to safely care for women and babies. We saw portable appliance testing had been completed for equipment such as cardiotocography trolleys. Staff could access computers on wheels to take into bays and rooms to ensure they could record contemporaneous notes. Managers told us they had good support from medical devices department. The department monitored all equipment servicing and informed managers when this was due to ensure servicing took place. They also provided equipment maintenance reports to managers to report on any maintenance carried out.

All community midwives were allocated their own equipment which they picked up from the unit at the beginning of each shift. We checked a sample of equipment bags held by community midwives and saw all equipment was present and items in date.

Staff disposed of clinical waste safely and we saw bins for disposal of sharps were labelled with a temporary closure and filled on or below line.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. Staff completed the Maternity Early Obstetric Warning System (MEOWS) to identify women at risk of deterioration. Ward managers monitored completion of the tool through regular audits. We reviewed the audits for January to March 2021. In January 2021 compliance with full completion was 70% and in February 2021 it was 69%, however this had improved in March 2021 to 93%. Managers told us they had seen a gradual improvement in compliance with MEOWS completion since late 2019, with the main areas of concern being staff signing and countersigning the records.

We reviewed eight women's records and saw MEOWS was completed, scored and escalated if required in all records.

The service used neonatal early warning scores to recognise babies at risk of deterioration. We saw these were fully completed, where appropriate, in all women's records we reviewed.

Staff completed risk assessments for each woman on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. The day assessment unit was midwifery led but consultant obstetricians were available for consultation and reviewed any complex cases. Community midwives used a risk assessment bundle which included all key risks including body mass index, gestational diabetes, smoking status and pre-eclampsia.

We saw fetal movements were recorded at each antenatal visit in all seven records we reviewed and fetal growth was plotted on the fetal growth chart.

We reviewed the records of two women who were admitted for early induction of labour and saw they had presented via day assessment unit and reduced fetal growth had been identified. They were reviewed by a consultant obstetrician prior to admission.

Staff knew about and dealt with any specific risk issues. The service had developed the role of fetal monitoring leads and had both midwives and consultants appointed as leads. There was a weekly review of all cardiotocography and maternity staff from across the trust could attend or dial in online.

The delivery rooms which contained birthing pools had appropriate equipment to remove women from the pool in an emergency.

VTE assessments were completed in all seven records we reviewed. VTE stands for venous thromboembolism and is a condition where a blood clot forms in a vein.

The service reported two incidents of sepsis between January and March 2021. We saw the service had presented an audit of sepsis in June 2020 and they told us the next audit was due in July 2021. The audit did not break down performance by each site so was for the whole of maternity services. We reviewed the audit and saw that of 17 records analysed, six cases of amber flag sepsis were identified, of which two women were not prescribed antibiotics within three hours. Twelve cases of red flag sepsis were identified of which four women did not receive antibiotics within one hour. Only eight of the 12 red flag woman had full sepsis six bundle completed within the first 60 minutes after being identified.

Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. We reviewed seven women's records and saw staff had completed a mental health assessment using the 'Whooley' questions. These are questions which allow health professional to screen women for depression. Staff had also asked questions regarding domestic abuse in all records.

Staff shared key information to keep women safe when handing over their care to others. We observed a woman having a caesarean section. We saw good communication between all members of the surgical team. The service used the World Health Organisation (WHO) surgical safety checklists five steps to safer surgery, which is a tool designed to improve the safety of surgical procedures. The surgical safety checklist was followed by all staff and we saw staff raise a safety concern and an effective management plan put in place. We reviewed three women's records where they had undergone a surgical procedure and saw the WHO surgical safety checklist was fully completed in all three.

Shift changes and handovers included all necessary key information to keep women and babies safe. We observed the team brief in theatre prior to a surgical procedure and saw all members of the multidisciplinary team were present and the team brief included all key elements of ensure safe treatment.

Midwifery staffing

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

The service had enough nursing and midwifery staff to keep women and babies safe. We saw staffing establishment on the maternity ward was based on a ratio of one midwife to six women. The inpatient ward had four transitional care beds, and these were supported by two neonatal nurses throughout the day. Out of hours additional support could be accessed through neonatal on call.

Managers accurately calculated and reviewed the number and grade of midwives and midwifery support workers needed for each shift in accordance with national guidance. Managers used the Birth Rate Plus tool to calculate the number of midwifery staff needed. Staffing levels were reviewed annually by senior managers and additionally following the end of student placements. Staffing on the delivery suite included a supernumerary shift co-ordinator. The night shift co-ordinator completed a daily staffing sheet, which was reviewed, and staff moved to support acuity and staffing levels in different areas as needed.

The service mostly provided one to one care in labour. The service provided information that showed in March 2021 they provided one to one care in labour for 97.7% of births against a target of 100%. This was not broken down by location. Managers told us they were working with staff to improve reporting of one to one care in labour as they believed the reason it was not 100% was due to errors in reporting by midwives.

There was a system of diverts which managers could use to ensure staffing matched acuity and demand across the maternity service. We saw this was used during our inspection with South Lakes Birth Centre being on divert meaning women may be transferred to the service at Royal Lancaster Infirmary where there was capacity.

The ward manager could adjust staffing levels daily according to the needs of women. Managers told us they had been supported to recruit midwives to provide cover for maternity leave. Managers told us there was a clear process for escalation of staffing challenges and they were supported to work between departments and use bank staff where needed. They told us they rarely needed to ask community midwives to staff the ward. During our inspection, we saw the maternity ward had more staff than required for the number of women admitted.

The number of midwives and healthcare assistants matched the planned numbers. We saw boards displayed at the entrance of delivery suite and the maternity ward that showed actual staffing matched planned staffing throughout our inspection.

The service had no midwifery vacancies.

The service had low turnover rates for midwifery staff. Managers told us the retention rate had improved. The service had a 12-month preceptorship programme for new midwives to encourage retention.

The sickness rate for midwifery staff was 6.3% in March 2021 against a trust target of 4.6%. Managers told us this mainly related to long term sickness absence which was being managed effectively through trust policies and procedures and individual case reviews.

The service did use bank and agency midwives. However, managers limited their use of bank and agency staff and requested staff familiar with the service. They gave the example of using the same agency midwife for eight years. All bank and agency staff had a full induction and understood the service as they were familiar with it as they already worked within it or had been long term agency workers.

Medical staffing

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

The service had enough medical staff to keep women and babies safe. Consultant obstetricians led twice daily ward rounds at 9am and 9pm. At the time of our inspection this was seven days a week. However, leaders told us they were currently reviewing job plans and the ward round model. The service had enough consultant obstetricians to enable them to have two present in theatre for complex caesarean sections.

The medical staff matched the planned number. They employed 13 consultant obstetricians and had resident consultants or registrars on each night shift.

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

The service always had a consultant on call during evenings and weekends. The service had resident consultants available at night during the week. At the weekend there was a resident registrar on at all times with consultant on call cover.

Maternity

Records

Staff kept detailed records of women's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Women's notes were comprehensive, and all staff could access them easily. However, staff told us that the patient record system was slow and difficult to use, and they were getting a new system in July 2021. This was to be trialled in antenatal clinics and community before being rolled out to inpatient areas.

We saw staff had access to records during ward rounds using computers on wheels which were available in the delivery suite and maternity ward. All community midwives had laptops so they could access electronic notes whilst out in the community.

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

Records were stored securely. Electronic patient records were accessed by staff through a secure log in. We reviewed seven women's records and saw all entries had a date and time and name of the staff member making the entry.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. We reviewed the controlled drug book in the day assessment unit and saw it was fully and accurately completed. Fridge temperatures were monitored daily, we reviewed the daily monitoring chart for April 2021 and saw all temperature checks were completed and within range. In delivery suite and maternity ward we saw all medicines and fridges were checked daily and all checks had been completed and signed.

Staff followed current national practice to check women had the correct medicines. We reviewed 11 electronic medicine administration records and saw they were fully and appropriately completed.

The service had systems to ensure staff knew about safety alerts and incidents, so women received their medicines safely. National safety alerts were circulated to staff using the electronic prescribing system.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. There was a list of triggers and types of incidents for staff to follow so they knew which incidents to report. Staff we spoke with told us the incident reporting culture had improved with staff more confident in submitting incident reports.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy. Staff we spoke with told us there was a new trust-wide incident reporting strategy and that they felt safe to report patient safety incidents. We reviewed the safety report for February 2021 and saw there had been an increase in near miss incidents reported in 2020. The report stated there were no common themes from incidents.

The service had reported relevant incidents to the Health Service Investigation Board (HSIB). They gave examples of learning implemented following recommendations from HSIB investigation reports and recommendations. However, action plans we reviewed following HSIB recommendations were not always effective or robust enough to mitigate risk and did not identify how learning would be shared across sites. For example, we reviewed one action plan which did not fully address the key finding regarding lack of recognition of placental trauma which led to a baby requiring resuscitation. We saw actions identified in response to HSIB reports did not have completion dates nor progress tracked.

The service had no never events on any wards. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Staff reported serious incidents clearly and in line with trust policy. Midwifery staff received training on how to recognise and report incidents and 98% of staff had completed this training.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation if and when things went wrong. Managers told us duty of candour letters sent as a result of perinatal mortality reviews were individually tailored to each woman and her family. We reviewed the service action log as a result of perinatal mortality reviews. There were three cases reviewed for the service, they had clear actions which had either been completed or were in progress at the time of our inspection.

Staff received feedback from investigation of incidents, both internal and external to the service. The electronic reporting system ensured feedback from incident reviews was sent to the person reporting the incident. Managers shared learning from incidents at the three-minute- safety brief held weekly, this was also read during handover and circulated to staff by email.).

Staff met to discuss the feedback and look at improvements to women's' care. All serious incidents were investigated using a root cause analysis approach and this was overseen and reviewed by the Care Group Governance Assurance Group.

There was evidence that changes had been made as a result of feedback. Staff told us about changes to the weighing frequency of babies to try and capture any weight loss as early as possible following an incident.

Managers investigated incidents thoroughly. Women and their families were involved in these investigations. Staff told us all incidents reported were sent to the governance team and a manager appointed to oversee investigation of the incident.

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, women and visitors.

Maternity

Safety data was displayed on wards for staff and women to see. The service continually monitored safety performance. The maternity dashboard was available on all computers as staff logged in so they could keep up-to-date with safety performance. The service had developed a monthly safety summary infographic for all staff. This had been developed with staff and gave information on key safety performance data and performance against targets.

Staff used the safety and performance data to further improve services. For example, one to one care in labour figures dropped below the target of 100% in March 2021. Managers had worked with staff to ensure they reported data correctly.

Is the service effective?

Requires Improvement 

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

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

We saw during inspection that several guidelines used in the service were out of date or did not have related proformas available. Among these, we noted the guideline for still birth, which had expired November 2020, appeared to be a generic form, and not identified with the trust's corporate branding. Contact details for staff included in this guideline also appeared to relate to a different NHS Trust altogether. We found the guideline for post-partum haemorrhage, and incidents complaints and claims had passed their review date of December 2020

However, we saw staff had access to some up-to-date policies and followed evidence-based practice and national guidance. For example, we saw documentation in women's records we reviewed at the start, end and during cardiotocography met National Institute of Health and Care Excellence (NICE) guidance.

Staff met at a monthly cross bay policies and procedures group to review policies and ensure they met current NICE guidelines.

We saw vitamin D was offered appropriately to women in line with national guidance in all records we reviewed. NICE guidance updated in 2017 recommended vitamin D should be offered to specific population groups including pregnant and breastfeeding women. Additional NHS guidance issued during the COVID-19 pandemic stated women should take 10 micrograms of vitamin D a day between October and early March to keep your bones and muscles health.

At handover meetings, staff routinely referred to the psychological and emotional needs of women, their relatives and carers. Women's' records we reviewed contained information on specific risk factors including body mass index, comorbidities, mental health and domestic abuse.

Nutrition and hydration

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

Staff made sure women had enough to eat and drink, including those with specialist nutrition and hydration needs.

Staff completed women's fluid and nutrition charts where needed. We saw fluid balance charts were fully completed, where appropriate, in all women's records we reviewed.

The ward manager audited fluid balance chart completion. We reviewed the audits for January to March 2021 and they showed full completion rates of 70% in January 2021, 69% in February 2021 and 78% in March 2021. Managers told us additional education had taken place with staff to improve compliance with fluid balance chart completion and it was included in midwifery mandatory training days. They told us the reason for poor compliance was due to a change in format of the fluid balance chart during the COVID-19 pandemic.

Specialist support from staff such as dietitians and lactation specialists was available for women who needed it. The service had one part time infant feed lead who led on work to become Baby Friendly Initiative (BRI) accredited. The service was not BFI accredited at the time of our inspection.

Managers told us they had just asked staff to submit expressions of interest so they could increase the number of breastfeeding champions available to support women. The service had plans to ensure all midwives attended breastfeeding training in the next two years.

Pain relief

Staff did not always assess and monitor women to see if they were in pain, nor give pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

We reviewed the audit of maternity early obstetric warning scores which was completed in January 2020 and saw only 40% of women had their pain score completed according to their clinical condition. This was an improvement on the 2019 audit which showed only 30% compliance.

Women did not always receive pain relief soon after requesting it. We reviewed the cross-trust audit of pain relief in labour conducted by the anaesthetic department which covered two weeks in December 2020. This showed that across Royal Lancaster Infirmary and South Lakes Birth Centre 81% of women received their epidural within the 30-minute timeframe in line with national recommendations and in two out of 16 cases there was no documentation of quality of pain relief made at 45 minutes.

However, during our inspection we saw staff assessed women's pain using a recognised tool and gave pain relief in line with individual needs and best practice. We saw women were offered pain relief during induction of labour in line best practice.

Patient outcomes

Maternity

Staff monitored the effectiveness of care and treatment. However, they did not consistently use the findings to make improvements. They did not consistently achieve good outcomes for women. The service was not accredited under relevant clinical accreditation schemes, such as Baby Friendly Initiative.

The service participated in relevant national clinical audits, such as MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries). We asked the service to provide any reports or action plans against MBRRACE outcomes, but the information supplied was not specific to this maternity service and did not reference any local learning or action plans. We reviewed the trust response to the national maternity and perinatal audit 2018-2019 and saw there was little detail in the action plan of how the service intended to meet key actions.

Outcomes for women were not always positive, consistent nor met expectations, such as national standards.

The service performed below the national target for continuity of care. At the time of our inspection, performance was 23.77% against a national target of 35%. Managers told us the service had struggled to introduce an effective model to deliver continuity of care outcomes with two pilot approaches which had not been wholly successful. They were recruiting additional midwives to set up a team to deliver continuity of care during our inspection.

Induction of labour in March 2021 was 47.62% which was above the national target of 36%. Managers told us that though they had not met the national target they had benchmarked against their peers and were not a negative outlier.

Managers told us caesarean section rates had been static over many years. In March 2021 the maternity dashboard showed 34.69% of deliveries were by caesarean section, 13.6% emergency and 21% elective. The caesarean section rate in April 2020 was 30.2% and the lowest was 29% in September 2020 and highest 49.6% in December 2020. Managers carried out regular caesarean section audits but recognised these could be improved to aid learning. They told us the emphasis was on the appropriateness of a caesarean section for each woman rather than their rates. Senior staff we spoke with were unable to describe how they had used this data effectively to make improvements in the service for women.

Following our inspection, the Health and Social Care committee recommended percentages should not be used to measure caesarean section rates in maternity services.

The service offered all women who had a previous caesarean section delivery an appointment at the vaginal birth after caesarean (VBAC) clinic.

Some staff told us they felt the caesarean section rate was high due to the women's choice, high induction of labour rates, more high risk women presenting and a risk adverse culture that moved to caesarean section rather than a difficult instrumental delivery.

The service had 34 term admissions to the neonatal unit between October 2020 and March 2021. This was a rate of 4.36% and within the 5% maximum performance indicator. However, this figure was for all maternity services at the trust and not specific to Royal Lancaster Infirmary.

Managers and staff used the results to improve women's outcomes. For example, the service had recognised they had a higher than expected number of post-partum haemorrhages between August and November 2020. They worked with

the education team to include targeted work on responding to post-partum haemorrhages in skills and drills training and made improvements to the post-partum haemorrhage trolleys. This had led to a reduction in post-partum haemorrhages to 2.1% in March 2021 against a target of achieving less than 2.5% of women having a post-partum haemorrhage with blood loss of more than 1500 ml.

Managers and staff carried out a programme of repeated audits to check improvement over time. However, this process had recently changed, and a new quality assurance recording system was in use at the time of our inspection. The new system did not include the maternity ward and therefore, managers on the maternity ward were unable to submit their ward-based audits through the quality assurance system. Manager told us they had escalated this to senior managers. However, managers told us they felt they got the information they needed at a local level to make improvements through ward manager and matron audits.

The service was not accredited by Baby Friendly Initiative though managers told us they had registered to go through the registration process and work had begun to meet the requirements.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. During the COVID-19 pandemic, staff continued to attend PROMPT training online and the service increased the number of face to face skills and drills training sessions to enable staff to attend face to face training. PROMPT stands for Practical Obstetric Multi-Professional Training and is training for professionals across disciplines in maternity services on responding to obstetric emergencies. Managers told us compliance with skills and drills training was above 90%.

Managers supported staff to develop through yearly, constructive appraisals of their work. 96.4% of staff on the delivery suite were up-to-date with annual appraisal and 75.6% on maternity ward. However, we saw low levels of compliance with medical staff appraisal with only 58.3% of medical staff having completed an appraisal.

Managers supported nursing and midwifery staff to develop through regular, constructive clinical supervision of their work. Staff could access regular clinical supervision and ad hoc support from a Professional Midwife Advocate (PMA). They also held restorative supervision sessions following any traumatic events or births. Managers told us they were actively recruiting more staff to become PMAs to enhance the support available.

The clinical educators supported the learning and development needs of staff. They were working with a local university to set midwife apprenticeships.

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

Managers made sure staff received any specialist training for their role. Midwifery and medical staff received training in cardiotocography and during our inspection we were told compliance was 91%. Cardiotocography means of recording the fetal heartbeat and uterine contractions during pregnancy. Staff had not been able to access neonatal life support training during the COVID-19 pandemic so the service had developed their own programme with the first training starting in April 2021.

Multidisciplinary working

Maternity

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

Staff held regular and effective multidisciplinary meetings to discuss women and improve their care. There was a consultant led ward round twice a day, which is in line with recent recommendations made in the Ockenden report. The Ockenden report is an independent review led by Donna Ockenden into maternity services and cases of serious and potentially serious concerns. The report made recommendations and immediate essential actions for all trusts to improve maternity services.

We observed a ward round and saw it was attended by all relevant members of the multidisciplinary team and followed a structured SBAR process. SBAR stands for situation, background, assessment and recommendation and is a way of ensuring all key elements of care and treatment are discussed in a structured way so everyone in the team has the information needed to provide safe care and treatment.

We observed staff handovers on delivery suite and maternity ward and saw they also included all relevant staff and followed the SBAR principles. We also saw there was a video call with other maternity units in the trust to escalated staffing and any issues as part of the handover.

Staff worked across health care disciplines and with other agencies when required to care for women. Midwifery staff we spoke with told us they had positive working relationships with medical staff, where they felt able to challenge and be listened to.

Staff referred women for mental health assessments when they showed signs of mental ill health, depression. They referred women to a qualified perinatal mental health midwife who provided additional support to women experiencing mental ill health.

Seven-day services

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

Consultants led daily ward rounds on all wards, including weekends. Women were reviewed by consultants depending on the care pathway. The service had twice daily consultant led ward rounds seven days a week in line with recommendations made in the Ockenden report.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Staff we spoke with told us they had no problems accessing scanning and diagnostic services, including out of hours.

Health Promotion

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

The service had relevant information promoting healthy lifestyles and support on wards/units.

Maternity

Staff assessed each woman's health when admitted and provided support for any individual needs to live a healthier lifestyle. The service had dedicated enhanced support midwives who provided smoking cessation support. The service recognised that access to smoking cessation services was different for women from different local authority areas and at the time of our inspection had submitted a business case to bring this support inhouse to improve access for all women.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care.

Staff gained consent from women for their care and treatment in line with legislation and guidance. We observed staff gaining and confirming consent in theatre prior to a caesarean section.

Staff clearly recorded consent in the woman's records. We reviewed three electronic records where consent had been taken and saw this was completed fully in all three.

However, the service told us they did not undertake individual consent audits and consent audits are undertaken as part of theatre audits, but the patients were not specific to maternity.

Nursing and midwifery staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards, through mandatory training days.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards and told us they received good support and advice from the safeguarding team when they needed it.

Is the service caring?

Good 

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

Compassionate care

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

Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way. Staff could access portable privacy screens to provide care to women and maintain their dignity. We observed a caesarean section being carried out and saw all staff maintained the woman's privacy and dignity throughout the procedure.

Maternity

Women said staff treated them well and with kindness. We saw a number of thank you cards and letters displayed with women using words such as 'amazing', 'caring', 'compassionate' to describe staff care towards them. Women had written that staff had gone 'the extra mile' to support them.

Staff understood and respected the individual needs of each woman and showed understanding and a non-judgmental attitude when caring for or discussing women with mental health needs. We saw staff discussed women's mental health needs during handover.

Staff understood and respected the personal, cultural, social and religious needs of women and how they may relate to care needs. Staff we spoke with gave examples if adjusting practice to meet a woman's personal needs for example by providing extra postnatal visits to offer additional breast-feeding support.

Emotional support

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

Staff gave women and those close to them help, emotional support and advice when they needed it. Staff offered debriefing to women and families following difficult births through the 'listen with mother' initiative and could refer women directly for this support through the electronic patient record system. Staff signposted women to external counselling services as there was no onsite or trust counselling service available. Bereavement midwives followed up all women who experienced still birth to offer support.

Staff supported women who became distressed in an open environment and helped them maintain their privacy and dignity. Staff could access a quiet room to take women and families who may be distressed or who had received bad news.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. The service had specialist bereavement midwives who supported women going through baby loss or had experienced previous baby loss. There was a bereavement room for women who had lost their baby where they could stay with their family and the baby's siblings. This had direct access to a garden area and the service had purchased a pram so families could use this to walk their baby outside or take their baby to the mortuary. The room could also be used for women to deliver babies who had sadly died in utero.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Bereavement midwives worked closely with local and national charities to ensure support was available for women experiencing still birth or previous pregnancy loss. They could access a range of tools to support women and families following baby loss including foot and handprint castings, photographs and wish quilts. They provided 'pregnancy after baby loss' journals to women along with a family support pack which were donated by a national charity. The service held a 'Wave of Light' event in October 2020 for women and families who had experienced baby loss and to raise awareness of baby loss. The service provided a 'rainbow' clinic which is a specific antenatal clinic for women who have experienced previous pregnancy loss and still birth.

Understanding and involvement of women and those close to them

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

Maternity

Staff made sure women and those close to them understood their care and treatment. The maternity ward had a laminated welcome leaflet and information sheets available at the side of each bed.

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

Women and their families could give feedback on the service and their treatment and staff supported them to do this. We saw the service monitored feedback provided by women and families through the Patient Advice and Liaison Service.

Staff supported women to make advanced decisions about their care. Women who choose a birth method which was outside national guidance were supported to develop and individualised birth plan. A safe and active birth midwife supported women to make advanced and informed decisions about their care.

Women gave positive feedback about the service. We saw between April 2020 and March 2021 96.7% of respondents to the family and friends test rated their care and treatment as good or very good.

The trust performed similarly to other trusts for all 19 questions in the CQC maternity survey 2019.

Is the service responsive?

Good 

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

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the needs of the local population. They worked with the local maternity voices partnership to ensure services met the needs of women in deprived communities for example engaging with a local teenage mother's group. They had also worked with the maternity voices partnership to produce videos in different languages to reach out to women in diverse communities and share information and encourage women to access services during the COVID-19 pandemic.

Facilities and premises were appropriate for the services being delivered.

The service had systems to help care for women in need of additional support or specialist intervention. Women could access support from specialist maternity obstetric physiotherapists and the service was taking part in a pilot pelvic health programme. Specialist and enhanced support midwives provided care to women who need additional support across a range of specialisms. These included safeguarding, bereavement, perinatal mental health. There was a clear pathway for staff to follow to refer women to specialist midwives and the enhanced midwives team.

The service held a 'rainbow' clinic. This was an antenatal clinic for women had experienced previous baby loss ran by a specialist bereavement midwife.

The service held a contract to provide new-born hearing screening and gave protected time to two trained staff Monday to Friday 10am to 6pm to carry out screening.

Managers ensured that women who did not attend appointments were contacted. Staff in the day assessment unit contacted all women who did not attend planned appointments.

The service relieved pressure on other departments when they could treat women in a Day Assessment Unit. There was a midwife-led day assessment unit which offered a range of pre-booked and drop-in appointments. The unit saw 20 to 25 women daily for pre-planned treatments such as ferinject (iron supplement) administration or to respond to specific concerns such as reduced fetal movements. The unit was open 7.45am to 8.45pm Monday to Friday and 10am to 6pm at weekends. Outside of these hours women were signposted directly to the delivery suite. The unit was supported by the consultant obstetricians who were on site and who attended to review scan if requested. The unit had a range of referral pathways for women including referral or specialist midwives, consultant led antenatal clinics and specialist physiotherapy. The unit also offered telephone advice and support to women who called with concerns during their pregnancy. We reviewed the standard operating procedure for the day assessment unit and saw it included clear indications for referral to the unit and an outline of basic antenatal checks required when a woman attended.

The lead midwife for perinatal mental health was seconded two days a week to the local maternity partnership to work at a regional level to develop perinatal mental health services.

Meeting people's individual needs

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

Staff made sure women living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff could access advice and support from the trust learning disability matron. They delivered training on learning and disability passports as part of midwife mandatory training days. Staff completed assessments of women's mental health needs and ensured they had an enhanced support plan in place, if needed, and communicated this to the ward and delivery suite.

Staff told us they worked with women with disabilities to allow them to visit the ward and delivery suite prior to giving birth to assess if any reasonable adjustments were needed or adjustments to their birth plans.

All baby cots were height adjustable so they could be used by women with physical disabilities or were wheelchair users. Staff told us they could access specialist equipment if needed and side rooms could be reconfigured to allow wheelchair access.

Staff could access bariatric equipment when needed through the trust medical devices department. the table in theatre had been changed to accommodate women with a higher body mass index.

Staff gave an example of support offered to a transgender woman through her journey though maternity services and they had received positive feedback from the woman about her experience.

Staff supported women living with learning disabilities by using 'This is me' documents and learning disability patient passports.

The service had information leaflets available in languages spoken by the women and local community. We saw health promotion posters displayed in the maternity ward in a range of languages.

Managers made sure staff, women, loved ones and carers could get help from interpreters or signers when needed. Staff could access translation and interpretation services for women who did not speak English as their first language. Community midwives could access translation services via their mobile phones to support women in the community.

Women who needed extra support as they chose maternity care outside of national guidance were supported by a safe and active birth midwife to develop an individualised birth plan. The safe and active birth midwife could also offer alternative therapy. Staff told us they had received positive feedback from women about this service.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge women were in line with national standards.

Managers monitored waiting times and made sure women could access services when needed and received treatment within agreed timeframes and national targets. Managers told us they worked collaboratively with other services in the care group to maintain services during the COVID-19 pandemic, for example finding alternative venues for antenatal clinics.

The number of bookings for delivery by 12 plus six weeks was monitored using the maternity dashboard. The dashboard for January 2021 showed 87% of women were booked for delivery by 12 plus six weeks.

Managers and staff worked to make sure women did not stay longer than they needed to. The service monitored postnatal length of stay. Technical issues with the electronic recording system meant that accurate data was not available for three months from November 2020 to January 2021. However, the maternity dashboard showed average length of postnatal stay had dropped to 9.8 hours in October 2020 to 2.8 in March 2021.

Managers worked to keep the number of cancelled appointments to a minimum. Staff contacted women booked to attend the day assessment unit who did not attend appointments to establish the reason for this.

Staff planned women's discharge carefully, particularly for those with complex mental health and social care needs. Community midwives provided visits for all women on day of discharge, day five and day ten. They could offer additional postnatal support visits over and above these if required.

Staff supported women and babies when they were referred or transferred between services. The maternity ward had four transitional care beds. These were beds where women who had babies who needed additional care and treatment from neonatal services, could stay on the ward with their baby supported by appropriately trained staff. This meant mother and baby were not separated.

However, managers told us they were unable to provide specialist clinics in all areas due to the challenge of the large geographic footprint of the trust.

Maternity

Learning from complaints and concerns

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

Women, relatives and carers knew how to complain or raise concerns. At the time of our inspection there was only one formal complaint which was being investigated. We saw data which showed the number of concerns raised to Patient Advice and Liaison was monitored against the number of care hours, however this was not broken into site specific data.

The service clearly displayed information about how to raise a concern in patient areas.

Managers investigated complaints and identified themes. All formal complaints were managed through the trust complaints department, who supported matrons to investigate theses and provide a response.

Staff knew how to acknowledge complaints and women received feedback from managers after the investigation into their complaint. All responses to formal complaints were signed off by senior leaders.

Managers shared feedback from complaints with staff and learning was used to improve the service. Managers reviewed complaints at a monthly managers meetings and feedback to staff.

However, staff struggled to give examples of how they used women's feedback to improve daily practice. Staff we spoke with said there were very few complaints and no themes or trends emerging from these.

Is the service well-led?

Requires Improvement 

Our rating of well-led went down. We rated it as requires improvement.

Local Leaders demonstrated they had the skills and abilities to run the service. They supported staff to develop their skills and take on more senior roles. They understood the priorities and issues the service faced. However, they were not always visible and approachable in the service for women and staff. There was a lack of continuity in midwifery leadership over time.

Staff we spoke with told us local managers and leaders were visible, approachable and supportive. We saw some senior leaders were visible on the unit throughout our inspection and had offices on the unit. There was a weekly meeting with the Deputy Head of Midwifery and all maternity matrons. Managers also attended fortnightly cross-trust managers meetings, which they stated helped with cross site collaboration. The clinical leads that cover for all three maternity locations also meet weekly, there is also a monthly medical staffing meeting that clinical leads, the Clinical Director and Clinical Service Managers attend to review staffing.

Midwifery staff could access support from a Professional Midwifery Advocate (PMA). PMAs offered regular drop-in sessions that midwifes could attend.

Maternity

The service was developing a leadership programme for senior midwives.

Local site leaders told us the senior team worked together well and attended a weekly formal catch up meeting. Leaders described good links and access to senior trust executives.

Managers told us that access to executives had improved and they did conduct regular walk rounds. Staff gave examples of when senior executives had been present at times of difficulty or crisis to offer support. However, some staff also told us executive leaders were not visible in the service.

The new non-executive maternity board champion had only recently been appointed and not all staff and managers knew who this was.

There was a lack of continuity in midwifery leadership over time. Staff told us this had led to a lack of clarity about the future direction and expectations in midwifery. At the time of our inspection, the Deputy Head of Midwifery was acting as Head of Midwifery and received support and coaching from an external Head of Midwifery. They attended weekly meetings with other Heads of Midwifery across the local maternity system.

Vision and Strategy

The service did not have a clear vision for what it wanted to achieve nor a strategy to turn it into action, developed with all relevant stakeholders. It was not clear how the development of a vision and strategy would be focused on sustainability nor be aligned to local plans within the wider health economy.

Local managers and leaders told us the vision for the service was under development. They told us they had attended meetings to begin to design a vision statement and the plan was to align this with the wider trust vision. However, they acknowledged this was work in progress. Local leaders told us both the clinical operational model and maternity strategy were due for review.

Senior leaders were not able to clearly articulate a vision and strategy for the service overall or at each location. They described the key priorities as improving the governance process and incident investigation process.

During our inspection we did not see any posters or displays which outlined the vision and values of the service.

Following our inspection, we asked the trust for information on the vision and strategy for the service. They told us they recognised the need to develop the vision and strategy for the service, but they were focused on ensuring midwifery leadership was in place and improvement work underway before developing this.

Culture

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

Staff we spoke with throughout the service told us they felt positive and proud to work for the service. Some staff who had transferred from other organisations told us there was a positive culture with good teamwork and support in the service.

We saw posters advertising the Freedom to Speak Guardian and how to contact them on display throughout the unit. Staff told us they felt confident to raise concerns with managers at a local level as well as being aware of how to raise them with the Guardian. New staff gave examples of how a learning approach was adopted when they had made a mistake and said there was a 'no blame' culture.

Managers we spoke with described a 'teach and treat approach' when concerns about care or treatment were escalated. This meant if a member of staff escalated a concern managers and medical staff either had to treat the concern or if they felt it did not require treatment then use the concern as an opportunity to teach and explain why they were not taking the concern forward. Managers said this had been received positively by staff.

The service had offered all staff COVID-19 risk assessments and 92% of staff had a risk assessment completed.

Governance

Leaders did not operate an effective governance process, throughout the service. Not all staff were clear about their roles and accountabilities. Staff had regular opportunities to meet, however there were limited opportunities for staff at all levels to learn from the performance of the service.

Leaders told us they recognised the need to improve governance processes and described the model they were using to begin this improvement work. Improvements were focussed on ensuring information flowed from ward to board and was not just held at management level. They were also focused on improving the incident investigation process and sharing learning from incidents and complaints. At the time of our inspection, improvement work on the governance processes was ongoing and not completed.

Some staff we spoke to told us they were not given clear expectations for their work and roles by leaders.

There were systems in place to share learning with staff about the performance of the service. The service had developed a picture-based information poster called 'safety summary', for all staff to share performance data based on the maternity dashboard. However, this was a new system and not fully embedded. The 'safety summary' was trust wide and not tailored to maternity services at Royal Lancaster Infirmary, which meant staff did not get information about specific performance to identify areas for learning in their areas or locations.

Though managers carried out a comprehensive range of local audits there were no established and reliable mechanisms or systems for reporting these audits upwards to senior managers and leaders.

Staff told us the maternity and gynaecology assembly, which was a cross-site forum for sharing learning and improvement ideas had been suspended during the COVID-19 pandemic. However, the assembly had resumed in March 2021.

The service had a panel to review progress against Kirkup recommendations. The trust shared a draft copy of the review. Of the 18 recommendations, the trust reported that 15 had been sustained fully and three were sustained partially.

The service had completed the maternity services assessment and assurance tool and submitted this to NHS England. The tool required services to complete a self-assessment against the seven immediate and essential actions arising from the Ockenden report. We reviewed the self-assessment and saw it was not fully completed. Some sections did not have a

description of how the service was measuring and reporting compliance with the essential action and there was not an indication of how risks were to be mitigated in the short term for all actions. It was not clear how actions identified to improve compliance with the immediate and essential actions were broken into realistic and measurable action plans with clear lines of responsibility identified.

Management of risk, issues and performance

Leaders and teams used some systems to manage performance, but these were not always effective. Not all relevant risks and issues were identified and escalated, nor actions identified to reduce their impact. Staff were not given opportunities to contribute to decision-making to help avoid financial pressures compromising the quality of care.

Managers carried out a range of quality assurance audits and told us outcomes from these were discussed at the Care Group Governance Assurance Group (CGGAG). This group was attended by the triumvirate and representatives of the whole women's and children's care group.

However, we were not assured effective action was consistently taken to make improvements following quality audits. For example, in June 2020 the audit of sepsis management showed compliance with completion of the maternity sepsis tool was 41% and there was poor documentation of the suspected source. The action was to encourage staff to complete this, there was no exploration of additional training needs or safeguard systems to ensure staff did this on a regular basis. Though a re-audit was recommended we were told the next sepsis audit was not due for another year. This meant there was a risk of continuing poor performance and poor outcomes for women with suspected sepsis.

The audit of maternity obstetric early warning scores had been presented in January 2020 and the re-audit was overdue and planned for June 2021. We saw there were areas of continuing poor compliance from previous audits for example, the recording of red and amber scores had declined from 71% in 2019 to 67% in 2020.This meant we were not assured leaders had oversight of progress on actions taken to address any poor or underperformance highlighted in audits.

The service told us surgical site infections following caesarean section were not monitored as part of surgical site infection surveillance but there was a plan to roll this out by speciality in future.

Action plans we reviewed for incidents that were referred to and investigated by the Health Service Investigation Board (HSIB) were not always effective or robust enough to mitigate risk and did not identify how learning would be shared across sites.

We asked the service to provide any reports or action plans against MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) audit outcomes. The information supplied was not specific to this maternity service and did not reference any local learning or action plans. We reviewed the trust response to the national maternity and perinatal audit 2018-2019 and saw there was little detail in the action plan of how the service intended to meet key actions.

There was a lack of local oversight and ownership of risk. Managers we spoke with told us there were no location specific risks for the service and no local maternity risk register, only an overall risk register for maternity services.

Actions taken to mitigate risks were not always clear. For example, managers told us the door keypad codes and access was on the risk register, however, managers and staff showed varying awareness of the mitigating actions to deal with this risk.

Maternity

Leaders told us they reviewed all risks with the risk team throughout January and February 2021 to ensure they were up-to-date and accurate but it was not clear how staff at ward level contributed to escalation of risks.

The service used the nationally recognised perinatal mortality tool to review all baby deaths and conducted a rapid review into all deaths. The service had not reviewed all historic cases at the time of our inspection. Managers told there was a plan to ensure this was completed by the end of May 2021.

Some staff we spoke to told us they had not been involved in contributing to changes in service structure which impacted on women's care. They told us when changes had been made they had been left to develop models of care with no clear leadership or direction.

The service reported they had achieved full compliance with the national maternity incentive scheme in years one and two.

Information Management

Although the service collected different data, leaders did not always analyse it to make improvements. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were not fully integrated; however, they were secure.

Managers told us they felt trust-wide quality assurance and audit systems did not always take account of maternity specific circumstances. The trust had introduced a new quality assurance system immediately prior to our inspection. The maternity ward had not been included in this system. Though managers told us they felt they had information at a local level to make improvements they felt systems did not allow for accurate reporting upwards and maternity ward based audits were not available through the quality assurance system to senior managers at the time of our inspection.

Some staff told us there were issues with online training compliance system and this meant it had been difficult to get accurate data on training compliance. However, they did say this was improving.

Managers told us the service was getting a new electronic patient record system in July 2021. This was to be trialled in antenatal clinics and community before being rolled out to inpatient areas.

The service had a digital midwife who validated all data submitted via the maternity dashboard.

The service provided the maternity dashboard for the service but told us it was difficult to capture consultant versus midwife led birth in the current system. They also there were technical issues in acquiring length of postnatal stay figures.

Engagement

Leaders did not consistently engage actively and openly with staff. There was some engagement with women, the public and local organisations to plan and manage services. There was limited collaboration with partner organisations to help improve services for women.

Staff told they tried to work with maternity services at South Lakes Birth Centre and Helme Chase but this was limited due to geographical constraints.

However, some staff also told us they had been involved in the design of the new enhanced midwifery model. The enhanced support midwives were a team of specialist midwives who provided individualised care to vulnerable women and families such as those living in poverty, asylum seekers and women with learning disabilities. At the time of our inspection, the service was developing this model with plans to incorporate other specialist midwife roles such as teenage pregnancy into the more generic enhanced support team.

Staff told us collaboration with some partners such as local authorities varied from area to area with it being difficult to establish links with some local authorities.

The service did collaborate and work with the local maternity voices partnership with regular meetings between senior midwifery managers and the chair of the maternity voices partnership. The service had commissioned a panel to review progress against recommendations in the Kirkup report which included external partners such as commissioners and the maternity voices partnership.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. Leaders encouraged participation in research. However, staff and leaders did not have a good understanding of quality improvement methods and the skills to use them.

Staff were working with the national research project 'Born into Care'. They worked with external partners to provide memory boxes for women whose baby was being removed into care following birth.

The service was part of a programme to prevent abusive head trauma in babies, as this had increased during the COVID-19 pandemic. This was an educational programme delivered to women and families to promote comfort methods and encourage them to never shake their baby. Staff told us this had been received positively by the women who had taken part and they had seen no increase in abusive head trauma during the pandemic.

The service was working with the local maternity system to ensure all women received safe sleeping advice throughout their pregnancy and therefore, prevent baby deaths. We saw safe sleep posters displayed in the maternity ward and all women were offered safe sleep assessments prior to going home with their baby and at their first postnatal appointment.

Leaders told us they recognised improvement could be made to handovers and this was ongoing improvement work with some initial actions such as poster to remind staff of the structure approach beside beds.

Though managers described learning from recent performance on post-partum haemorrhage they told us there were no other workstreams ongoing to make improvements in other areas.

However, following our inspection the service provided evidence of several improvement workstreams such as postnatal mental health and improving the environment that had been discussed at the maternity and gynaecology assembly since March 2021.

Some staff expressed frustration that quality improvements initiatives they suggested were not acted upon even when there was evidence to support the improvement.

Maternity

Though leaders described quality improvement models and initiatives it was not clear how staff engaged with these. There was a mechanism for feedback to staff through the three-minute brief but this was for information only not action or involvement in the improvement process. Leaders told us they had recognised this issue and were looking to improve this through ongoing improvement workstreams.

Westmorland General Hospital

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Description of this hospital

Westmorland General Hospital is a part of the University Hospitals of Morecambe Bay NHS Foundation Trust. It has an urgent treatment centre and a midwifery-led maternity unit and provides elective surgery and out -patient services.

We visited Westmorland General Hospital as part of our unannounced inspection from 20 to 22 April 2021.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

We visited urgent and emergency care and maternity core services as part of the inspection.

The Urgent Treatment Centre (UTC is staffed by GPs, doctors, emergency nurse practitioners and nurses.

The UTC became part of University Hospitals of Morecambe Bay Foundation Trust in April 2018. Prior to this is it was managed by a different foundation trust. The UTC was initially a Primary Care Assessment Service. It was then reclassified to an UTC in line with national guidance.

The UTC is designed to treat patients with minor illnesses and injuries. Patients with more serious conditions such as chest pains, strokes, serious illness or serious injuries attend the nearest Accident and Emergency department in Lancaster. If a patient attends with these more serious conditions, then the trust arranges for transfer to the nearest emergency department whilst maintaining the patients care and safety within the unit capabilities.

The UTC operates between 0800 and 2200 seven days a week.

Helme Chase is a midwife-led unit, based at the Westmorland General Hospital. A midwife-led unit means there are no doctors present. Women can give birth at Helme Chase 24 hours a day, seven days a week, supported by a midwife.

Women who have been identified with an uncomplicated pregnancy, i.e. they are unlikely to develop any complications during pregnancy, whilst giving birth, or after their baby is born, can choose to give birth at Helme Chase.

Community midwifery services provide antenatal, intrapartum and postnatal care including birth at home.

Between April 2020 and March 2021 there have been 15 babies born at Helme Chase. The birth rate prior to the COVID-19 pandemic was reported as 10 to 12 births per month including home births.

Our findings

We were not able to observe care and treatment as no one was using the service during our site visit.

Our rating of this location went down. We rated it as requires improvement because:

- Across both services, staff did not always feel supported by the executive leadership team and reported they were not visible.

Maternity care

- There was not always enough staff to care for women and keep them safe. Concerns were identified in relation to cleaning the birthing pool. The design, maintenance and use of facilities, premises and equipment in maternity services were not managed well to keep people safe. Maternity staff did not always complete and update some risk assessments for each woman nor take action to remove or minimise risks. Staff did not always identify and quickly act upon women at risk of deterioration. The maternity service did not always have enough staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. The maternity service did not always manage safety incidents well.
- The service did not always provide care and treatment based on national guidance and evidence-based practice. Managers did not check to make sure staff followed guidance. There was a lack of clear information to evidence how the service monitored the effectiveness of care and treatment. The service could not demonstrate how they used findings to make improvements and achieve good outcomes for patients. The service did not always make sure staff were competent for their roles.
- The service did not plan and provide care in a way that met the needs of local people and the communities served. Women could not always access the service when they needed it nor receive the right care promptly.
- The service did not run services well using reliable information systems or always support staff to develop their skills. Leaders did not operate an effective governance process and not all relevant risks and issues were identified and escalated with actions identified to reduce their impact. It was unclear what the vision was for the service.

However:

- Across both services, staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Staff kept good care records and managed medicines well.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

Urgent and emergency care

- The service had enough staff to care for patients and keep them safe. The service controlled infection risk well. Staff assessed risks to patients, acted on them and safety incidents well and learned lessons from them.
- Staff provided good care and treatment. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients. Patients were advised on how to lead healthier lives and supported them to make decisions about their care. Key services were available seven days a week.

Our findings

- Urgent and emergency services had improved and planned towards care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. We saw information about how patients could give feedback throughout the centre. People could access the service when they needed it and did not have to wait too long for treatment.
- Local leaders ran the urgent treatment centre well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service had improved since the last inspection and engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Maternity care

- Patients and women were given enough to eat and drink, and pain relief when they needed it.

Urgent and emergency services

Good ↑

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff and made sure everyone completed it.

At our last inspection we told the trust to have a plan in place for staff mandatory training so all staff have completed their mandatory training. The centre had improved and all staff received and kept up to date with their mandatory training. Staff told us about the ongoing improvements with mandatory training.

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

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

Managers monitored mandatory training and alerted staff when they needed to update their training.

Safeguarding

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

At our last inspection we told the trust to ensure staff are up to date and aware of their responsibilities in relation to consent, mental capacity and mental health thus protecting patients from inappropriate care and treatment. The centre had improved and staff received training specific for their role on how to recognise and report abuse. Safeguarding completion rates had improved since the last inspection. For level one training the compliance rate was 100%, level two 100% and level three 93.8%. Training rates for the Mental Capacity Act and Deprivation of Liberty Safeguards were 100%.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Support was available to patients attending the centre.

Safeguarding support was available to all staff at the centre from the trust's safeguarding team. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Cleanliness, infection control and hygiene.

Urgent and emergency services

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

The centre was visibly clean. Throughout the inspection we saw cleaning staff working around the department and staff told us that the teams were responsive when areas needed to be cleaned. We saw that staff were cleaning trolleys and rooms between patients and deep cleans were completed as necessary. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

There were adequate supplies of personal protective equipment (PPE) and we saw that staff used it appropriately and in accordance with government guidelines. There was information on the walls of the department about appropriate PPE usage.

During COVID the centre had pathways for testing patients with potential COVID to allow for safe movement around the centre. At the time of inspection this was still in place.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

At the last inspection we told the trust to ensure there was a safe place to support and treat patients who were living with a mental health condition; this reduced the risk of them self-harming. The centre had improved and had adapted an area for patients living with a mental health condition. There were no ligature risks and there were protocols in place for removing furniture that could be used as a weapon.

At the time of inspection there was also additional plans in place to adapt a new room that would be more suitable for people with mental health needs. Staff we spoke with showed us the plans which were about to begin and the benefits to patients.

Staff carried out daily safety checks of specialist equipment including the resus trolley, and all checks were in date and accurately recorded. The service had enough suitable equipment to help them to safely care for patients.

Due to the size of the centre there was issues with storage. We saw that three oxygen cylinders were stored incorrectly. We informed the unit manager and immediate action was taken.

In the centre there was designated areas for triage and eye tests which were visibly clean.

The children's area in the waiting room was monitored by CCTV from the medical decision room. However, line of sight was still a risk as the position of the reception did not allow for children to be monitored safely at all times.

At the time of inspection, a business plan was in place to change the layout of the reception area that would improve the line of sight to the children's area.

We checked the resuscitation room which was well-equipped, and we observed patients received immediate care and treatment in the resuscitation room that was doctor led.

Assessing and responding to patient risk

Urgent and emergency services

Staff completed risk assessments for each patient swiftly. Staff identified and quickly acted upon patients at risk of deterioration.

Patients were triaged on attendance by a qualified nurse who assessed each patient, gave pain relief if it was required and carried out basic observations. They could also request x-rays and perform tests such as electrocardiograms (ECGs). The triage nurse then categorised the patient depending how urgently they needed to be seen.

Staff used a nationally recognised tools to identify deteriorating patients, including children. This was evidenced in the patient records we reviewed. National early warning score system (NEWS) and paediatric early warning scores (PEWS) were recorded accurately.

Staff were prompted on the electronic record system to 'consider sepsis' and escalate to a doctor if required. Staff we spoke with talked us through the sepsis policy and protocol. Patients being treated for sepsis were nursed in the bays and transferred out via ambulance to the nearest and most appropriate emergency department.

There were handover huddles every time staff started shifts or more frequently if required. These were led by the unit manager, doctor or nurse in charge of the department. Staff shared key information to keep patients safe when handing over their care to others.

Shift changes and handovers included all necessary key information to keep patients safe.

Staffing

The centre had enough clinical and nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

At the last inspection there were concerns regarding the reviewing of staffing establishments. This had improved and we saw that there were enough nursing and support staff to keep patients safe. Staff told us that the planned numbers had improved including having the appropriate skills mix and this included having additional advanced nurse practitioners (ANP) in post. We saw that managers accurately calculated and reviewed the number and grade of nurses and other health professionals for each shift in accordance with national guidance.

The culture of the department was very supportive across grades and professional groups. We observed good working practices and relationships between all staff.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

We looked at seven patient records. Patient notes were comprehensive, and all staff could access them easily.

When patients were transferred to another department there was no delay in accessing the information. However, confidentiality and sharing information in the reception area was not always done in line with national guidelines. People who used the centre could hear personal information being read out in the reception putting people's confidentiality at risk.

Urgent and emergency services

At the time of inspection there was a business plan in place to alter the reception area that would ensure peoples' personal information was not heard by other people using the service.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines.

At our last inspection we told the trust to ensure all medicines including controlled drugs are stored appropriately and checked in line with trust policies. At this inspection we found that staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Managers ensured that actions from patient safety alerts were implemented and monitored.

At our last inspection staff did not always report incidents due to time constraints. On this inspection staff told us they were now supported and knew what incidents to report and how to report them.

Staff told us that they raised concerns and reported incidents and near misses in line with trust policy. Staff told us that with ongoing training and support they have improved the completion of reporting incidents since the last inspection. We saw that when an incident was reported managers responded about any learning or changes made as a result.

Is the service effective?

Good ↑

Our rating of effective improved. We rated it as good.

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver care according to best practice and national guidance. We looked at seven policies and found these to be continually reviewed and up to date.

There were clinical guidelines available on the intranet and these were easily accessible; Guidelines we reviewed were up-to-date and had been reviewed and revised since our last inspection. In the centre, there were laminated sheets for pathways that included adult and paediatric algorithms for life support/ choking/ anaphylaxis, and these were easily accessible by staff.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

Nutrition and hydration

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

Patients could access water in the department and staff told us they could access light snacks for patients who needed to eat for medical reasons.

Specialist support from staff such as dietitians and speech and language therapists were available to come the centre for patients who needed it.

Pain relief

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

Patients received pain relief soon after it was identified they needed it, or they requested it. We observed staff asking patients who had arrived at the centre about their pain and supported them to make a decision about any additional pain relief in line with their individual needs.

We spoke to three patients who told us that they were offered pain relief at triage and the nurse explained the treatment.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The centre did not take part in national royal college of emergency medicine (RCEM) audits because it did not meet the inclusion criteria.

The centre manager told us that they carried out a programme of local audits to check improvement over time. We saw audits for re-attendees and the manager told us that they worked with partner agencies improve overall care and these had been embedded since this last inspection and achieved good outcomes for patients. Trust wide unplanned reattendance was 8.7% in December 2020 which was similar to the England average.

Managers shared and made sure staff understood information from the audits. Improvements identified were checked and monitored.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. We spoke to a range of qualified staff who all told us that the unit manager and clinical lead held regular supervisions and supported staff with their development. The centre had improved since the last inspection and all clinical staff had paediatrics training. Nursing staff told us that they had completed paediatric life support training and that if they required advice, they could request this from paediatrics nurses at Lancaster Royal Infirmary.

The centre manager and clinical lead gave all new staff an induction that was focused on their role. On day of the inspection we saw a new doctor being supported by the clinical lead who was reassuring and supportive.

At the last inspection we told the centre to have robust plan in place for staff mandatory training so all staff have completed their mandatory training. The centre had improved and managers supported staff to develop through yearly, constructive appraisals of their work. During the COVID pandemic there was a new updated appraisal that was adapted accordingly. Staff were supported throughout the pandemic and this reflected the changes and ongoing needs of staff.

Not all of the GPs at the centre had a background in emergency medicine at the centre. However, The NHS guidance for UTC principles and standards states UTC should be GP led, staffed by GPs, nurses and other clinicians and this reflects the staffing model at the centre.

Staff also told us staff had received more comprehensive training. We saw that this included advanced life support and that all staff at the centre had completed this.

The clinical educators supported the learning and development needs of staff. Nursing staff told us that they received support from the doctors at the centre.

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

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

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

Multidisciplinary working

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

There had been improvements since the last inspection and staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

Urgent and emergency services

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. We spoke to staff and they explained the process of referral. The centre used SBAR (situation background assessment and recommendation) handover tool to ensure all key elements of care and treatment are discussed in a structured way so everyone in the team has the information needed to provide safe care and treatment.

The centre worked with other departments on the hospital site to support patients who had additional health and social care needs. Staff showed us how they could access patient information using an electronic system. This included information such as previous clinic letters, test results and x-rays. Staff could also access patient GP records with the agreement of the patient. All staff could access information with the most up to date medications and health conditions to enable them to make a better diagnosis and treatment plan.

Seven-day services

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

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services for the time the centre is open, Monday to Sunday 0800 to 2200.

Posters and leaflets were visible in the centre and accessible in the main reception area advising patients about support services like health and wellbeing services to patients.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

The centre had improved from last inspection and staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

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

Is the service caring?

Good 

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

Compassionate care

Urgent and emergency services

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

Staff were responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

However, we found that patient's personal information on arrival to the UTC was not kept confidential. This was highlighted with the unit manager and plans were in place to change the process.

At the time of inspection there was no visible information for patients who wanted to request a chaperone. Staff we spoke with did tell us that patients could request a chaperone.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. At a handover meeting, we observed staff referring to the psychological and emotional needs of patients, their relatives and carers.

Staff provided emotional support to patients, families and carers to minimise their distress. We observed staff offered emotional support to children and their parents and took time to interact with children and their parents in a considerate way and thoughtful manner. Though we did not see any patients with mental health needs whilst on inspection staff told us the importance of supporting patients who became distressed in an open environment and helped them maintain their privacy and dignity.

Understanding and involvement of patients and those close to them

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

We observed staff at the centre treat children in a reassuring, calm and professional manner. Patients we spoke to said that staff were friendly and reassuring.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We saw equality and diversity training formed part of the centres mandatory training schedule and we saw evidence that this had been undertaken by clinical and non-clinical staff.

Is the service responsive?

Good ↑

Our rating of responsive improved. We rated it as good.

Service delivery to meet the needs of local people

Urgent and emergency services

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

Since the last inspection the centre had implemented and embedded standard operating procedures for transferring patients to appropriate care settings. Staff explained the procedures for safe transfer and for ailments that could be treated at the centre. Staff showed us how they could access the standard operating procedures on the intranet.

The centre had engaged with local communities, local holiday lets, campsites and tourists promoting the services that the centre provided and how to access them. This included what type of ailments could be seen at the centre and this was an ongoing piece of work due to the nature of the centre and the types of patients that visited, particularly in the summer months when tourism numbers increase.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet their needs. Staff told us that they could refer patients to support services if they thought patients needed additional help or support.

We saw that the service had information leaflets available in languages spoken by the patients and local community. The centre had access to interpreting services for people whose first language was not English.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

The urgent treatment centre service was available between 0800 and 2200 seven days a week throughout the year.

Managers and staff worked to make sure patients did not stay longer than they needed to. We observed patients being treated in a timely way and did not have a long wait to see a doctor, nurse or any health professional. The department consistently met the four-hour performance standard. Staff did tell us about the issues of transferring patients to appropriate care settings and the challenges involved and the improvements made since the last inspection. The centre had improved since the last inspection and senior management were aware of these issues and there are now pathways in place for all staff to follow for common ailments or injuries to ensure best practice and appropriate treatment plans were followed.

Improvements had been made since the last inspection as a number of bloods test could now be done on site at the centre. Patients with chest pains or suspected heart attack should go to the nearest accident and emergency department. However, some patients self-presented at the centre and they could require troponin blood testing, which detects if troponin is present in the blood stream, indicating possible heart attack were at risk as these had to be sent to another location and results could take up to four hours for results of the tests. Staff told us that it can take up to four hours to get the results from the troponin blood test putting the patient at risk.

Urgent and emergency services

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

Managers investigated complaints and identified themes. We looked through three recent complaints and found that the managers had acted appropriately. Comprehensive responses and apologies in line with Trust policy.

Is the service well-led?

Good ↑

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

Leadership

Local leaders had the skills and abilities to run the service and they supported staff to develop their skills and take on more senior roles. However staff told us there was a lack of visibility of senior leaders.

There was effective local leadership of doctors and nurses in the department which had improved since the last inspection of the service. Staff told us that in the department there was strong support from their manager. They said that there had been clear improvements in patient care and patient safety following the last inspection. There was a new matron in post and staff reported that the local leadership were supportive and visible.

The departmental clinical lead was well-sighted on the issues facing the department. However, staff reported that they were frustrated in risks to patients by a lack of support from executive team for inappropriate transfers. Staff told us the senior leaders did not regularly visit the service.

Vision and Strategy

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

The trust vision was: *"We will consistently provide the highest possible standards of compassionate care and the very best patient and colleague experience. We will listen to and involve our patients, service users, colleagues and partners."*

There were five core values, known as the five P's, these being, patients; people; partnerships; progress and performance.

These were outlined in the trust strategy 2019-2024 that was aligned with the Better Care Together health economy transformation programme.

We saw that the five core values were embedded, and governance meeting agendas were based on these five topics. The vision was displayed on notices around the centre and the wider hospital site

The clinical strategy 2019 to 2024 contained a number of objectives under the emergency and urgent care model. This included to work with Bay Health and Care partners to ensure a comprehensive streaming model is in place to ensure that only patients who require emergency services attend accident and emergency departments while continuing to deliver urgent care services at Westmorland General Hospital.

The objectives for the centre were spread across a number of strategies. When asked about a strategy for the urgent and emergency care departments, senior managers told us that there was a wider strategy for the medicine care group to identify priorities over the next 12 months. Each department was developing a "plan on a page" that fed into this, but we were told that this had been delayed since January 2021.

Culture

Staff felt respected, supported and valued at a local management level. They were focused on the needs of patients receiving care, including during busy periods. The service had an open culture where staff could raise concerns.

The atmosphere in the department, whilst busy at times during inspection, was calm and staff were aware of their roles and what they needed to do. We observed that staff worked closely together for the needs of patients.

There was a culture of teamworking in the centre. All staff worked together well with the patient as their focus. The atmosphere in the department showed staff focus was on treating patients in a caring way and we observed that staff took time to support each other.

Doctors reported and we saw that they had a good working relationship with nursing staff and that managers in the department had an "open door" policy.

Governance

Leaders operated effective governance processes, throughout the service and with partner

organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

At the last inspection we told the trust to ensure all departmental risks are reflected on the risk register. The centre had improved, and we found that the risk register was reflective of the issues facing the centre.

The Urgent Treatment Centre was part of the medicine care group. There was a triumvirate leadership team for the medicine care group, this being a clinical director, associate director of nursing and associate director of operations. They were supported by a governance business partner and two deputy associate directors of nursing. The associate director of operations, governance business partner and one of the deputy associate directors of nursing had only been in post for a short time. Local leadership was strong, however; there was very little oversight from senior leadership

Urgent and emergency services

At the last inspection we told the trust to ensure robust governance processes were in place which are embedded in practice. The centre had improved and we saw there was a clear governance framework in place that enabled key issues and messages to be communicated from the centre to the board and vice versa.

There was a monthly medicine care group governance and assurance group meeting attended by the matron, clinical lead and service manager including the urgent treatment centre. This meeting covered a standard agenda following the assurance slide deck from each department. This included; incidents (numbers, types, trends, root causes and lessons learned); NICE guidance; cancer targets; risk registers and learning to improve.

The local leadership at the centre told us that key messages from the governance meeting were reported to the care group and in turn to the quality committee from which key message were reported to the trust board.

There were weekly medical leads meetings and a senior nursing group meeting where key messages were delivered from executive and board level and these were cascaded down to staff in the department through the learning to improve bulletin and daily huddles.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

The medicine care group had a risk register. The biggest risk at the urgent treatment centre was inappropriate attendances to the centre. Management were aware of this risk and had put actions in place including sending out media communication to local holiday lets to engage with tourists and people from outside the area.

The risk matrix was based on the likelihood of the risk occurring and the severity of impact to give a red, amber or green rating. Controls and actions to mitigate the risk were also on each risk report.

The highest risk was inappropriate attendances and at time of inspection the centre was preparing for the summer surge with holiday makers and tourists visiting the area once lockdown restriction due to the pandemic were lifted.

Information Management

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

Data was collected to measure performance using several IT systems. Included in this were the time from arrival to treatment, overall time in the centre and outcome such as discharge or transferred.

There was a secure electronic incident reporting system in place that could be used to analyse themes and trends in reported incidents to enable reviews and appropriate mitigating actions to be taken.

Staff had access to policies and procedures via the trust secure intranet and staff demonstrated that these could be accessed easily.

Patient records were stored securely on an electronic patient record system.

Urgent and emergency services

Engagement

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

Patients were able to leave a patient feedback about their experiences at the centre.

The trust had been working with charities to improve support to veterans, many of whom suffer from mental health and musculoskeletal conditions.

The chief executive held forums for staff called “Tea and Talk” where any issues or concerns could be raised. Some staff delivered a “topic of the month” and delivered training to colleagues and had notice boards dedicated to the topic in the staff room.

There was a range of communications to staff to advise them of changes and improvements, such as emails, staff huddles, an improvement newsletter and ward meetings for each grade.

Staff had also been involved in the proposed improvements to the centre such as the mental health room and overall layout of the centre. Management and staff showed us the plans and how such changes would have a positive impact on the centre and the people who used it.

Learning, continuous improvement and innovation

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

Staff in the centre were committed to improving the facilities and environment for patients with mental health conditions and children.

This included the introduction of a pager system for patients with learning disabilities or autism so that they were able to remain in a car rather than in a waiting room before being seen.

The frequent attenders team who had worked with mental health services, the ambulance service and CCG to ensure that care plans were in place for patients with mental health conditions attended the centre regularly to reduce the number of visits to the department and ensure these patients had support from more appropriate services.

Maternity

Inadequate

Is the service safe?

Inadequate

Our rating of safe went down. We rated it as inadequate.

Mandatory training

The service provided mandatory training in key skills to staff and made sure everyone completed it, however, this often had to be completed by staff outside of working hours.

Nursing and midwifery staff we spoke with told us they received and kept up to date with their mandatory training. Community midwives were given one day per year protected time for online mandatory training. However, staff told us it was difficult to complete in the time frame resulting in training being done in their own time.

Following our inspection, the service told us they increased the number of mandatory training dates available to four per year from April 2021. They told us managers could use the 24% uplift built into staffing establishment to additional protected time to staff if needed.

The mandatory training was comprehensive and met the needs of women and staff. Staff told us that in addition to attending the NHS 10 core skills training, they completed training in incident reporting and fetal monitoring. Staff also attended three mandatory training days each year, one of which was for PROMPT training. PROMPT stands for Practical Obstetric Multi Professional Training and is training for professionals across disciplines in maternity services for responding to obstetric emergencies. During the pandemic this training was moved to online modules to ensure staff could continue to keep up to date with training and the face to face training restarted for groups of six people in April 2021.

Managers told us that during the COVID-19 pandemic compliance with mandatory training had been reviewed at each 'SITREP' call between matrons, ward managers and senior managers and these were held three times a week

Staff received additional training in response to identified risk. For example, in response to serious incidents staff received training on how to recognise and manage post-partum haemorrhage prior to the reopening of Helme Chase following closure during lockdown.

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities, and autism. Staff received perinatal mental health training during the mandatory training days.

Safeguarding

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

Nursing and midwifery staff received training specific for their role on how to recognise and report abuse. Staff compliance with level three safeguarding adults and children training across the trust was 94%. However, this is not broken down for each site so we could not be assured if all staff at Helme Chase had completed the relevant safeguarding training.

Safeguarding training had continued during the COVID-19 pandemic, with safeguarding supervision available either face to face or virtually for staff.

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. There were two safeguarding support midwives who worked across the trust's maternity services, to provide specialist support for any identified safeguarding concerns.

Staff had access to the national child protection information sharing system, and checked this system if any woman attended the hospital to give birth who had not been booked in.

The electronic patient record system included a 'flag' for safeguarding so staff could easily identify known safeguarding concerns with a woman and her family.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with gave examples of identifying potential safeguarding concerns and reporting these appropriately to internal safeguarding team and external agencies to safeguard the woman and her family.

The safeguarding team had a duty line which staff could contact Monday to Friday from 9am to 5pm.

A specialist midwife for vulnerable families was assigned to Helme Chase. However, midwives at Helme Chase reported they did not feel they had the same access to the specialist midwives as their colleagues based at the Royal Lancaster Hospital and the South Lakeland Birthing Unit at Furness General Hospital. The service told us safeguarding supervision was offered throughout the pandemic. However, staff told us safeguarding took up a lot of their time and was not considered in the staffing numbers. Staff also told us that due to the size of the unit and geographical restrictions they did not get the same exposure to, or number of, safeguarding concerns as other units.

Staff followed the baby abduction policy. The policy was reviewed in October 2020 and included a clear one-page flow chart for to staff follow in the event of a suspected baby abduction. A baby abduction drill had taken place in January 2021.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept equipment and the premises visibly clean. Staff mainly used equipment and control measures to protect women, themselves and others from infection. However, we were not assured the birthing pool was cleaned in line with trust policy.

The unit was clean and had suitable furnishings which were clean and well-maintained.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE), being bare below the elbows, face masks and hand hygiene measures. Staff washed their hands before and after providing care using the World Health Organisation five moments for hand hygiene. We observed staff followed 'bare below the elbows' guidance.

Hand hygiene and cleanliness audits confirmed that these were 100% compliant. Rates of infection for clostridium difficile and methicillin-resistant staphylococcus aureus were displayed on the entrance to the unit with no reported infections for the month prior to our inspection. The maternity dashboard indicated there had been no sepsis incidents reported.

However, the service did not have a specific policy for cleaning of the birthing pool. The service provided information that showed they had a water birth policy which included how to clean the pool. This referred to the water safety standard policy which was not provided by the trust but was not specific to the cleaning of birthing pools. The service told us the birthing pool cleaning policy was waiting to be ratified and implemented during our inspection. We saw staff cleaned the birthing pool using a sodium chloride solution which was not the product specified in the trust policy nor supplied through trust procurement arrangements.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment were not managed well to keep people safe.

The service did not always have enough suitable equipment to help them to safely care for women and babies. We found relevant equipment safety checks were not always completed. For example, we found a breast pump that was due an equipment check in 2018 and suction equipment that had not been tested and the test was due in 2019. Infant scales were not always calibrated and maintained in line with best practice.

We found a delivery bed continued to be used despite two missing parts and these had been ordered in October 2020. We also found a bathroom light was not working which we brought to the attention of staff and it was replaced immediately. We found two full sharps bins in an unlocked storage cupboard along with other equipment. The sharps bins were closed so did not pose an immediate risk. We spoke to staff who did not know who was responsible for ensuring the full sharp boxes were disposed of.

Staff checked home birthing kits weekly. However, we founds some items in a bathroom, which was being used for storage, were out of date. Examples included moisturiser and urine testing equipment.

The design of the environment did not always follow national guidance. The environment was cluttered, with clinic rooms, birthing rooms and bathrooms being used as storage facilities. Staff were not always clear who had responsibility for the equipment held in these storage areas. We saw equipment was stored in the bathroom which meant this could not be used by women whilst they were on the unit.

Staff we spoke with stated the environment was not always used appropriately for the benefit women who chose to deliver at Helme Chase. The unit had three delivery rooms, however, only one was in use at the time of our inspection. We saw the other two rooms were used as ante-natal clinics. Staff we spoke with told us they had not been consulted regarding these changes and they had been implemented at trust level. However, this was at the start of the COVID-19 pandemic and urgent actions were required due to the closure of other venues.

Helme Chase had facilities to meet the needs of woman who wished to use the birthing pool. However, we were told by staff that six people were required to remove a woman from the pool in the event of an emergency using the net available. In addition to the two staff in attendance at the birth, staff would call upon the birthing partner and a porter to assist which would be four people. However, the water birth policy states that three people are required.

There was an additional bath (not a birthing pool) which staff told us could be used as a 'birthing pool'. However, it was not fit for purpose as a birthing pool and did not have the facilities to remove a woman in the event of an emergency as the net was kept in the birthing pool room. Following our inspection, the service told us that though the bath was installed to provide additional capacity for water births it had not been used as such since 2014.

However, we also saw staff had some suitable equipment to help them safely care for women and babies. For example, all community midwives were provided with their own equipment which they kept in their vehicles or on the unit. In addition, the home birth emergency obstetric bags, emergency grabs bags and emergency drug bags were available. Due to the COVID-19 pandemic, on call midwives collected equipment from the unit before attending homebirths which recommenced in November 2020.

We saw equipment and bags were checked weekly and documented on schedules. We found one bag had urine analysis sticks which were out of date these were removed when escalated to staff.

Community midwives transported medical gases using specific holders in their vehicles to prevent movement in line with best practice. Their vehicles also had stickers displayed stating that gases were being transported. Medical gas stickers were purchased by the service. However, some staff told us they were not provided with these and they had to source them online.

Staff carried out daily safety checks of specialist equipment. There was an adult resuscitation trolley and we saw the daily check list register was fully completed. We carried out a random check of the trolley and its contents and saw all equipment was in date.

Assessing and responding to patient risk

Staff did not consistently complete and update some risk assessments for women nor always take action to remove or minimise risks. Staff did not always identify and quickly act upon women at risk of deterioration.

Staff used a nationally recognised tool to identify women at risk of deterioration during labour. They were required to use the Modified Early Obstetric Warning System (MEOWS) tool during labour and also at admission and discharge from the unit.

Staff did not use a nationally recognised tool to identify women at risk of deterioration as they were not routinely required to use the Modified Early Obstetric Warning System (MEOWS) tool as all women were low risk. At our last inspection we saw staff used the MEOWS tool and it was not clear why this changed.

Staff did carry out routine observations after labour. However, we reviewed the audit of observations from January to March 2020. We saw that in three out of nine births no observations were recorded after delivery of the placenta. In eight of the nine births, observations were only recorded once and not repeated. This meant there was a risk that women may deteriorate, and staff would not recognise this as observations were not being routinely carried out.

The service had recognised the need for improvement and identified actions to be completed by August 2020. However, this was delayed due to the implementation of e-observations and was due to be reviewed again in June 2021 to see if observation recording had improved.

The service was planning to implement a new electronic record system, anticipated to be in place in July 2021. We were told proposals for the new system were shared with the board in December 2020.

Staff did not always complete risk assessments for each woman on transfer to or admission to the unit. This was because out of hours, if a woman was in labour, she called the out of hours number and the on-call midwife called the woman to arrange a time for her to attend the unit. This was based on the time it took for a midwife to arrive at the unit rather than an assessment of specific risk issues. If the woman arrived before the midwife, the night sister or a porter at Westmorland General Hospital would open the unit for the woman meaning the woman was potentially left in labour without a midwife present.

The service had reviewed all cases for the last four years and found one occasion where a woman arrived and a second midwife was not present but the woman was cared for by one midwife and a nurse.

We were told if a woman arrived before the midwife an incident form would be completed but this situation had not occurred in the last 12 months, as the unit was closed due to the COVID-19 pandemic. Staff told us if a second attendee was required during labour the night sister could be used as a second midwife, however she was not a qualified midwife.

Midwives completed risk assessments at booking to identify women with any medical, obstetric, psychological or lifestyle risk factors. This determined if a woman was high or low risk. High risk women were referred to consultant led antenatal clinics. Midwives we spoke with told us risk assessments were repeated at each antenatal visit.

However, we saw an incident was reported where a woman with complex issues had her care transferred to another unit and not all appropriate risk assessments had been completed nor reviewed during antenatal care.

Staff knew how to identify and act upon women at risk of deterioration during a home birth. There were clear escalation processes in place should a woman require consultant led care. However, there were no clear individualised birth plans for transfer of women in labour nor robust transfer handover checklists.

Where consultant input was required because of complications in labour, women were transferred by ambulance to either the Royal Lancaster or Furness General Hospital. There were clear processes in the event of maternal transfer by ambulance, from home to one of the acute hospital sites. There was nothing specific in the home birth policy regarding transfers from Helme Chase. However, the home birth policy cited an additional maternity transfer policy, which the service was unable to provide at the time of the inspection.

However, staff did not always escalate women at risk of deterioration appropriately. For example, staff told us in an emergency during birth staff gave women the choice as to where they would like to deliver either at Furness General Hospital or Royal Lancaster infirmary. This was based on women's choice rather than any specific risk assessment or birth plan.

We reviewed incidents reported between October 2020 and March 2021 and saw there were two incidents where a woman was transferred to another unit from Helme Chase due to complications in labour. In one incident, the situation was not escalated in a timely or appropriate way as transfer was delayed with a lack of communication between teams and ambulance transfer time not being factored into the escalation.

The service had systems and processes to support staff if an immediate emergency transfer was needed. However some community midwives reported that if they called for an immediate emergency transfer from a home birth to the consultant led units there was no plan in place to identify which acute unit the woman would go to. Staff told us they were not notified when the acute units were busy and would struggle to accept a woman in labour in an emergency. This meant there was a risk an emergency transfer may be delayed.

Staff did not share key information to keep women safe when handing over their care to others. Women requiring transfer from Helme Chase were usually taken to the Royal Lancaster Infirmary as it was the closest unit. The ambulance response time was reported to be eight minutes and the transfer time between the units was reported to be 30 minutes. The trust had not ensured that all documentation used to support the delivery of care was appropriately reviewed. The transfer checklist staff told us would be completed for women in labour at home whose care needed to be escalated for transfer to hospital care was overdue for review since March 2021. During the inspection we saw that not all staff know how to access the checklist.

We also saw two incidents reported between July and November 2020 where either records were not available to staff at other units or communication was poor when transferring care. However, staff told us they audited transfer checklist forms to ensure transfers took place appropriately.

Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. Staff could refer women requiring mental health assessment and support to a dedicated perinatal mental health midwife.

Staff knew about and dealt with any specific risk issues. The unit had no cases of sepsis in the last 12 months. There was a sepsis pathway in place and staff knew how to use this. Women who required additional support were referred to the enhanced support team who worked across the three maternity locations to provide enhanced support for women with complex needs or underlying conditions.

Midwifery staffing

The service did not always have enough staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment.

The service did not always have enough nursing and midwifery staff to keep women and babies safe. This was because the unit had one allocated midwife when open and this was four days a week. If that midwife was absent from the unit another community midwife or bank staff would be allocated. Following our inspection, the service the service told us they were starting a project to look at the staffing model for home births in response to staff concerns.

Staff told us there was not always enough midwives to cover every on call required, this was because every midwife would have to agree to be on call each week and this did not always happen. This meant there was a risk that women may have to be transferred to another unit to give birth. Staff told us this had not happened due to the low birth rate and closure during the COVID-19 pandemic.

There had been a reduction in midwife establishment at Helme Chase since our previous inspection. At this inspection, staffing establishment for the unit and community midwifery team altogether was 11.74 full time equivalent staff, this included six maternity support workers. At our last inspection the service had 15.4 whole time midwives. The number of core staff for the birthing unit itself had also reduced as well as the opening hours for the unit.

It was not clear if the reduction in staffing was in response to declining birth rates as the unit was closed during the COVID-19 pandemic and this impacted the number of births at the unit. Staff told us the service had not used a recognised acuity tool to review staffing but had reviewed staffing internally.

The service had 1.74 whole time equivalent vacancies for midwifery staff at the time of our inspection.

Out of hours the unit was not open and an on call system was used if a woman went into labour. We reviewed incidents reported on the national system between October 2020 and March 2021 and saw there were three reported incidents which related to staffing shortages and lack of on call at Helme Chase.

Following the inspection we were informed that the community team are sometimes required to rearrange or reallocate their community workload to attend a birth. This is done as a team to ensure all women and babies receive the visits they need for safety and support. The unit was staffed to a ratio of one midwife per woman in labour with a second community midwife on call to provide additional support when required. However, staff told us if another woman went into labour at the same time either at home or in the unit this impacted on midwives' ability to provide routine postnatal and antenatal care.

In addition, if a woman arrived at the unit out of hours and in labour and a midwife was not present, she would be admitted and initially cared for by a member of staff without appropriate midwifery qualifications. However, there had been no incidents of this happening in the last 12 months but there was a risk this may occur in future.

Staff expressed concern that not always having enough midwives to cover all births affected women's choice in selecting Helme Chase. Staff felt this impacted on the staffing numbers as they told us they believed they could not get more midwives unless the birth rate increased. Staff described this situation as 'very demoralising.'

Managers reviewed staffing but they were unable to explain the criteria for the staffing establishment review.

Though some staff told us the trust staffing review, in terms of caseloads, did not take into consideration the travel time for home visits and used the same criteria for urban midwives covering a smaller geographical footprint and those covering large rural areas; the service told us a 15% uplift had been given in the review to support rural travel arrangements.

Staffing levels displayed on the notice board at Helme Chase indicated that the staffing ratio for the unit for the day during our visit matched the numbers planned. However, the community midwives numbers were not known.

The service reported low sickness rates. Information provided by the service showed midwifery and nursing absence at Helme Chase including planned absence, study leave, and sickness for March 2021 was 34.1%. The previous month was 37.4%.

Medical staffing

There were no medical staff at Helme Chase as this was a midwifery led unit.

Records

Staff kept detailed records of women's care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Women's notes were comprehensive, and all staff could access them easily. Women's notes were kept on an electronic patient record system. Records accurately recorded the woman's choice, risk assessments, mental health assessments and women's individualised care plans. All women's' risk assessments were documented on a tab within the patient record. Any changes were reflected in the woman's care plans. Babies' records were also stored and recorded on the electronic record system and the personal child health record (red book) was given to each baby.

When women transferred to a new team, staff told us there were no delays in staff accessing their records. The electronic record system had a red flag to indicate where a woman had a particular need, such as a safeguarding concern.

However, we found one incident reported in July 2020 where staff did not have all the information needed due to incomplete electronic records and the paper records not being available.

The electronic patient record system produced time stamps and staff names were identified when online records were written or edited. The service was planning to implement a new electronic record system, which was anticipated to be in place in June 2021. Staff requested paper records where available to check previous medical histories and pregnancies prior to the introduction of the electronic record system.

Records were mostly stored securely with electronic records accessed by individual staff through password log-in.

Paper records were kept in a locked cupboard in reception, however we found baby records in an unlocked cupboard used for storing equipment that had not been stored securely. When escalated, these records were removed immediately.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines in line with the provider's policy. Medicines were found to be recorded correctly, checked, dated and signed by staff daily. We saw that there was enough stock of medication which was rotated to ensure items were given by the most recent 'use by' date at the front and items with the latest 'use by' date at the back.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Controlled drugs used in the pain management of intrapartum care was stored appropriately in a locked cupboard. Controlled drugs required for a home birth were kept locked in the drugs fridge in a 'easy to grab' home birth box.

The medicine fridge temperature was checked daily and documented and there was guidance next to the fridge of what to do in the event the temperature of the fridge was wrong.

The service had systems to ensure staff knew about safety alerts and incidents, so women received their medicines safely. Medicine allergies and prescribed medicines were documented on the electronic patient record and a warning was flagged on the system.

Incidents

Maternity

The service did not always manage safety incidents well. However, staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff knew they should apologise and give women honest information and suitable support.

Staff knew what incidents to report and how to report them. Midwifery staff received training on how to recognise and report incidents. There was a list of triggers and types of incidents for staff to follow so they knew which incidents to report. We were told and information requested from the trust showed that there had been no serious incidents on the unit within the last 12 months. Staff we spoke with gave examples of situations they would report as an incident.

The service had no never events on any wards. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

However, we reviewed incidents reported through National Reporting and Learning System (NRLS) between April 2020 and May 2021 and found two incidents where there was potential for learning which had not been highlighted by staff nor was there any evidence of learning or immediate action to mitigate the risk of the incident reoccurring.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy. We saw the service reported seven incidents through NRLS between April 2020 and May 2021.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us if an incident did occur it was escalated to a manager and feedback was given in person. Staff told us learning was also discussed after an incident was reported.

All serious incidents were investigated using a root cause analysis approach and this was overseen and reviewed by the divisional Care Group Governance Assurance Group.

Staff understood the duty of candour. There had been no incidents in the last 12 months where duty of candour had been enacted. However, staff told us they would be open and transparent and give women and families a full explanation if and when things went wrong. Staff told us if a patient was involved with the incident, they were always apologised to.

Managers debriefed and supported staff after any serious incident. Midwives could access support from practice midwifery advocates when required where incidents were identified. Staff received feedback from investigation of incidents, both internal and external to the service. Local managers described how important information and learning relating to incidents was shared with staff in a '3-minute brief' at handovers. Some staff said that the three-minute briefings were not always effective but that they were helpful as a trigger for staff to look up changes to guidance such as the National Institute of Health and Care Excellence (NICE) guidelines.

Is the service effective?

Requires Improvement

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

Maternity

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice. Managers did not check to make sure staff followed guidance.

Staff did not always follow up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance**.** Some staff reported that policies contradicted each other with guidelines that were unclear. Some staff reported that the care provided did not always meet trust guidance as the guidance they had to follow was not always up-to-date or ratified. We were also told that the guidelines were difficult to find on the system. Midwives reported being conflicted as to whether they should follow the National Institute of Health and Care Excellence (NICE) guidelines or the emails sent from the trust with updates or the processes they were currently following.

From information requests from the trust, we found that not all policies and procedures were updated, had lengthy delays to implement or were not ratified. For example, the guideline for still birth had expired November 2020, it appeared to be a generic form, and not identified with the trust's corporate branding. Contact details for staff included in this guideline also appeared to relate to a different NHS Trust altogether. Following our inspection, the service told us they followed the North West Coast Regional Still Birth guideline and this had been updated in March 2021 and was available to staff on the intranet.

The guideline for post-partum haemorrhage, and incidents complaints and claims had passed their review date of December 2020.

At our last inspection we found staff could not easily locate guidance documents and they were not always specific to the service at Helme Chase. We found the same at this inspection.

Nutrition and hydration

Women were given information to support them with their feeding choice for their baby. Breast feeding was very closely monitored by support staff in the community and staff spoke very passionately about breast feeding. Breast feeding support continued throughout the pandemic to women at home.

Managers told us they had just asked staff to submit expressions of interest so they could increase the number of breastfeeding champions available to support women.

All staff were currently working towards the UNICEFs UK Baby Friendly Initiative (BFI) accreditation. The Baby Friendly initiative is a worldwide programme of the World Health Organisation and UNICEF to promote breast feeding. The service was not BFI accredited at the time of our inspection.

Pain relief

We were told that controlled drugs and Entonox (a pain-relieving gas) were available for use in pain management for a home birth. If stronger pain relief was required for women birthing at home they were transferred to the birthing unit to support closer monitoring.

Patient outcomes

Maternity

There was a lack of clear information to evidence how the service monitored the effectiveness of care and treatment for women using the service. The service could not demonstrate how they used findings to make improvements and achieve good outcomes for women.

The service participated in relevant national clinical audits, such as MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries). We asked the service to provide any reports or action plans against MBRRACE outcomes, but the information supplied was not specific to this maternity service and did not reference any local learning or action plans. We reviewed the trust response to the national maternity and perinatal audit 2018-2019 and saw there was little detail in the action plan of how the service intended to meet key actions.

The trust monitored the number of babies born before arrival (BBA) which were displayed on the maternity dashboard. These were grouped with home births so it was unclear how babies born before arrival was monitored.

There was a trust wide audit plan which included Helme Chase. The service used feedback from family and friends test data, Maternity Voices Partnership and the 'listening with mother' service to evaluate local outcomes.

Outcomes for women were not always positive, consistent nor met expectations, such as national standards.

The service performed below the national target for continuity of care. At the time of our inspection, performance was 23.77% against a national target of 35%. Managers told us the service had struggled to introduce an effective model to deliver continuity of care outcomes with two pilot approaches which had not been wholly successful. They were recruiting additional midwives to set up a team to deliver continuity of care during our inspection.

The service was not accredited by Baby Friendly Initiative though managers told us they had registered to go through the registration process and work had begun to meet the requirements.

Competent staff

The service did not always make sure staff were competent for their roles. However, managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were qualified but did not always have the experience, skills and knowledge to meet the needs of women. The unit was staffed by one midwife and on call community midwives. The service reported low number of births both in the unit and home births, usually two to three per month. The midwives did not rotate to other units or teams to maintain their competency and experience in deliveries. Staff told us they had received skills and drills training and could access additional support from practice development midwives. However, some staff expressed concern about maintaining competency and skills given the low number of births on the unit and at home.

Some midwives on preceptorship said that whilst they had been well supported by specialist midwives, they had to seek out specialist training because they had been put in situations, they were not confident in. They had experienced delays in their induction and reported training days did not always take place. In addition, they were not always given protected time to attend training.

However, managers told us they gave all new staff a full induction tailored to their role before they started work. Staff we spoke to said that they had completed a three-day induction in emergency protocols and suturing.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff received annual appraisals which were 95% completed at Helme Chase compared to 84% for midwives across all three sites. 'COVID-19 Appraisals' had also taken place.

Staff told us the clinical educators supported the learning and development needs of staff. They were also working with a local university to set midwife apprenticeships.

Practice educators were based at Lancaster and although they could be accessed remotely for advice, many staff said they had not been a frequent presence at Helme Chase.

Multidisciplinary working

Midwives worked together as a team to benefit women. They supported each other to provide good care.

Staff held regular team meetings. There were monthly team meetings for all staff both community and on the unit which everyone was expected to dial in to.

Staff referred women for mental health assessments when they showed signs of mental ill health, depression. They referred women to a qualified perinatal mental health midwife who provided additional support to women experiencing mental ill health.

Seven-day services

Not all key services were available seven days at Helme Chase such as diagnostic services and pathology as this was a low-risk birthing service.

The unit is a midwifery led unit and does not have consultant presence or ward rounds.

Health Promotion

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

The service had relevant information promoting healthy lifestyles and support on the unit. There were parenting classes available and leaflets promoting this in the waiting areas. There was also an online application offered by the service which provided details of different classes and information on a range of topics.

There was also information noted for women dependent on alcohol or drugs available in the waiting room as well as information on the application.

Staff assessed each woman's health when admitted and provided support for any individual needs to live a healthier lifestyle. Smoking cessation information for maternity services was reported to be 84%. Staff focus for health promotion was on breast feeding support and smoking cessation.

Referrals could be made to a dietician if the woman had a body mass index (BMI) over 35.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Maternity

The service had policies and procedures for staff to follow in line with national guidance to gain women's consent. Staff received training on how to support women who lacked capacity to make their own decisions or were experiencing mental ill health.

Nursing and midwifery staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards, through mandatory training days.

However, the service told us they did not undertake individual consent audits.

Is the service caring?

Inspected but not rated

Compassionate care

Staff treated women with compassion and kindness but did not always able to respect their privacy and dignity due to the environment.

Women said staff treated them well and with kindness. We saw positive feedback on the notice board from women who had used the service. During our inspection, information posted on the notice board showed the service had received 12 compliments in March 2021.

However, the one birthing room in use at the time of our inspection was next to the antenatal clinic. This did not protect women's privacy and dignity as they could be overheard when in labour. However the service told us no woman had ever been in labour when there was a clinic in the adjoining room.

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

Women and their families could give feedback on the service and their treatment. A box was provided where women and their family could leave completed 'friends and family test' forms to share compliments or complaints that were reviewed to make improvements on the unit.

The trust performed similarly to other trusts for all 19 questions in the CQC maternity survey 2019.

Staff offered debriefing to women and families following difficult births through the 'listen with mother' initiative and could refer women directly for this support through the electronic patient record system.

Is the service responsive?

Requires Improvement

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

Maternity

Service delivery to meet the needs of local people

The service did not plan and provide care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care. However, the COVID-19 pandemic had impacted the services ability to plan and deliver services based on the need of local women.

During the COVID-19 pandemic Helme Chase was closed for women who would have chosen to birth there. The unit midwife was redeployed to staff community clinics that could not take place in their usual venues in the community due to the pandemic.

Facilities and premises were not always appropriate for the services being delivered. This was because since the reopening of the unit only one delivery room remained in use as other rooms and storage was being used by other services. In addition, a busy clinic was held next to the birthing room. Staff told us they were uncertain about the future of Helme Chase as a birthing unit.

Women were offered choice of maternity care and as far as possible, depending on the level of risk, the service aimed to accommodate women's preferences in this. Prior to the pandemic, community midwives provided antenatal care in local clinics as an alternative to hospital attendance.

The service worked with the maternity voices partnership to produce videos in different languages to reach out to women in diverse communities and share information and encourage women to access services during the COVID-19 pandemic

The trust had systems to help care for women in need of additional support or specialist intervention. There was a clear pathway for staff to follow to refer women to specialist midwives and the enhanced midwives team. However, women requiring specialist or enhanced support were referred to consultant led care.

The clinical support workers were trained to undertake newborn hearing screening tests in the community if it was not conducted whilst mother and baby were still on the unit.

Managers ensured that women who did not attend appointments were contacted. Community midwives contacted all women who did not attend planned appointments.

The lead midwife for perinatal mental health was seconded two days a week to the local maternity partnership to work at a regional level to develop perinatal mental health services.

Meeting people's individual needs

The service was inclusive and took account of women's individual needs and preferences.

Managers made sure staff, women, loved ones and carers could get help from interpreters or signers when needed. Staff could access translation and interpretation services for women who did not speak English as their first language. Community midwives could access translation services via their mobile phones to support women in the community.

The staff we spoke to were very passionate about women having choice around their pregnancy and birth. They discussed women's choices at booking and the information provided and the women's preferred choice documented on the woman's records on the electronic record system.

Maternity

Access and flow

Women could not always access the service when they needed it nor receive the right care promptly. Waiting times from referral were in line with national standards.

Managers did not make sure women could access services when needed. This was because of the limited opening hours of the unit and on call staffing model which meant women's access to birth in the centre was limited to when a midwife could arrive.

Women did not always receive the right care promptly out of hours as this was coordinated through a central on call system and the midwife called the woman back. This could lead to delays in responding to a woman. We saw three incidents reported that related to difficulties accessing on call midwives.

However, managers and midwives told us they worked collaboratively with other services in the care group to maintain services during the COVID-19 pandemic, for example providing venues for antenatal clinics at the Helme Chase site which became a community hub during the pandemic for clinics that could not be provided by doctors surgeries and children's centres.

Managers monitored waiting times. The number of bookings for delivery by 12 plus six weeks was monitored using the maternity dashboard. The dashboard for January 2021 showed 98.15% of women were booked for delivery by 12 plus six weeks, with 96.49% in February and 96.30% in March 2021. There were 14 births from the unit reopening in October 2020.

Learning from complaints and concerns

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

The unit had no recorded complaints in the last 12 months and at the time of our inspection.

The service clearly displayed information about how to raise a concern in patient areas. There was a 'friends and families' box in the unit where women and families were able to put complaints or compliments.

Staff could give examples of how they used women's feedback to improve daily practice. The unit had 'you said, we did' board at the doors of the unit that showed what women had complained about or areas they have suggested need more work. On the 'you said, we did' board for March, women said they wanted 'more provision for breast feeding support' and so the unit set up a breast feeding café and support visits and actively encouraged attendance at Helme Chase for support.

Is the service well-led?

Inadequate

Our rating of well-led went down. We rated it as inadequate.

Maternity

Leadership

There was a lack of leadership and continuity for the maternity service due to vacant posts and interim arrangements. They did not understand and managed the priorities and issues the service faced. They did not always support staff to develop their skills and take on more senior roles and were not always visible and approachable in the service for women and staff.

There had been a lack of continuity in midwifery leadership over time. At the time of our inspection, the Deputy Head of Midwifery was acting as Head of Midwifery and received support and coaching from an external Head of Midwifery.

There was a full time matron who covered Helme Chase and community midwifery, this this was a Cross Bay post. Part time cover was provided for two days a week from one of the other maternity units.

Staff told us this had led to a lack of clarity about the future direction and expectations in midwifery and the future of the unit.

Staff we spoke with told us team managers were visible, approachable and supportive. However, Managers and staff told us that executive leaders were not visible in the service at Helme Chase.

Midwifery staff could access support from a Professional Midwifery Advocate (PMA). PMAs offered regular drop-in sessions that midwifes could attend.

Leaders told us the senior team worked together well and attended a weekly formal catch up meeting. Leaders described good links and access to senior trust executives.

However, the new non-executive maternity board champion had only recently been appointed and not all staff and managers knew who this was.

They attended weekly meetings with other Heads of Midwifery across the local maternity system.

Vision and Strategy

The service did not have a vision for what it wanted to achieve nor a strategy to turn it into action, developed with all relevant stakeholders. It was not clear how the development of a vision and strategy would be focused on sustainability nor be aligned to local plans within the wider health economy.

Staff at Helme Chase stated that they were not considered in the wider trust strategies and did not feel supported. Midwives told us the trust did not consult with them on decisions that affected Helme Chase.

Staff were not aware of a vision or strategy for Helme Chase maternity services. There was no wider strategy or vision for maternity services. However, senior leaders told us the vision for the service was under development.

Senior leaders were not able to clearly articulate a vision and strategy for the service overall or at each location. They described the key priorities as improving the governance process and incident investigation process.

Maternity

Following our inspection, we asked the trust for information on the vision and strategy for the service. They told us they recognised the need to develop the vision and strategy for the service but they were focused on ensuring midwifery leadership was in place and improvement work underway before developing this.

Culture

Staff did not always feel respected, supported and valued. However, they were focused on the needs of women receiving care. The service promoted equality and diversity in daily work.

Staff we spoke with throughout the service told us that everyone was approachable up to the Head of Midwifery. They felt positive and proud to work for the service, but they did not always feel valued by the executive team. It was noted by staff that the chief executive or other senior leaders did not mention or thank the staff at Helme Chase for keeping services running through the pandemic.

Some staff who had transferred from other organisations told us there was a positive culture with good teamwork and support in the service.

Governance

Leaders did not operate an effective governance process, throughout the service and with partner organisations. Not all staff were clear about their roles and accountabilities. Staff had regular opportunities to meet, however there were limited opportunities for staff at all levels to learn from the performance of the service.

Leaders told us they recognised the need to improve governance processes and described the model they were using to begin this improvement work. Improvements were focussed on ensuring information flowed from ward to board and was not just held at management level. They were also focused on improving the incident investigation process and sharing learning from incidents and complaints. At the time of our inspection, improvement work on the governance processes was ongoing and not completed.

There were systems in place to share learning with staff about the performance of the service. The service had developed a picture-based information poster called ‘safety summary’, for all staff to share performance data based on the maternity dashboard. However, this was a new system and not fully embedded. The ‘safety summary’ was trust wide and not specific to Helme Chase maternity services at Westmorland General Hospital, which meant staff did not get information about specific performance to identify areas for learning in their areas or locations.

Staff told us the maternity and gynaecology assembly, which was a cross site forum for sharing learning and improvement ideas had been suspended during the COVID-19 pandemic. However, the assembly had resumed in March 2021.

Work in action plans following the Kirkup review was ongoing at the time of our inspection. The trust shared a draft copy of the review. Of the 18 recommendations, the trust reported that 15 had been sustained fully and three were sustained partially.

Management of risk, issues and performance

Leaders and teams used some systems to manage performance, but these were not always effective. Not all relevant risks and issues were identified and escalated, nor actions identified to reduce their impact. Staff were not given opportunities to contribute to decision-making to help avoid compromising the quality of care.

Managers carried out a range of quality assurance audits and told us outcomes from these were discussed at the Care Group Governance Assurance Group (CGGAG). This group was attended by the triumvirate and representatives of the whole women's and children's care group.

However, we were not assured effective action was consistently taken to make improvements following quality audits. For example, in June 2020 the audit of sepsis management showed compliance with completion of the maternity sepsis tool was 41% and there was poor documentation of the suspected source. The action was to encourage staff to complete this, there was no exploration of additional training needs or safeguard systems to ensure staff did this on a regular basis. Though a re-audit was recommended we were told the next sepsis audit was not due for another year.

The audit of maternity obstetric early warning scores (MEOWS) had been presented in January 2020 and the re-audit was overdue and planned for June 2021. Helme Chase was not included in these figures as they were not expected to undertake MOEWS for women in labour. Managers did carry out an audit of observations at Helme Chase but it was not clear how this linked to the MEOWS audit and actions to address poor performance had been delayed. This meant we were not assured leaders had oversight of progress on actions taken to address any poor or underperformance highlighted in audits.

There was a lack of local oversight and ownership of risk. Senior managers told us there was only an overall risk register for maternity services.

Actions taken to mitigate risks were not always clear. For example, if a women presented at the birthing centre before the midwife on call she was let in by the night sister and an incident form completed. It was unclear what would happen if the on call midwife was held up inadvertently.

Leaders told us they reviewed all risks with the risk team throughout January and February 2021 to ensure they were up-to-date and accurate, but it was not clear how staff at ward level contributed to escalation of risks.

The service used the nationally recognised perinatal mortality tool to review all baby deaths and conducted a rapid review into all deaths. The service had not reviewed all historic cases at the time of our inspection. Managers told there was a plan to ensure this was completed by the end of May 2021.

Some staff we spoke to told us they had not been involved in contributing to changes in service structure which impacted on women's care. They told us when changes had been made they had been left to develop models of care with no clear leadership or direction.

Information Management

Although the service collected different data, leaders did not always analyse it to make improvements. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were not fully integrated; however, they were secure.

The trust had introduced a new quality assurance system immediately prior to our inspection. This was not yet embedded at Helme Chase.

Some staff told us there were issues with online training compliance system and this meant it had been difficult to get accurate data on training compliance. However, they did say this was improving.

The service had a digital midwife who validated all data submitted via the maternity dashboard.

The service provided the maternity dashboard for the service but told us it was difficult to capture consultant versus midwife led birth in the current system. There were also technical issues in acquiring length of postnatal stay figures. The maternity dashboard for Helme Chase contained minimal information and it was not clear how managers used the information on the dashboard to improve services.

Managers told us the service was getting a new electronic patient record system in July 2021. This was to be trialled in antenatal clinics and community before being rolled out to inpatient areas.

Engagement

Leaders did not consistently engage actively and openly with staff.

Staff said they tried to work with maternity services at South Lakes Birth Centre and Royal Lancaster Infirmary, but this was limited due to geographical constraints.

Staff told us leaders did not consult them or include them in plans about the future of the service. Staff gave examples of how they felt they did not receive the same support or consultation as colleagues in other maternity units.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. Leaders encouraged participation in research. Staff and leaders did not have a good understanding of quality improvement methods and the skills to use them.

The service was part of a programme to prevent abusive head trauma in babies, as this had increased during the COVID-19 pandemic. This was an educational programme delivered to women and families to promote comfort methods and encourage them to never shake their baby. Staff told us this had been received positively by the women who had taken part and they had seen no increase in abusive head trauma during the pandemic.

The service was working with the local maternity system to ensure all women received safe sleeping advice throughout their pregnancy and therefore, prevent baby deaths. We saw safe sleep posters displayed in the maternity ward and all women were offered safe sleep assessments prior to going home with their baby and at their first postnatal appointment.

Leaders told us they recognised improvement could be made to handovers and this was ongoing improvement work with some initial actions such as poster to remind staff of the structure approach beside beds.

Though leaders described quality improvement models and initiatives it was not clear how staff engaged with these. There was a mechanism for feedback to staff through the three-minute brief but this was for information only not action or involvement in the improvement process. Leaders told us they had recognised this issue and were looking to improve this through ongoing improvement workstreams.

Furness General Hospital

Dalton Lane
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www.uhmb.nhs.uk

Description of this hospital

Furness General Hospital is operated by the University Hospitals of Morecambe Bay NHS Foundation Trust. It provides emergency care to around 350,000 people across North Lancashire and South Cumbria.

We visited Furness General Hospital as part of our unannounced inspection during 20 to 22 April 2021. We visited the emergency department as part of the inspection. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

At the last inspection in December 2018, the emergency department at Furness General Hospital was rated as requires improvement. The emergency department services were rated as good for caring and requires improvement for safe, effective, responsive and well led.

During the inspection we found areas of concern that led to a further unannounced focused inspection in medicine for the stroke care pathway.

We did not inspect all of the key lines of enquiry as our concerns were related to specific risks around the stroke care pathway. We inspected against parts of the safe, effective, caring and well-led key questions.

Following this inspection, under Section 31 of the Health and Social Care Act 2008, we imposed urgent conditions on the registration of the provider in respect to the regulated activity; Treatment of disease, disorder and injury and diagnostic screen procedures. We took this urgent action as we believed a person would or may be exposed to the risk of harm if we had not done so. Imposing conditions means the provider must manage regulated activity in a way which complies with the conditions we set. The conditions related to the stroke pathway at the Royal Lancaster Hospital and the Furness General Hospital.

Since the conditions were imposed, the trust responded immediately and put actions in place to improve the service. These were ongoing at the time of publication of the report.

Our rating of this location went down. We rated it as requires improvement because:

Urgent and Emergency Care

Our findings

- We found not all staff had training in key skills or could evidence they had completed training in understanding how to protect patients from abuse. Staff in the department did not control infection risk well. The service did not always have enough medical staff to care for patients and keep them safe. Although they managed incidents, not all learned lessons were shared with staff.
- Staff did not always provide care and treatment in line with best practice, there was no evidence of how managers or senior leaders measured the effectiveness of the service. We found not all patients were given pain relief when they needed it. Staff caring for patients in the department had not completed training to look after stroke patients.
- All staff were committed to continually learning and improving services. However, we found no evidence on how the service improved the paediatric service. There was a good understanding of quality improvement methods and the skills to use them, but they did not always address all issues in the department.
- Leaders understood and managed the priorities of the department but did not always recognise the issues the service faced. They did not always operate effective governance processes, throughout the department or identify risks. Staff did not always feel respected and supported, service leaders said they promoted equality and diversity in daily work, but this was not reflected in the staff survey results. The service had an open culture where patients, their families could raise concerns without fear, but staff said they could not.

However:

- Staff offered patients food and drink if they had been in the department for a long time. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment

Medical Care

- Following this inspection, under Section 31 of the Health and Social Care Act 2008, we imposed urgent conditions on the registration of the provider in respect to the regulated activities; Diagnostics and Screening and Treatment of Disorder, disease and Injury. We took this urgent action as we believed a person would or may be exposed to the risk of harm if we had not done so. Imposing conditions means the provider must manage regulated activities in a way which complies with the conditions we set. The conditions related to the stroke services at Royal Lancaster Infirmary and Furness General Hospital. In light of this, we suspended the ratings for Medical care including care for older people.
- The trust did not have an effective risk and governance system for the whole stroke pathway.
- The service did not always manage patient safety incidents well. Staff recognised and reported incidents and near misses. Managers did not always investigate incidents and share lessons learned with the whole team and the wider service in a timely manner.
- Local policies did not always reflect best practice guidance.

Our findings

- We were not assured that the trust were using the findings to make improvements and achieve good outcomes for patients. The vision and strategy for stroke care was not aligned across the trust.

However,

- The service had enough staff to care for patients and keep them safe. Staff assessed risks to patients, acted on them and kept good care records.
- Staff provided good care and treatment and managers made sure staff were competent. Staff worked well together for the benefit of patients and key services were available seven days a week.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

Surgery

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Most staff felt respected, supported and valued. Staff understood the service's vision and values, and how to apply them in their work. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However,

- We found entrances to wards and fire doors were not secured.
- On some wards medicine were not always consistently stored in line with trust policy.
- The service performed worse than expected for some national audit indicators.
- The number of staff that had completed their appraisals did not meet trust targets.
- The service performed worse than national standards for waiting times from referral to treatment. The average length of stay for patients having trauma and orthopaedics surgery was worse than national average. Whilst the services had plans in place to improve this, these measures had not been fully implemented and had not yet led to any significant improvement in the services.

Our findings

Maternity

- The service did not always have enough midwifery staff to care for women and keep them safe. The service did not always control infection risk well. Staff did not always assess risks to women or act on them. Care records were not always easily accessible or kept up to date.
- Staff did not always assess and monitor women to see if they were in pain, nor give pain relief in a timely way. Outcomes for women were not always positive, consistent nor met expectations, such as national standards, such as for Cesarean section rates.
- The service used different systems for recording and administering medicines and leaders had identified this as a risk, but actions had not been taken to follow up.
- Systems for sharing important safety information day-to-day were not well embedded.
- Although staff completed training, Leaders did not always make sure staff were competent. Key services were not always available seven days a week.
- Although leaders monitored the effectiveness of the service. they did not consistently use reliable information systems to enable them to run services well. The service did not have effective governance processes and systems to manage risk, issues and performance. There was no clear vision and values for maternity services that was understood by staff. Not all staff were clear about their roles and accountabilities. Opportunities for staff to develop their skills were limited.

However,

- Staff had training in key skills, understood how to protect women from abuse, and followed systems to manage safety incidents and learn lessons from them. Staff provided good care and treatment and gave women enough to eat and drink.
- Staff collected safety information and used it to improve the service and followed systems for managing medicines.
- Staff worked well together for the benefit of women, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to relevant information.
- Staff treated women with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to women, families and carers.
- Most staff felt respected, supported and valued. They were focused on the needs of women receiving care. The service engaged well with women and the community to plan and manage services and all staff were committed to improving services continually.
- The service planned care to meet the needs of local people and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.

Urgent and emergency services

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

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

Mandatory Training

The service provided mandatory training in key skills including the highest level of life support training to all staff and made sure everyone completed it.

Staff used a web based electronic system to book training.

We were told staff undertook competency and relevant mandatory training to enable them to support the department. Some topics were delivered face to face and others online.

Training was staggered throughout the year; this was so that managers could maintain staffing levels in the department.

Medical and nurse staff compliance rates for mandatory training was above 95% for some modules, including information governance, infection prevention control and equality, diversity and inclusion.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all staff had completed training on how to recognise and report abuse.

The department reported 58% of medical staff and 25% of nursing staff had not completed safeguarding level 3 training on how to recognise and report abuse. This was a concern found at the last inspection and had not been addressed.

The department treated both adults and children in the same department and there was a risk that staff did not have the appropriate level of training required to identify and act on potential safeguarding concerns in relation to the patients they treated.

The department had a safeguarding lead and safeguarding supervisors who were paediatric trained. However, paediatric nurses were not always in the department to support staff when dealing with a paediatric safeguarding concern.

However, staff screened paediatric patients for any safeguarding concerns at booking and had access to the child protection information sharing system. The Child Protection Information Sharing Project is an NHS England sponsored work programme, dedicated to providing an information sharing solution that will deliver a higher level of protection to

children who visit unscheduled care settings such as accident and emergency departments, minor injury units, paediatric assessments and walk-in centres. Reception staff were alerted when booking in a child as to whether that child was on the child protection register, a "looked after child" or whether concerns had been flagged by social services staff.

Safeguarding alerts were placed in the patient electronic record to alert staff about any protection plans in place.

Safeguarding training also included PREVENT, part of the government anti-terrorism strategy about safeguarding vulnerable people from being radicalised; child sexual exploitation and female genital mutilation.

Staff used the trust's referral guidance called "Who do I tell?". This was a red, amber or green rating (RAG) system and was dependent on the circumstances of the presentation. Green presentations did not meet a safeguarding referral, an amber rating required a safeguarding incident report to be completed and red called warranted a referral to the local authority.

Cleanliness and infection control

The service did not always control infection risk well, however staff kept equipment and the premises visibly clean. Most staff used equipment but did not always use control measures to protect patients, themselves and others from infection.

Staff did not always use control measures to protect patients, themselves and others from infection. Although the hospital had systems and processes to reduce and mitigate the risk of infection staff did not always follow them. For example, we observed staff did not maintain social distancing between patients or themselves.

On multiple occasions we saw that staff did not adhere to wearing a mask. Staff interacted closely with patients and the immediate physical environment, without wearing their masks appropriately. We noted masks were worn under the chin and not above the nose

There was no protocol in place to manage walk in patients with Covid symptoms at the time of inspection. Although there was for patients who were brought in by ambulance.

However, all the areas and equipment we inspected including corridors, waiting areas, patient bays, offices, and utility areas were visibly clean and tidy.

Cleaning tasks were scheduled to ensure areas were cleaned regularly. This included daily cleaning of corridors, bays, and main areas. Domestic staff used colour coded bags to segregate infected linen from clinical waste, and colour coded mops were used in the same way. Deep cleaning was undertaken based on a schedule which the trust managed centrally.

Staff used cleaning schedules to demonstrate areas had been cleaned. However, we found on three occasions they were not completed,

Hand hygiene was audited on a monthly basis. The audit results for September 2020 to February 2021 showed between 98% and 100% compliance.

There was quick point of care testing in place for those patients who may be presenting with Covid-19 symptoms with a turnaround time of around 10 minutes to obtain the test results.

Equipment

The maintenance and use of facilities, and equipment kept people safe. Staff were trained to use equipment. Staff managed clinical waste well.

The design, maintenance and use of facilities, premises and equipment kept people safe.

Staff carried out daily safety checks of specialist equipment. All three resuscitation bays were clear from clutter, equipment trolleys were labelled and readily available. The resuscitation trolleys and the difficult airway trolley had been checked daily as per trust policy.

The waiting area was adequate, we observed there was enough seating for patient's whist waiting to be seen.

There were adequate stocks of equipment in the department and we saw evidence of stock rotation to ensure that equipment was used before its expiry date.

Electrical equipment had been safety tested in the department; this was on a rolling programme basis.

We reviewed documentation to demonstrate fridges storing medicines were checked. Trust policy instructed staff to check the fridge temperature daily to ensure a suitable range was maintained.

The mental health room in the department was ligature free, it contained three heavy chairs, a TV and was pleasantly decorated. There were no blind spots and doors had viewing panels. Staff and patients had access to an emergency alarm system. Mental health patients were assessed in the room and then moved to a trolley in majors. Staff said the curtains would always be left opened. We were told ligature risks were removed.

Needle sharp bins in the department were not over full (more than ¾ full) and the bins were dated and signed by a member of staff, (as required by the trust's policy). However, we found one waste bin which was over full and stained with blood. This was immediately changed after it was raised with staff.

Assessing and responding to risk

We found concerns in relation to stroke care and some delays in treatment for patients when the department was busy. Staff did not always complete National Early Warning Scores (NEWS) for each patient and therefore we were not assured how quickly staff acted upon patients at risk of deterioration.

We found stroke patients arriving in the department did not always receive all elements of the stroke pathway treatment in a timely way and in accordance with the trust's stroke pathway. We were not assured that all doctors in the emergency department had received and completed relevant training to care for a patient and had the competencies to carry out thrombolysis. There was no assurance system in place to review, assess or monitor the competencies of medical staff giving thrombolysis.

At the time of the inspection three out of sixteen patients waited more than 15 minutes for an initial assessment by the triage coordinator.

Urgent and emergency services

The department used a National Early Warning Score (NEWS) system for acutely ill patients, which supported staff with the early recognition of deteriorating patients. This ensured early intervention from skilled staff. We checked records and found eight out of sixteen records had evidence of NEWS. This meant 50% of the records we reviewed did not have a NEWS documented.

The trust reported the median time spent in the ED between November 2020 and April 2021 was 97 minutes. We found there was no adequate and appropriate safe space available for children with suitable supervision by emergency staff in the department. In one record we found one child had absconded and staff were alerted by another patient. At the time of inspection, the department had not risk assessed the closure of the department and safety of children waiting in the ED.

Staff we spoke with said all Band 6 paediatric and adult nurses were European Paediatric Advanced Life Support trained. However, the department reported 25% of band 6 nurses had completed the training and 100% of band 7 staff had. The service reported none of the band 5 nurses were trained in European Paediatric Advanced Life Support.

Where the department had no paediatric nurses on shift, we were told there was always trained nurses that were able to deliver basic paediatric life support. However, 91% of band 6 nurses and 72% of band 5 nurses had completed training.

Additionally, paediatric resuscitation scenarios with part of the routine learning to support staff.

Training rates for nurses and health care assistant staff were 87% for adult basic life support at the time of inspection.

However, staff were able to describe protocols to screen and stream patients. This included patients with suspected COVID-19. Any COVID-19 positive patients were taken in one of three dedicated rooms.

The resuscitation areas appeared well staffed and critically ill patients in the department at the time of inspection had been seen in a suitable timescale and treated appropriately.

Walk in patients were registered by the receptionist and directed to the waiting room where they waited to be called by the triage health assistant.

Patients were triaged based upon their presentation when booked into the Emergency Department by band 3 triage assistant, they undertook bloods, observations and ECG etc. The severity and risk level of the patient's condition was determined by their presentation and the outcome of the triaging tool used in the 'minors' area This reflected the order in which patients were seen by a clinician.

Patients received an initial assessment by a band five or six triage nurse, once seen they were streamed to the most appropriate area for diagnostics or treatment which was coordinated by the band 3 support coordinator The initial assessment included investigations that would assist clinicians with a diagnosis and treatment.

Patients arriving by ambulance entered through a dedicated entrance specifically for ambulances. During busy times, staff reported clinicians would go out to the ambulance to review the patient if paramedics raised concerns about the patient's conditions. A communication board in the department kept staff up to date with details of any patients waiting in the ambulance. At the time of inspection, we did not observe any patients held outside the department.

Urgent and emergency services

A dedicated nurse triaged patient who arrived by ambulance, when the ambulance bay was not busy the nurse undertook work in the majors area. The department coordinator wore a yellow or red badge so that staff could identify who was coordinating.

The Royal College of Emergency Medicine guidance on the initial assessment of emergency patients (2017) states face to face contact with the patient should be performed in an environment that has sufficient privacy to allow the exchange of confidential information and that the assessment should be carried out by a clinician within 15 minutes of arrival. Time from arrival to initial assessment data showed the department saw on average patients within 15 minutes, this was below (better than) the overall England median between April 2020 and January 2021.

During the inspection, records showed the department celebrated being the best performing department for ambulance handover times. This meant patients were handed over and clinically assessed within 15 minutes of arrival and ambulances were able to clear the department to attend to another call.

Risk assessments were used to record and act on risks of reduced skin integrity, falls, venous thromboembolism (blood clots), safeguarding vulnerability or delirium (confusion). The patient record system prompted staff to consider these risks and provided instructions should the risk be present. We reviewed five risk assessments which were all appropriately undertaken and actioned.

Children were fast tracked when they arrived in the emergency department (ED). Staff followed a strict protocol to ensure children were managed appropriately. Any child scoring less than three on the triage assessment tool remained in the department until they were reviewed by a senior house officer or a registrar. Children who presented with a score more than three were moved to the resuscitation cubicle and stabilised.

Nurse Staffing

The department had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, the department did not always deploy enough paediatric nurses into the department to care and treat children. Managers in the department regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency settings (2012) states that there should always be two registered children's nurse in the emergency department. At the time of inspection there were three paediatric nurses in the department and only one on per shift until 10pm.The trust recognised the nurse staffing did not meet the guidelines of the standards set out by the RCPCH but ensured there was adult nurses who were always trained in paediatric life support in the department.

However, nurse staffing across the department was determined by completing a recognised workforce planning tool. This tool, developed by the Royal College of Nursing Emergency Care Association and Faculty of Emergency Nursing, was specifically for use in Emergency Departments to allow any disparity between nursing workload and staffing to be highlighted.

The electronic rostering was completed by a band 6 nurse and was put out two weeks in advance. At the time of the inspection the department was at full establishment, this meant the department was staffed with eight registered nurses during the day between 7 am until 8 pm, seven overnight and six during the twilight shift. Staffing rotas showed all shifts were covered.

In May 2021, the department reported an annual sickness rate of 5% and a vacancy rate of 3%.

The service had a private group chat, on social media, for any unfilled shifts. Staff generally chose to accept unfilled shifts as overtime. The department used bank nurses to fill any gaps in the rota due to annual leave or sickness. This meant the same nurses were used, who we familiar with the department and the facilities.

Morning and evening handovers were attended by all staff on shift. They were carried out at 7 am and 7 pm. Topics discussed in the handovers included staff allocation, departmental issues to share, allocation of supernumerary staff and any support required.

Medical staffing

The department did not always have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Since the last inspection the department had increased their medical team but there were still gaps in the medical staffing rota.

The consultant staffing cover in the department did not always met the Royal College of Emergency Medicine (RCEM) (2018) staffing guidelines to provide a sustainable service. At the time of the inspection there were four whole time equivalent (WTE) consultants employed for the Emergency Department and one vacancy on the consultant rota. Currently this was covered by a long-term locum. There were plans in place to fill the vacancy with three middle grade doctors who were about to complete the CESR course. The CESR course is a training programme medical staff undertake in a specific speciality.

The department reported between 9%- 24% of shifts were unfilled in the reporting period of January 2021 – April 2021. As part of their action plan to increase the medical staffing in the department, senior leaders had appointed 10 medical staff since May 2020. As part of the action plan the trust were developing their own medical staff through the CESR programme.

The paediatric ED was not staffed with a paediatric emergency medicine consultant with dedicated session time allocated to paediatrics. This meant the department did not meet standard nine of the Facing the Future: standards for children and young people in emergency care settings. However, the department had access to the medical and nursing staff on the paediatric ward 24 hours a day seven days a week.

Medical staffing rotas demonstrated that a consultant was present in the department between 8am and 10pm between Monday to Friday and 8am -4pm at the weekends. The medical team handover was carried out at 8 am and 10 pm. Staff had access to an on-call consultant after 10pm.

The department had introduced the “EPIC doctor. The Epic doctor was a middle grade doctor who provided support to junior medical staff. The EPIC doctor floated between minors and majors helping with managing the flow in the department. They completed a board round with the band 6 nurse in charge to review each patient and discuss the appropriateness of where patients were placed. For example, they reviewed if patients required a bed in ACU or could be discharged home.

In May 2021, the department reported an annual sickness rate of 0.2% and a vacancy rate of 3%. The vacancy was filled by a long-term locum.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Discharge summaries and letters were generated through the IT system. A copy was given to the patient and sent to the patients GP through the post.

Records were clear, up to date, stored securely and easily available to all staff providing care. All electronic patient's notes could only be accessed by authorised staff.

We reviewed thirteen sets of adult patients' records and found completion of documentation varied. For example, assessments of pressure ulcers, and falls were fully documented but NEWS and pain scores were not always documented.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Controlled drugs were managed appropriately, and accurate records were maintained in accordance with trust policy. We saw medicine balance checks were regularly updated.

The department was visited by the pharmacist every day to check stock levels. Medicines were dispensed using an electronic dispensing system which required fingerprint technology to access the system. This system allowed for staff to audit the pathway and have oversight of the inventory.

Medicines requiring refrigeration were stored securely, the maximum and minimum temperatures had been recorded in accordance with national guidance.

Patient Group Directions (PGDs) are legal frameworks that consent registered health professionals to administer specified medicines to a pre-defined group of patients, without them having to see a doctor or nurse prescriber. All PGDs were in date, signed by two pharmacists and an emergency department consultant and were available electronically.

Incidents

The service managed patient safety incidents. Staff recognised and reported incidents and near misses and reported them appropriately. Although managers investigated incidents, they did not always share lessons learned with the whole team and the wider service.

The department showcased lessoned learnt from previous incidents on the "lesson learned board". Although staff said they recognised and reported serious incidents and near misses and managers told us they investigated incidents. During the inspection staff were unable to tell us about the most recent never event or any actions put into place to prevent the event from happening again. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death.

Incidents were reported through an electronic system, staff graded incidents in relation to the severity of harm.

Urgent and emergency services

When things went wrong, staff apologised and gave patients honest information and suitable support. Duty of Candour incidents were reviewed and investigated by the matron. There were robust processes in place to ensure the regulation was followed appropriately.

We reviewed three Duty of Candour incidents and found patients received a face to face apology if they were still in the hospital or a telephone call. The incident was discussed at meetings and lessons learned were followed up.

An alert on the patient file alerted staff a Duty of Candour investigation was being carried out. This stayed on the patient's file until the investigation was complete.

Is the service effective?

Requires Improvement 

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

Evidence-based care and treatment

The department did not always provide care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients subject to the Mental Health Act 1983, but mental health risk and capacity assessments were not always carried out in line with the trust policy in a timely way.

Staff did not always follow best practice and national guidance. For example, pain was not assessed in line with paediatric national standards and care was not delivered in line with Public Health England Covid protocols.

Guidance was documented and available on the trust intranet. The guidance covered topics including management of head injury, deep vein thrombosis (blood clot), burns, sepsis, and allergies.

Staff used local guidance alongside nationally developed tools to screen and manage patients presenting with concerns such as major trauma or sepsis. We saw examples of national guidelines such as International Guidelines for Management of Sepsis and Septic Shock 2016) being referred to in local policies and procedures, during our inspection.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. We saw evidence of pathways to support staff care for patients with mental health concerns.

Nutrition and hydration

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

Staff gave patients enough food and drinks to meet their needs and improve their health.

The department provided sandwiches and hot and cold refreshments for patients and loved ones.

The service made adjustments for patients' religious, cultural and other preferences by including vegetarian.

Pain

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

On inspection four out of thirteen adult records we reviewed did not have pain score documented and one patient we spoke with had been in the department for two hours and had not had their pain assessed.

We found pain was not appropriately assessed in children, the last paediatric RCEM pain audit reported of the 50 paediatric records reviewed, 11% of children did not receive a pain assessment within 15 minutes, furthermore 50% of children with moderate and severe pain did not receive analgesia within 20 minutes.

We discussed pain assessments with senior leaders of the care group division, who were unable to provide information on the actions put in place to improve pain assessments and documentation in the department for both adults and children.

Patient Outcomes

Staff did not always monitor the effectiveness of care and treatment. As a result, they were unable to benchmark their effectiveness of clinical practice and patient outcomes against similar departments.

The trust did not submit data for the three Royal College of Emergency Medicine (RCEM) audits they were eligible to participate in for 2019/2020 due to the pandemic. They did not participate in all the RCEM audits for 2020/2021 as there was a delay in uploading the data. Local data was being collected and was going to be uploaded to the national portal to allow comparison of national data. Local leaders were unable to evidence clinical outcomes against clinical standards to which all emergency departments should aspire to achieve. We found senior leaders of the care group division had no insight to the progress of the actions in place to address this.

Furthermore, we found there was a lack of local audit activity, and it was unclear what actions had been taken as a result of audit outcomes. Senior leaders of the care group division were unable to provide an explanation to how actions had been implemented in the department to address any gaps.

The trust's SSNAP data showed poor patient outcomes, data showed a deteriorating score between June – December 2020. They performed worse than the national average on a number of standards including percentage of patients scanned within one hour of clock start, percentage of all stroke patients given thrombolysis, percentage of patients who were thrombolysed within 1 hour, percentage of stroke patient seen by a stroke specialist consultant within 24 hours and the percentage of patients assessed by a stroke nurse. However, we found the stroke pathway at this site was well supported by three physicians. Although the overall SSNAP data was poor across the trust, we found evidence of physicians in the department ensured patients were scanned in a timely way.

We found no evidence of the department collecting performance data on paediatric outcomes. Senior managers we spoke with said the women's and children's division picked this up. However, a review of clinical governance and audit meetings minutes showed no evidence of this.

Competent staff

Urgent and emergency services

The service generally made sure staff were competent for their roles but there were gaps in the training and competencies of medical staff giving thrombolysis treatment to stroke patients. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

The service made sure staff were competent for their roles. All staff completed a trust induction and a local induction. Staff we spoke with said they underwent different trust wide competency-based assessments for procedures such as venepuncture and administrating intravenous drugs.

A practice educator supported nurses to maintain and further develop their professional skills and experience. This helped maintain competencies in a range of subjects. Staff we spoke with said they were supported to develop and complete training.

Managers appraised staff's work performance and held supervision meetings with them to provide support and development, 88.5% of nursing staff had received an up to date appraisal and 60% of medical staff.

The trust had a process in place to support nursing and medical staff in revalidation procedures. Revalidation is the new process that all nurses and medical staff in the UK will need to follow from to maintain their registration with the Nursing and Midwifery Council (NMC) and General Medical Council (GMC). We found not all staff had completed their revalidation but were aware it needed to be completed by the end of August 2021.

Nurses were trained to provide advanced paediatric life support. However, the local leadership had not ensured all adult nurses caring for children had completed appropriate paediatric life support training.

Multidisciplinary working

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

We found there were effective relationships between the departments to support the patient journey.

Staff supported each other to provide good care. They had reliable links into services that maintained a rounded approach to caring for their patients.

Staff had access to the bereavement specialist nurse who supported both staff and patients.

Ambulatory care unit and the surgical assessment unit attended morning huddles to capture any patients requiring transfer to the unit, they also discussed patients ready for discharge or those requiring further diagnostics.

Advanced nurse practitioners worked alongside medical staff in the emergency department providing advanced care for patients that historically may only have been provided by doctors. This helped make sure medical staff were available to care for more patients without delay.

Seven-day services

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

Urgent and emergency services

The department saw adults and children in the department 24 hours a day, seven days a week.

Staff had access to a paediatric on call doctor 24 hours a day seven days per week.

Diagnostic services within the department, could be accessed 24 hours, seven days a week.

A pharmacist visited the department seven days a week and were contactable 'out of hours.

The trust bereavement team were available to provide specialist support for families and loved ones. They operated from 9am to 5pm between Monday and Friday and on and on call basis outside of these times.

Physiotherapist worked in the department Monday – Friday and were on call at the weekends.

Health promotion

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

Staff identified those who may need extra support during assessment and signposted them to the right services.

Staff involved in initial assessment asked patients about smoking habits and alcohol consumption during assessment which helped capture national priorities to improve the population's health.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. Doctors and nurses obtained verbal consent from patients before providing care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health, but capacity and mental health risk assessments were not always undertaken in a timely way, in line with trust policy.

The department did not have a Mental Health nurse, which meant there was no dedicated person in the department to promote the delivery of mental health services or support staff coordinate care. Senior leaders recognised this but were unable to provide actions of how they addressed this.

A 136 room was in the mental health department; however, we were told that if a patient was in the 136 room this may delay visiting a patient in the department. Staff said at times MH patients waited long periods for an assessment and that could be up to 12 hours. This meant patients living with a mental health illness was not always seen in a timely way, at the time of the inspection one patient waited longer than 12 hours to be assessed.

Children with mental health concerns waited in the same area as adults, records showed one patient waited two hours and 30 minutes until they were admitted to the paediatric ward. The child did not have a CAHMS assessment carried out until two days later. We found one patient waited 4 hours for a single point contact assessment, this was conducted over the phone by a paediatric nurse in the department.

We heard staff explaining treatments and diagnoses to patients, checking their understanding, and asking permission to undertake examination and perform tests.

Urgent and emergency services

Training in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards was included within the mandatory safeguarding training.

Staff undertook a range of training to assist their patients. The department reported 100% compliance rate in dementia training and 88.7% in Autism training

We spoke with nursing and medical staff that were able to describe the relevant consent and decision-making requirements relating to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Standards (DoLS) in place to protect patients.

Staff were clear about their responsibilities in gaining consent from people including those who lacked capacity to provide informed consent to care and treatment. They followed national guidance to gain the patients' consent.

Staff used Fraser guidelines and Gillick competency principles when assessing capacity, decision making and obtaining consent from children. The 'Gillick Test' assists clinicians to ascertain if a child under 16 years of age has the legal capacity to consent to medical examination and treatment. The child must be able to demonstrate enough maturity to understand the nature and implications of the proposed treatment options, including the risks. Fraser guidelines are used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment.

There was a sign, at the nurse's station for the Mental Health Liaison Team, the team was available 24 hours a day.

A qualified practitioner would always assess a patient. security would be approached for observation of a patient, but this was at night only

The CAMHS provision was available between 9-5 Monday to Friday. Staff had access to the single point of access line after 5pm. Any referral made after 2pm meant children were not assessed face to face by a CAMHS nurse that day. They received a phone call to assess their mental health and were given an appointment for the next day to be seen.

We reviewed three paediatric mental health records, we saw that safeguarding referrals were completed, and a mental health triage assessment was completed within 15 minutes of arrival.

Is the service caring?

Good 

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

Compassionate Care

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

We saw staff caring for patients with compassion and feedback from patients confirmed that staff treated them with kindness.

Urgent and emergency services

Staff respected the patient's privacy and dignity, pulling curtains around bay areas. Feedback from people using the service and those close to them were positive about the way staff treated them.

Staff responded compassionately to patients when they needed help. We observed staff comforting patient who were anxious, upset and experiencing pain.

We spoke with patients and six carers. They were complementary of the staff. Comments included that staff were friendly, and they treated patients with dignity and respect.

Staff felt the organisation acted on concerns raised by patients. We found drop off and pick up spaces were introduced after patients said there wasn't enough parking bays.

Emotional support

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

Staff gave examples of working under emotionally demanding conditions during major incidents, offering emotional support to loved ones under difficult circumstances.

Bereavement team members worked closely with staff in the department to ensure support was provided continuously. There was support available for the bereaved from the chaplaincy service and bereavement service.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. We listened to conversations between staff and patients and heard staff answer questions and explain differently to those that did not understand certain elements of their treatment plan.

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients and their carers told us that staff were friendly, and they felt they could talk to them if they needed to.

Is the service responsive?

Good ↑

Our rating of responsive improved. We rated it as good.

Service delivery to meet the needs of local people

Urgent and emergency services

The service planned and provided care in a way that met the needs of local people and the communities served.

The urgent and emergency care service was available 24-hours a day throughout the year.

Facilities and premises were appropriate for the services being delivered. Signage was also available throughout the hospital which helped visitors find their way to the department.

The waiting area had enough seating for patients. We saw a smaller waiting area for children which was identified with child friendly wall decorations. However, was closed due to Covid 19.

From the waiting area patients were streamed either to the emergency areas or a GP (provided by the service) if appropriate which helped reduce wait times.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Visitors with hearing loss could access a hearing loop from the main reception.

The communication board listed all available resources to staff and patients whilst in the department. For example, we saw that sign language interpreters could be booked, children could use the pain score tool to show staff the level of pain they were in and staff could access an interpreter for patients whose first language was not English

Information leaflets on a range of conditions were available in the department.

Staff captured the patient's preferences using the patient passport, this was kept with the patients notes so that all staff caring for the individual could familiarise themselves with the patient's needs.

There was notice boards in the department with photographs of the staff and a description of what the different coloured uniforms meant. This meant patients were able to identify staff and their role.

The department were keen to better their patient experience, the" you said we did board showed" patients said there was limited parking, the department introduced drop off point.

However, the paediatric waiting area was closed because of Covid-19 and children waited in adult areas. Senior leaders of the medical care group were unable to tell us what plans were in place to safely open this area.

Access and flow

People could access the service when they needed it and received the right care promptly. However, the department did not always meet standards for waiting times from referral to treatment and arrangements to admit, treat and discharge patients.

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

Urgent and emergency services

Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards but the department had improved their position after deploying specific roles in the department to help with the flow

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 achieved 89.7% compliance rate at the time of inspection and maintained between 80% and 95% between January 2020 – April 2021

The department reported the mean time from arrival to treatment for paediatric attendees between November 2020 and April 2021 was 32 minutes. Additionally, they reported 98% of children were admitted, transferred or discharged within four hours. However, 3.5% of 2269 attendees left without being seen in the same reporting period.

Managers and staff worked to make sure patients did not stay longer than they needed to. The emergency department live tracking screen was updated frequently with current patient locations. This meant staff were aware of which patients were in their area.

Emergency nurse practitioners worked within the department and facilitated a minor injury streaming system to treat patients with minor injuries. This helped improve the flow of patients through the department and reduced waiting times for patients with minor injuries.

Advanced Nurse Practitioners (ANPs) in the department assessed, examined, diagnosed and treated a range of patient presentations. This service was developed as part of the workforce plan considering local recruitment challenges. The ANPs are involved in departmental teaching, clinical audit and lead various clinical projects within ED.

The department provided an Emergency Nurse Practitioner Service (ENP) which provided nurse-led care for all the adults and children who presented to the department and were streamed into the "minors' stream". The ENPs worked independently and helped free up medical staff to see patients with more complex problems.

Learning from complaints and concerns

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

We saw posters and leaflets in patient areas on how patients could make a complaint. Patients raised complaints via the Patient Advocacy and Liaison Service (PALS).

The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. Complaints were reviewed and investigated by the matron.

The service included patients in the investigation of their complaint.

Learning from complaints was discussed at senior meetings and departmental staff meetings.

Patients and relatives, we spoke with on inspection said they were confident about how to make a complaint.

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Is the service well-led?

Requires Improvement 

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

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities but did not always recognise the issues the service faced. For example, leaders were unable to provide insight to the paediatric ED provision, which meant they were unfamiliar with the priorities to ensure the service for children followed best practice. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

We interviewed the senior medical care group leadership team, who were familiar with the current challenges impacting on the service's performance. These included pressures from COVID-19 pandemic, stroke transfers, staff recruitment and retention and an increasing number of ED attendances. However, they were not familiar with plans to address the overarching action plans for the department to mitigate the risks identified such as poor audit uptake, lack of paediatric staffing, closure of the children's waiting room and poor NEWS documentation.

The local leadership team were committed and passionate about the service and worked to ensure patients were kept safe. For example, the stroke pathway at Furness General Hospital was well supported by active clinicians who worked hard to give patients the care and treatment they needed. However, we identified risks that had not been mitigated and acted at care group level

Senior managers in the department recognised patients were not always reviewed by a speciality team in a timely way, however we found no evidence of how the medical care group leadership team were addressing this issue.

Throughout the inspection we saw department leads walk round the department, speaking with and supporting staff. This was also evident from the discussions we had with staff.

They supported staff to develop their skills and take on more senior roles.

Urgent and emergency services

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. However, we were not assured leaders and staff understood and knew how to apply them and monitor progress.

The service area strategy fed into the wider medicine care group strategy. This was underpinned by the trust priorities and the care group priorities. Each service produced a plan on a page which fed into the main business plan. However, at the time of inspection the ED plan had been delayed since January 2021 and we found no actions in place to address this.

The trust vision was: *"We will consistently provide the highest possible standards of compassionate care and the very best patient and colleague experience. We will listen to and involve our patients, service users, colleagues and partners."* However, we found no evidence of the department listening to or involving children or parents in developing the paediatric ED service they provided.

Senior leads had worked with external organisations to reduce the number of patients waiting at the hospital. They worked collaboratively with health and care providers to review how services were delivered.

Governance

Leaders did not always operate effective governance processes, throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss the service they offer.

There was no clear governance channel into the wider organisational management structure that oversaw the paediatric provision in the emergency department. At the triumvirate meeting we were not assured senior leaders had oversight of the activity and performance in the paediatric emergency department. Senior leaders confirmed they did not attend any meetings relating to the paediatric provision and did not review any data activity. This meant they were unable to provide clarity of actions taken to address the paediatric RCEM audit results, the lack of paediatric emergency medicine consultant cover in the department and reopening of the children's ED area.

Although staff we spoke with said they attended weekly meetings which provided a platform to discuss agenda items such as department issues, staff concerns and patient feedback.

Leaders operated effective governance processes, throughout the service and with partner organisations. For example, the department worked with external providers to achieve an improved ambulance handover time.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. A range of meetings allowed for staff at all levels to discuss and learn from SIs, mortality reviews, complaints and audit.

All meetings reported into the divisional governance and assurance group, the divisional management board and the divisional performance meeting. These meetings were attended by the triumvirate which included the clinical director, divisional general manager and an assistant chief nurse.

Key performance metrics were regularly reviewed. We saw in care group meetings minutes, senior leaders discussed topics such as ambulance handover times, waiting times from referral to treatment and arrangements to admit, treat and discharge patients.

Deaths were reviewed by medical examiners, site-based mortality reviewers review cases weekly. Any learning was discussed in the monthly care group meeting. Board assurance was provided through quarterly mortality reports.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and identified actions to reduce their impact. Staff did not always contribute to decision-making to help avoid financial pressures compromising the quality of care.

The medicine care group risk register was available and had been defined to detail overarching risks under themes. The main themes reported at the time of inspection were urgent care standards, estates, workforce & mental health service/ provision. However, the lack of a paediatric emergency medical consultant or paediatric nurses was not on the risk register. Therefore, this meant the department did not recognise this as a risk.

Leaders said they used systems to manage performance effectively in the adult emergency department, however the department did not participate in clinical audit and were unable to benchmark clinical practice against similar departments.

We also found there were no systems in place to manage the performance and activity of the paediatric provision. For example, leaders of the medical care group division were not sighted on the poor paediatric resuscitation training compliance rates amongst the adult nurse staffing group. They told us that children were looked after by adult nurses who were competent to deliver life support if a paediatric nurse was not available.

We saw that there was limited monitoring of performance through audit activity. Managers in the department recognised they had not submitted the last set of data for the 2019/2020 RCEM audits and said there had been a delay in uploading the latest set of data. We found no assurance that the senior leadership team for the medical care group division was sighted on how the department was going to deliver the audit data and drive improvements through these audits this was not on the risk register.

Senior leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. We saw that risks were discussed at care group governance meeting. The meeting was attended by matrons and service managers who were asked to cascade information to their team. However, in meeting minutes we found no evidence of the risks we identified on site being escalated or discussed.

At the time of the inspection an external risk consultant had been commissioned to work with the trust to support the development, implementation and adoption of new risk management processes including a new risk strategy and risk policy. We were told this work will inform the trust's approach to risk management in the future.

Culture

Staff did not always feel respected, supported and valued. The service said they promoted equality and diversity in daily work and provided opportunities for career development. However, the staff survey results did not reflect this and it was not fully embraced. The service was working towards an open culture where patients, their families could raise concerns without fear, but this work was not embedded and was ongoing.

Staff we spoke with felt that they were valued and respected by their peers and leaders. The staff survey reported 44.3% of staff in the medical care group had experienced discrimination relating to their ethnic background and 27% because of their gender.

There were mixed feelings about the separate grade staff meetings, some staff said they allowed them to freely raise concerns and speak up and others said it segregated the different staff groups.

Staff had access to the freedom to speak up guardian but 45% of staff in the staff survey reported they did not feel safe to speak up about anything that concerned them.

Staff did not always feel respected, supported and valued. Staff were positive and proud to work at the service. The staff survey reported 66.7% of staff in the medicine care group said they were enthusiastic about their job.

Senior leaders were keen to support staff with health and wellbeing. They told us they were introducing wellbeing champions across the division. On inspection we saw notices requesting staff to apply to become a champion in their area.

Leaders of the service said they promoted an open culture and encouraged staff to discuss any concerns with their manager. The department's meetings and notice boards highlighted improvements and changes made through learning from complaints and incidents and provided information to support the health and wellbeing of staff.

All staff had access to "colleague support you" booklet. The booklet included information on a range of wellbeing topics and numbers and links to mental health organisations or support groups.

Senior leaders informed us that the trust was working to improve the experiences of those colleagues with protected characteristics. Minutes from the anti-racism influencers group detailed how the staff were working together to promote a more inclusive workplace.

We saw that the trust promoted equality, diversity and inclusion through newsletters and took part in awareness weeks such as LBGT week.

Information Management

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

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Urgent and emergency services

Innovation, improvement and sustainability

All staff were committed to continually learning and improving services. However, we found no evidence on how the service improved the paediatric service. There was a good understanding of quality improvement methods and the skills to use them, but they did not always address all issues in the department. Leaders encouraged innovation and participation in research.

The staff survey reported 74% of staff said senior managers did not act on feedback and 73% of staff said senior managers did not involve staff in important decisions.

We did not see any evidence of the department inviting children, young people and their parents/carers to provide feedback on the service received in the urgent and emergency care setting to improve service provision.

Staff had a good understanding of quality improvement methods and the skills to use them. Work streams looking at support services in the ED were underway. For example, we saw that the service was currently looking at their falls provision and working towards ensuring all aspects of the patient's journey was safe. However, there were no workstreams in place to address the 2019/2020 RCEM audits, audits relating to the paediatric ED service

All staff were committed to continually learning and improving services. Since the last inspection the department had made improvements to the flow of the department. They had reduced their ambulance handovers to 16 minutes by deploying a dedicated handover nurse who managed patients arriving by ambulances.

Leaders encouraged innovation and participation in research. The trust contributed to research during the pandemic, patients were screened to appropriate trials. Additionally, the department was one of the few sites whose staff took part in COVID 19 vaccine studies.

Medical care (including older people's care)

Inspected but not rated

Is the service safe?

Inspected but not rated

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use the relevant equipment.

The hospital did not have a stroke unit, however all patients who had experienced a stroke were cared for on designated wards, the Complex and Coronary Care Unit (CCCU) and Ward 6. Those patients who had undergone thrombolysis were cared for on the coronary care unit. After 24 hours of observation a repeat CT scan was done, if no further problems were identified the patient would be transferred to ward 6.

Stroke patients were not admitted to any other ward areas in the hospital, the only exception to this would be intensive care.

The CCCU was an eight-bedded unit which had recently had new monitoring facilities installed.

Whilst the service had enough suitable equipment to help them to safely care for patients; there were challenges with other facilities. The gym used to help with rehabilitation has been repurposed during the pandemic. There was a general lack of space for therapy equipment and the kitchen facilities to support patient rehabilitation were a considerable distance from Ward 6.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a recognised tool in assessing and responding to patient deterioration in line with guidelines and best practice. In addition, the trust used the National Institute of Health Stroke Scale (NIHSS) score assess stroke patients. This tool identifies the level of neurological impairment a stroke has had on a patient.

We reviewed four sets of patient records in depth, tracking them from the emergency department to ward 6 or CCCU. The records showed staff had completed the relevant risk assessments including, NIHSS Scores risk assessments for each patient.

Staff knew about and dealt with any specific risk issues. Documents were available in the department which detailed the NIHSS assessment and scoring and the thrombolysis toolkits.

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

Stroke treatment is time critical and for this reason, ambulance staff pre alerted the hospital of incoming patients experiencing stroke symptoms so that the hospital was ready to receive and assess the patient in a timely manner.

During the day all stroke patients were attended by the stoke team. The consultants are notified of pre- alert stroke patients. Out of hours telestroke services would be accessed by medical staff in the emergency department. The telestroke system consists of a two-way video and audio conference facility. Telestroke allows specialist on call stroke consultants to remotely access patients and view CT brain scan images across the network sites. The telestroke consultant would be available to remotely assess the patient and provide decision making around thrombolysis.

A key diagnostic procedure in the stroke pathway is an urgent CT scan to check for either a bleed or a blood clot in the brain. If a CT scan shows no evidence of a bleed, patients undergo further testing by way of a CT angiogram.

The Sentinel Stroke National Audit Programme (SSNAP) includes data on scanning including the number of patients who receive a CT scan within an hour. SSNAP data for this site showed a consistent rating of A, from quarter four in 2019/2020 to quarter four in 2020/2021. This is the highest (best) rating.

We spoke with radiology staff who clearly described the process to ensure CT scanning was undertaken in a timely way for stroke patients. This included CT being pre-alerted for any stroke patients to ensure scanners were made available.

A thrombectomy is a procedure to remove a blood clot. This is a specialist service and is not provided at every hospital. The procedure must be undertaken within six hours of a person experiencing a stroke. A thrombectomy service was not provided at this trust, patients identified as suitable for this treatment were transferred to another trust in the North West.

Information was displayed informing staff on scanning procedures to ensure appropriate scanning was undertaken which did not delay patients who would be suitable for the thrombectomy service.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The number of qualified nurses on CCCU ensured that British Association of Stroke Physicians (BASP) guidelines were met. The ward had eight beds and had planned levels of four qualified nurses at all times. We reviewed staffing rotas which confirmed planned staffing levels were consistently met.

The wards used a staffing acuity tool (safe care acuity tool) in which the patients acuity scoring was measured against the safer nursing care evidence-based tool, reportable through “Safecare”. The online Safecare highlighted any concerns around staffing levels. The clinical site manager and matron had the responsibility to ensure the ward had the correct numbers of staffing.

Ward 6 had 36 beds. The ward had four staff on maternity leave but the nursing establishment was over by four whole time equivalent staff.

The ward planned to have six qualified nurses on duty during the day and three at night. From reviewing four weeks of staffing rotas we saw that these numbers were achieved.

Any gaps in the rota were covered by staff working additional shifts, there was no use of agency staff. There was a band six nurse on each shift.

In addition, there were two band eight advanced nurse practitioners (ANP's) and third undergoing training, in the stroke team who supported the wards and the emergency department.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience. However, patients were mainly kept safe from avoidable harm and were provided the right care and treatment through the dedication of the existing team.

There were three consultants providing medical cover, including stroke services at Furness General Hospital. One of the consultants worked part time. They provided cover from 7am to 6pm, Monday to Friday. Consultants were on call at weekends and attended for a couple of hours on Saturday and Sunday to support seven-day stroke assessments. A one in three rota supported the delivery of the stroke service. The consultants also provided cover for patients with other medical conditions in the hospital.

SSNAP data for this site showed that specialist assessments, which included, proportion of patients assessed by a stroke specialist consultant physician within 24h of clock start; was rated between A and B from quarter four in 2019/2020 to quarter four in 2020/2021. A rating of A is the highest (best), a rating of E is the lowest (worst).

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive and fully completed in the records we reviewed; all staff could access them easily.

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

Records were stored securely.

Incidents

The service did not always manage patient safety incidents well. Staff recognised and reported incidents and near misses. Managers did not always investigate incidents and share lessons learned with the whole team and the wider service in a timely manner.

Between 1 April 2020 and 1 April 2021, we reviewed incident data from the National Reporting and Learning System (NRLS). We found 152 incidents related to stoke services. The data we examined did not always specify which hospital site the incidents related to. However, the information showed that patients were exposed to the risk of harm.

Medical care (including older people's care)

The NRLS data reviewed from April 2020 to April 2021 showed evidence of inappropriate treatment. Examples included, medications given to patients after thrombolysis which are contraindicated, and a catheter being inserted within 24 hours of receiving thrombolysis treatment. This is contraindicated within 24 hours of thrombolysis treatment due to a risk of bleeding.

All staff were aware of the process for reporting incidents. However, from the NRLS data we reviewed, we lacked assurance that incidents were always graded appropriately. For example, there were a number of incidents related to delays in providing treatment which were graded as low harm.

Following the inspection, the trust completed further analysis of these incidents. They identified some were duplicates so the number of incidents was 111. Five of these were relevant to the stroke pathway and were graded moderate or above. Learning had been identified and action plans were in progress.

We were told the number of mortality reviews for stroke patients were above average. There was cross site working between Furness General Hospital and Royal Lancaster Infirmary (FGH) for mortality reviews with shared learning.

Is the service effective?

Inspected but not rated

Evidence-based care and treatment

The service provided care and treatment based on national guidance and managers checked to make sure staff followed guidance. However, local policy did not always reflect best practice guidance.

Staff provided treatment and delivered care according to national guidance. From speaking with staff and from the records we reviewed we saw that the stroke team were always involved in treatment and care of patients presenting with the symptoms of a stroke.

Outside of normal working hours telestroke would be used by medical staff in the emergency department to support appropriate decision making.

However, from reviewing documents we found that national guidance was not always reflected in local policy. For example, inserting nasogastric tubes and catheters within 24 hours of thrombolysis was not reflected in the trusts local policy, but is included in national guidance.

Nutrition and hydration

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

From the records we reviewed we found that swallowing assessments were undertaken in a timely way. The stroke advanced nurse practitioners (ANP's) and several of the staff on ward 6 were trained to undertake these assessments.

It was recognised that speech and language therapy (SALT) input was a challenge and this was reflected in the hospitals SSNAP data. This showed that from 2019 to the most recent data in quarter four of 2020/2021 the rating for speech and language therapy had deteriorated from a C rating to and E rating.

Information on the stroke improvement plan was provided after the inspection. This identified an action of restarting Saturday working for the SALT team by the end of May 2021. However, another action of reviewing SALT staffing had an end date of September 2021, so it was not clear how the trust planned to implement this.

There was also an action related to SALT indicators for SSNAP. There was an end date of the 26 July 2021, however there was no identified resource or details about how this would be achieved.

From our observations and discussions on site we saw that staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.

Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition and weekly audit of fluid balance charts was undertaken.

Patient outcomes

Staff monitored the effectiveness of care and treatment for stroke patients through contributing to National Audit Programmes. We were not assured that the trust were using the findings to make improvements and achieve good outcomes for patients.

The service participated in the Sentinel Stroke National Audit Programme.

Outcomes for patients, which covered 10 domains from initial assessment and treatment to discharge, had deteriorated over time. In quarter one of 2019/2020 the service at this site had an overall SSNAP rating of B. At the time of inspection this had deteriorated to a D.

We spoke with the stroke team during our inspection and were made aware that some of the changes that had to be made to patient pathways because of the impact of Covid would have a direct impact on the sites SSNAP data. For example, during the pandemic, stroke patients were admitted to Ward 9, meaning patients were not in the right place and unable to access all treatment and therapies. This had been added to the risk register.

Therapy outcome measure were not always being measured effectively and we were told this was still being developed.

We lacked assurance over what actions were being taken in response to the SSNAP audit data. We were provided with an action plan, but this had little detail and did not provide assurance that actions to make improvements would be implemented in a timely manner.

Senior nurses described a number of local weekly audits which were undertaken. Examples included; use of red bands to indicate when a patient had allergies, hand hygiene and NEWS2.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work.

Managers supported staff to develop through yearly, constructive appraisals of their work. This gave staff the opportunity to discuss training needs with their line manager and supported them to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role, this included swallow assessments and insertion of nasogastric feeding tubes. Several staff had completed this training with more booked on to training in June 2021.

Medical staff in the emergency department described a number of training sessions for nursing and medical staff provided by the stoke team. This was done in response to new staff joining the department to improve their knowledge and understanding regarding stroke care. Areas covered included the stroke pathway and specific training for staff groups.

Multidisciplinary working

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

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

Staff worked across health care disciplines and with other agencies when required to care for patients.

Patients on the stroke care pathway had input from the stroke team and were reviewed by relevant consultants.

Therapy staff we spoke with reported that they had been trialling a new integrated team to support the needs of stroke patients. This included acute and rehabilitation care in the hospital and in the community to try and provide an equitable service. This was a challenge due to the size of the therapy team and the geographic area covered. During the inspection we observed the negative impact of one member of the team being unavailable for service delivery.

Seven-day services

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

The service did not have the provision for thrombectomy services on site. Thrombectomy services were available between 8am and 5pm on a Monday to Friday at another hospital. Due to the travel distance, to the hospital that provided this service, patients could only be referred up to 4pm for this treatment. The treatment window for a thrombectomy is six hours from the time of the known onset of stroke symptoms.

Telestroke services were available overnight during weekdays, from 5pm until 8am, and 24 hours a day at the weekends.

Medical care (including older people's care)

From January 2021 CT scanning at this site was available 24 hours a day, seven days a week. Prior to this out of hours and at weekends was via an on-call service. This was a positive change to the service.

Therapy services were only provided Monday to Friday with no weekend service. The impact of this was reflected in the SSNAP data for the site, with the therapy domains all currently rated as E. It was unclear from the action plan provided by the trust how they were going to address this gap.

Is the service caring?

Insufficient evidence to rate

Is the service responsive?

Insufficient evidence to rate

Is the service well-led?

Inspected but not rated

Leadership

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

The stroke service had strong clinical oversight and management within the team at Furness General hospital. The teams were aware of the challenges and were working hard to provide a safe service for patients. This was achieved through the dedication and hard work of the staff.

The clinical leaders were very knowledgeable and experienced and shared this with the wider teams, such as the emergency department to provide safe care and treatment for stroke patients.

Staff on the wards were supported to undertaken further training to benefit patients.

Vision and Strategy

The vision and strategy for stroke care was not aligned across the trust.

We were told that the strategy for stroke care was dependent on wider discussions and decisions within the health economy and the Lancashire and South Cumbria Integrated Care system (ICS). The trust's CEO was the ICS lead for stroke services across the geographical area.

Medical care (including older people's care)

At the time of inspection, the stroke services at Furness General Hospital and the Royal Lancaster Infirmary operated independently and care pathways were not aligned. The actions on the stroke improvement plan were site specific and did not appear to be focused on aligning the services.

Governance

Leaders did not operate effective governance processes, throughout the service and with partner organisations to ensure effective care and treatment of stroke patients. Although, staff at the local operational level were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

We found there was a lack of robust governance systems and processes for the stroke pathway. It was not clear from the evidence reviewed and staff interviewed that there was a clear communication channel from the clinical teams involved in stoke care to the board. Staff including senior leaders, could not clearly articulate the governance framework for this.

Audit data from the Sentinel Stroke National Audit Programme (SSNAP) from January 2019 to December 2020 showed the trust were performing worse than the National average on a number of standards. The overall rating for this site, during this time period, had deteriorated from B to D. The domains related to thrombolysis and therapy input all had deteriorated to an E rating.

After the inspection, we requested the trust action plan in relation to the SSNAP audit data. We were provided with an improvement plan. This contained 167 'tasks' however it was unclear how these would be implemented, who had responsibility and what would evidence their impact. Several of the tasks also had long time frames for implementation. For example, ensure Thrombolysis pathway is utilised completed by 30 September 2021.

Immediately after the inspection CQC took enforcement action using our urgent powers whereby we imposed conditions under section 31 on the trust's registration as people may or will be exposed to the risk of harm. These included: -

- the provider must implement an effective risk and governance system for the whole stroke pathway.
- othe provider must operate an effective clinical escalation system to ensure stroke care and treatment is assessed and implemented in a timely way.
- the registered provider must implement an effective system to ensure that all clinical staff have the knowledge, competence, skills and experience to care for and provide treatment to patients presenting with symptoms of stroke.

The trust responded and has provided information on the immediate actions they had taken to mitigate the risks we had identified at the inspection. The trust has since produced a detailed action plan, focusing on the conditions of registration and will be providing regular reports to CQC on the actions taken to improve the quality and safety of services. CQC will continue to monitor these actions through our routine engagement.

Management of risk, issues and performance

Senior leaders did not use systems to manage performance effectively. However, the local leadership identified and escalated relevant risks and issues and identified locally actions to reduce their impact. They had plans to cope with unexpected events.

Medical care (including older people's care)

Senior leaders could not clearly articulate how risks were being managed and identified; risks to patients on the stroke pathway were not recorded on the risk register. The risk register supplied did not identify the risk, delays and potential harm to patients requiring care and treatment for stroke symptoms.

From reviewing trust board papers between September 2020 and March 2021, there is little mention of stroke services and no information related to any risks associated with the service or incidences of patient harm or treatment delays. We were concerned that at a more senior level the stroke pathway and outcomes for patients were not being addressed in a meaningful and timely way.

The local service leads were aware of the risks to the services and the actions required to mitigate and make improvements.

Surgery

Good

Is the service safe?

Good

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

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it, however the mandatory training compliance rate did not meet the trust's target in all modules.

Mandatory training was a mixture of face to face training and e-learning modules. Managers monitored mandatory training and alerted staff when they needed to update their training. Managers told us that there was a system in place to monitor mandatory training compliance rates on a monthly basis, and that staff and line managers were notified when a training module was due for renewal or had expired.

The trust set a mandatory training compliance rate target of 95% for all modules. The trust provided us with mandatory training compliance rates split by clinical care group for over the last 12 months and therefore the mandatory training data for surgery also includes data for critical care. At the time of our inspection most staff within the surgical care and critical care group at this hospital had completed their mandatory training but the trust's target mandatory training compliance rate target of 95% training had not been achieved in all modules.

The surgical care and critical care group at this hospital had achieved the trust's mandatory training completion target of 95% for a range of topics including; conflict resolution, equality, diversity and inclusion, information governance level one, infection prevention and control level one and level two, FT3 general fire safety awareness, health and safety, waste management, manual handling, hand hygiene, safeguarding adults and children level one and level two, mental capacity act and deprivation of liberty safeguards and adult safeguarding level three and medicine management.

However, the surgical care and critical care group at this hospital had not achieved the trust's mandatory training compliance target of 95% in a number of modules including; FT2 departmental fire safety awareness (94%), medical gases awareness user safety (92%), glucose and ketone meter (91%), safeguarding children level three (73%), think family safeguarding children and adult level three (84%), basic life support (92%), paediatric basic life support (93%) and medical gases awareness safety (92%).

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. However, the number of staff that had completed the higher level of children's safeguarding training did not meet trust targets.

The trust set a training compliance rate target of 95% for all safeguarding vulnerable adults and children modules. The trust provided us with safeguarding vulnerable adults and children training module compliance rates split by clinical care group for over the last 12 months and therefore the data for surgery also includes data for critical care. At the time

of our inspection most staff within the surgical care and critical care group at this hospital had completed training modules in the safeguarding of vulnerable adults and children. 99% of staff had completed children and adults safeguarding training level one, 98% of staff had completed children and adults safeguarding training level two and 98% of staff had completed mental capacity act and deprivation of liberty safeguards and adults safeguarding training level three. However, the number of staff that had completed safeguarding children level three training was 73% and think family safeguarding children and adults level three training was 84% which were below the trust target of 95%.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. During our inspection we saw that the trust had safeguarding policies which were available via the trust's intranet to support staff to raise safeguarding concerns. Staff we spoke to knew how to access safeguarding policies.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff we spoke to were aware of the trust's named lead for safeguarding adults and children and provided examples of when they had made a safeguarding referral to raise concerns.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

During our inspection we saw that wards and theatres we visited were visibly clean and had suitable furnishings which were well-maintained. We saw that cleaning records were in place for staff to document the cleaning of the environment and equipment. The cleaning records we reviewed on the wards and theatres we visited demonstrated that staff cleaned the environment and equipment consistently. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw that staff used the "I'm clean" sticker system on wards which indicated when equipment had last been cleaned.

We saw that there were enough hand washing sinks and alcohol gel hand rub in all areas that we visited and observed that staff washed their hands and followed the world health organization's five moments for hand hygiene guidance. Staff told us that environment and equipment cleanliness and staff hand hygiene compliance was routinely monitored through a monthly ward audit and monthly matron assurance audit which demonstrated good rates of compliance.

The wards and theatres we visited had arrangements in place for the handling, storage and disposal of domestic and clinical waste and sharps.

Staff worked effectively to prevent, identify and treat surgical site infections. There had been four surgical site infections reported by the surgical services at this hospital during the past 12 months.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff we spoke to were aware of current infection prevention and control guidelines, including the process for screening patients for Covid-19, MRSA and Clostridium Difficile prior to and during an admission to wards and theatres. Staff told us that patients identified as having a current or previous infection were isolated in side rooms and appropriate signage was used to indicate the potential for infection in order to protect staff and patients. Staff told us that they could access further support and advice from the hospital's infection, prevention and control team.

The areas we visited had enough supplies of personal protective equipment (PPE) and we saw that staff used this in line with trust policy. There was information displayed at ward entrances about appropriate PPE usage and an area for staff to don and doff PPE with supplies of surgical face masks and aprons and with access to a hand washing sink, hand wash and alcohol gel hand rub.

As part of the trust's response to the Covid-19 pandemic the service had environment risk assessed each ward to ensure the appropriate social distancing guidance for staff and patients was in place to prevent potential transmission of the Covid-19 virus. On each ward we visited we saw that staff break rooms, clean utility rooms, dirty utility rooms, medicine storage rooms and patient day rooms had been covid-19 environment risk assessed for maximum occupancy and where required excess seating was removed. We saw that the maximum occupancy of each room was clearly displayed on room doors. We also observed that staff followed the trust's covid-19 social distancing and PPE policies.

Environment and equipment

The design and maintenance of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, we found entrances to wards and fire doors were not secured.

During our inspection we found that there was a potential risk posed to the safety and security of patients on the surgical wards at this hospital. We found that the entrance doors to all surgical wards and the fire doors on these wards were propped open and were not able to be secured by any mechanism. We raised this concern with the surgical senior leadership team who told us that doors to ward entrances and fire doors should be kept closed at all times and that they would take the required action in these areas. We were informed by the senior leadership team that this matter had been identified as a security risk and that there were approved plans to install a keypad entry system for the surgical ward entrance doors to improve security, however we were told that in the event of an emergency that the surgical ward areas could be locked down by the hospital to ensure the safety and security of patients.

Staff did not consistently carry out daily safety checks of specialist equipment. During our inspection we saw that there was a sealed and tagged resuscitation trolley available in all the areas we inspected that contained emergency equipment and medicine. All disposable equipment on the trolley was sealed and all required equipment was present. The resuscitation trolley equipment was checked on a daily basis by staff. However, we reviewed the resuscitation equipment check logbook on the joint day surgery unit (DSU) and elective orthopaedic unit (EOU) and found that the daily resuscitation trolley was not recorded as being checked by staff on five occasions between 31 January 2021 and 31 March 2021. We also noted that as part of the safety assurance checks for each ward, a daily safety assurance check form was completed by the nurse in charge to ensure required safety checks were completed by staff. On four out of five of these occasions, the nurse in charge had signed the daily safety assurance check form to confirm that the resuscitation trolley check had been undertaken and recorded by a staff member, and on the remaining one occasion the resuscitation trolley check was not completed by the nurse in charge.

We also found on ward 4 that the resuscitation trolley equipment check was not recorded as completed by staff in the logbook on two occasions between 31 January 2021 and 31 March 2021, however the nurse in charge had signed the daily safety assurance check form on these two occasions that the resuscitation trolley check had been undertaken and recorded by a staff member.

We saw that clinical and non-clinical waste was segregated into colour coded bags safely disposed of by the estates staff.

Surgery

The environment and equipment on the wards we visited were well maintained, however we found that the wards struggled for appropriate storage areas and that storage rooms on wards were cluttered with equipment and we saw in some areas that patient equipment and fluids were stored on the floor. We raised this with managers who told us that an area on one ward had been identified as a main storage area for all wards to address this, but more storage space was required.

The service had enough suitable equipment to help them to safely care for patients. We saw that there was adequate stock and a process of regular review was in place to ensure that patient consumable equipment was within their expiry date. Equipment we saw including, portable suction machines and blood pressure monitors were all visibly clean and had portable appliance testing (PAT) stickers displayed that were within date of last testing.

Patients could reach call bells and staff responded quickly when called. Patients we spoke to told us that staff were attentive and responded to call bells and requests for assistance.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration

We reviewed a sample of patient records and saw that staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. We saw that risk assessments were conducted for venous thromboembolism (VTE), pressure ulcers, nutritional and hydration needs, risk of falls and infection control risks. During our inspection we also saw that staff conducted comfort care rounds every four hours to assess patients' condition and to identify any issues promptly that may need to be escalated. Staff we spoke to knew about and dealt with specific risk issues such as sepsis, VTE, falls and pressure ulcers.

The trust used the national early warning score system (NEWS2) a nationally recognised tool to identify deteriorating patients that require escalation of their condition. The NEWS2 score was recorded and monitored in the patient's electronic patient record which staff had access to. We reviewed a sample of patient records and saw that staff used the tool in line with the trust's policy to identify deteriorating patients and escalated patients appropriately.

The trust provided us with the results of their national early warning score (NEWS2) audit that was completed to assess staff's compliance against trust's policy. The trust audited 45 patient records of patients who received care and treatment at the trust between May 2020 and April 2021 in the general surgery directorate and the audit demonstrated a compliance rate of 95%.

There surgical services completed a monthly audit of all patients at the trust that had been screened for sepsis to monitor patient outcomes and staff compliance with trust policy. There had not been any patients identified with sepsis in the surgical wards at this hospital during the period of February 2021 and March 2021 that the audit data provided covered.

We observed two theatre teams undertaking the 'five steps to safer surgery' procedures, including the use of the World Health Organization (WHO) checklist. The theatre staff completed safety checks before, during and after surgery. The trust provided us with the audit data for the safer surgery WHO checklist across the surgical theatre areas at this hospital

that was completed monthly to check staff compliance. This was an observational audit completed by a senior member of staff to observe staff practice based on 10 audit standards (including staff participation in the brief, sign in and time out phases). The monthly audit results between September 2020 and March 2021 demonstrated consistently high levels of staff compliance of 98% or more over this period.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). Staff we spoke to told us that the hospital had a service level agreement with a neighbouring NHS trust that provided mental health crisis care, mental health review of patients and support and advice for staff. Staff described the process in place to keep patients safe whilst waiting for specialist mental health input.

Staff shared key information to keep patients safe when handing over their care to others. During our inspection we observed a staff handover on a ward at shift change and saw that handovers included all necessary key information to keep patients safe.

Nurse Staffing

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

During our inspection we saw that the wards and theatre areas we visited had enough nursing and support staff to keep patients safe and that the number of nurses and healthcare assistants matched the planned numbers. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Managers we spoke to told us that they could adjust staffing levels daily according to the needs of patients through the use of bank and agency staff that worked in the services regularly and were familiar with the services policies and processes. Managers told us that they made sure all staff including bank and agency staff had a full induction and understood the service. Staff we spoke to on the wards and in theatres told us that they had a full induction and competency-based training plan and that they felt supported by managers.

The service had low vacancy rates for nursing staff as the trust had recently recruited a number of newly qualified and international nurses on the surgical wards at this hospital. This had an impact on the skill mix across the wards as not all newly recruited staff had fully completed the required competency based training relevant to the area in which they worked, however the wards used nursing staff with the relevant competencies and the support of junior doctors from other areas when required.

The theatre staff at this hospital were overseen by the matron for theatres. At the time of our inspection the surgical theatres had a low number of staffing vacancies. We reviewed a sample of theatre staffing rotas and saw that operating theatres had sufficient numbers of staff, in line with national guidelines, such as the association of perioperative practice (AfPP).

The trust provided us with data over the period of April 2020 and February 2021 for the turnover rate at trust-wide level for nursing and midwifery staff which demonstrated an increasing turnover rate from 4.5% in April 2020 to 5.2% in February 2021. Managers told us that it was difficult to recruit and retain staff due to a national shortage of nursing staff

and geographical implications, however the trust had a recruitment and retention strategy in place which included "growing their own" nursing staff through the trainee nursing associate programme and the recruitment of newly qualified and international nurses. There had been an improvement in nurse staffing vacancies in the surgery division since our last inspection.

The surgical care group senior leadership team told us that they had recently started to review the current nursing staff establishment to determine whether this was sufficient for the surgical services going forward, in line with the trust's nursing recruitment strategy 2021 and workforce plan 2021/22.

Medical staffing

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

The wards and theatre areas we inspected had sufficient numbers of medical staff with a good skill mix on each shift to ensure that patients were safe. We reviewed a sample of medical staffing rotas and saw that the service always had a consultant, junior doctor and middle grade doctor each surgical specialty 24 hours per day, including a separate 24 hour on call rota for evenings and weekends.

The ward and theatre staff told us that consultants and doctors were accessible and provided support when required and that daily consultant-led ward rounds took place across the surgical wards seven days per week. Staff also told us that medical outlier patients were frequently placed on the surgical wards, however we were told by staff that there was a medical consultant 'buddy system' in place which ensured medical outlier patients were reviewed each day by an appropriately skilled medical consultant.

At the time of our inspection the service were actively recruiting for two consultant doctors and one middle grade doctor positions, however the service was having difficulty in recruiting to these vacancies. There had been an improvement in medical staffing vacancies in the surgery division since our last inspection. The senior leadership team told us these posts had been covered by locum doctors on extended contracts, and that these doctors had a full induction to the service and were familiar with the hospital's policies and procedures.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, and easily available to all staff providing care, however patient records were not all stored securely.

The service used a mixture of paper records and electronic patient records and if patients were transferred to a new team, there were no delays in staff accessing their records. During our inspection of the surgical wards and theatres we looked at a total of 24 patient records, and we found that records were completed comprehensively by staff. We saw that as part of the matron's safety assurance monthly audit that a sample of patient records were checked for accuracy and completeness and that recent audits demonstrated good rates of compliance.

However, patient records were not all stored securely. On three of the four surgical wards that we visited we found that note trolleys at the nurses' stations containing patient paper records were left unlocked and open, and unattended by staff at times.

Surgery

Medicines

The service used systems and processes to safely prescribe, administer and record medicine. However, on some wards medicine were not always consistently stored in line with trust policy.

The Trust had an electronic prescribing and medicines administration recording system in place. During our inspection we reviewed four patients records and saw that staff followed systems and processes when safely prescribing, administering and recording medicine and that staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

Staff we spoke to on the wards told us that a pharmacist carried out daily medicine reviews on the wards remotely via the electronic patient record system due to the covid-19 pandemic to limit the number of staff on wards, however at the time of our inspection pharmacy staff were returning to be consistently ward based. Staff we spoke to told us they felt they had appropriate support from the pharmacy team.

We spoke to pharmacy managers that told us there was one pharmacist member of staff that provided pharmacy cover for the four surgical wards, however the service also had pharmacy technicians trained in medicine reconciliation level 1 and level 2, to support the timely reconciliation of patient medicine.

We saw that all medicine on wards were stored in keypad locked rooms and controlled drugs were stored in lockable medicine cupboards and medicine fridges. We reviewed a sample of medicine in the medicine cupboards on three wards and found that these were well ordered, tidy and all within expiry date. However, staff did not consistently store and manage these in line with the trust's policy. We found on the day surgery unit (DSU) that the medicine stored in the medicine room at ambient room temperature had not been escalated on the 23 occurrences that the room was out of temperature range as per the trust policy in the months of March 2021 and April 2021. We raised this with managers and found that these occasions were not escalated in line with trust policy.

There was a system for monitoring the medicine fridge temperature and a process for escalating to the pharmacy team and estates if the fridge temperature went out of the trust policy range of two to eight degrees centigrade. We reviewed the medicine fridge temperature logs on three wards and found on ward 4 that the medicine fridge was out of the required range on 10 occasions in April 2021 and 20 occasions in March 2021 and on ward 2 the medicine fridge was out of the required range on one occasion in April 2021. Staff we spoke to on the wards did not all understand the process for medicine fridge temperature monitoring and escalation. We raised this with managers and found that these occasions were not escalated in line with trust policy.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

There was an electronic incident reporting system in place and staff we spoke to were aware of their responsibilities to report incidents, near misses and raise concerns. Staff we spoke to were aware of their responsibilities under the duty of candour and spoke about the importance of being open and transparent, and giving patients and families a full explanation if and when things went wrong.

Surgery

We looked at a sample of incidents reported on each ward and saw that staff raised concerns and reported incidents and near misses in line with trust policy and that staff received feedback from investigation of incidents.

The governance business partner reported there had been 39 serious incidents reported by the critical care and surgery care group across the trust during the past 12 months. This included 12 surgical incidents, 12 diagnostic incidents, seven treatment delays, four slips, trips and falls, two instances of suboptimal care of the deteriorating patient, one medicines incident and one pressure ulcer incident.

The service reported that there were ten incidents rated moderate harm and above at this hospital over the last 12 months. The service had one Never Event in the surgical theatres at this hospital over the last 12 months where a patient following a surgical procedure had a retained foreign object inside their body, however the patient did not come to harm. Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each Never Event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event. We saw that managers shared learning about never events with their staff and across the trust.

Staff told us that learning from incidents was shared through hospital-wide alerts and newsletters and staff we spoke to were aware of recent incidents and the learning implemented from these. We were told by managers that incidents were reviewed weekly and monthly by each surgical specialty and by the surgical care and critical care group to identify trends and to improve practice and the service for patients.

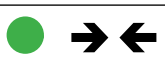
Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

During our inspection we saw displayed on notice boards on each ward and theatre area we visited that information relating to patient safety, including pressure ulcers, hospital acquired infections, falls and staff hand hygiene compliance was displayed.

Managers told us that safety incidents such as pressure ulcers and falls were monitored and reviewed as part of monthly surgical speciality level meetings and surgical care and critical care group meetings.

Is the service effective?

Good 

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Surgery

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We reviewed policies and clinical pathways and found that these based on best practice guidance such as from the Royal College of Surgeons and the National Institute for Health and Care Excellence (NICE). Staff accessed policies through the trust's intranet, and we saw that these were within their review date and easily accessible.

The surgical services participated in both national and local clinical audits. The surgical specialties at this hospital were involved in 39 national and local clinical audits during the past 12 months and 11 of these had been completed to date and the remaining audits were in progress. Managers told us that outcomes from audits were reviewed in audit meetings by each surgical speciality were improvements and updates to processes were discussed

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. We observed mealtimes on the wards and saw that patients who required additional support with their eating and drinking were assisted appropriately by staff. We saw that food and drink was available and in reach of patients. Patients told us that the food and drink available met their needs and that they had adequate choice, and patients were complimentary of the quality of the food. Drinks and snacks were available to patients between mealtimes. Staff told us that specialist support from staff such as speech and language therapists was available for patients who needed it.

We reviewed electronic and paper records for patients and saw that staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff used the Malnutrition Universal Screening Tool (MUST) tool, which is a nationally recognised screening tool to identify and monitor patients at risk of malnutrition.

Patients waiting to have surgery were not left nil by mouth for long periods. Systems were in place that followed current best practice guidelines to identify patients that were required to fast before surgery.

We saw that there were posters displayed on wards we visited that promoted Albert's Campaign. This was a campaign which aimed to prevent dehydration and acute kidney injury in inpatients, that had been developed by a neighbouring NHS trust and the service had introduced the campaign on their surgical wards. The campaign used a visual system of red, amber and green lidded water jugs, that assisted staff to identify patients at risk, encouraged increased water intake in patients, and prompted staff to escalate patients appropriately where hydration needs were not met.

Pain relief

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

Patients received pain relief soon after requesting it. Patients that we spoke to told us that they received pain relief when they requested it or were due pain relief, and that staff checked that pain relief had been effective after it had been administered.

Surgery

Staff prescribed, administered and recorded pain relief accurately. Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. We reviewed a sample of patient pain management records in the surgical theatres and surgical wards and saw that pain assessments were carried out and recorded by staff and that pain relief was prescribed, administered and recorded accurately in the electronic patient records.

Pain scores were recorded electronically on the electronic patient record. Staff used pain assessment tools to monitor pain symptoms at regular intervals. Staff assessed patient's pain using either a universal pain assessment tool for patients that were able to communicate or the Abbey Pain Score for patients who were unable to clearly articulate their needs.

Managers told us that pain relief assessments were included in the matron's monthly audit to check that patient were assessed and monitored for pain and given pain relief in a timely way.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for most patients. Most clinical audit outcomes were comparable to expected national standards, however the service performed worse than expected for some national audit indicators.

Elective admissions

Hospital episode statistics (HES) data between November 2019 and October 2020 showed that all patients at this hospital had a lower than expected risk of readmission for elective admissions when compared to the England average. Between the same period urology and general surgery patients at this hospital had a lower than expected risk of readmission for elective admissions when compared to the England average. However, trauma and orthopaedics patients at Furness General Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.

Non-elective admissions

Hospital episode statistics (HES) data between November 2019 and October 2020 showed that all patients at this hospital had a higher than expected risk of readmission for non-elective admissions when compared to the England average. Between the same period general surgery and trauma and orthopaedic patients had a higher than expected risk of readmission for non-elective admissions when compared to the England average. However, urology patients had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

The senior leadership team told us they did not have any specific concerns in relation to patient readmissions and the untoward readmission rates may be due to data quality or coding issues in relation to the reporting of patient readmission rates due to the inclusion of planned re-attendances being included in the data.

Audits

The national hip fracture audit 2019 showed that this hospital performed worse than the England and Wales average for three out of six indicators including, crude overall length of stay, crude proportion of patients documented as not developing a pressure ulcer and crude perioperative medical assessment within 72 hours rate.

Surgery

The national bowel cancer audit of 2020 showed that the trust performed worse than the national average for post-operative length of stay greater than five days after major resection. The trust performed within the expected range for the audit indicators relating to operative mortality rate, unplanned readmission rate and temporary stoma rate.

The national emergency laparotomy audit (NELA) in 2018 showed this hospital achieved the national standard of above 85% in two out of five indicators, however this hospital achieved below the national standard at rate of between 50% and 80% for three out of five indicators. The hospital performed within the expected range for risk adjusted 30-day mortality.

The national oesophago-gastric cancer audit 2018 also showed the trust performed within the expected range for all eligible audit indicators.

Senior leaders told us that the surgical care group had monthly surgical speciality audit meetings where audit outcomes were monitored, and that managers and staff used the results and these meetings to look for ways to improve patients' outcomes.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. The number of staff that had completed their appraisals did not meet trust targets.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers we spoke to told us that each member of staff had an individual competency and training plan which was linked to the appraisal process. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers described how competency and training plans for staff were linked to the area that staff worked and modelled on patient cohorts.

Due to the covid-19 pandemic and social distancing restrictions the service were unable to continue with face to face team meetings. Managers and staff told us that because of the restrictions the service utilised encrypted social media messaging applications to provide team updates to all staff and share learning. Staff told us that team updates were ad hoc but they felt informed about any important changes.

The trust provided the appraisal rate data by CQC core service. The trust had provided data split by clinical care group and therefore the appraisal data for surgery also includes data for critical care. The trust set a target of 95% for staff appraisal completion, however this had not been achieved. As of May 2021, 86% nursing and care staff in the surgical care and critical care group at FGH had an appraisal in the last 12 months. As of May 2021, 62% of Medical staff in the surgical care and critical care group at FGH had an appraisal in the last 12 months.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff attended some meetings using digital technology due to social distancing restrictions related to the covid-19 pandemic. Staff we

spoke to on the wards and theatre areas told us that there was effective multi-disciplinary working and relationships with doctors, allied health professionals and specialist nurses. Staff we spoke to told us that there was a supportive relationship between theatres and wards and that consultants and doctors were accessible for advice and support when required.

We observed staff handover meetings on the wards that took place between senior nurses at the times of shift changes to ensure staff were informed of any issues and concerns and updated about patients' care and treatment. We also observed discharge meetings on the wards that were held to discuss patients awaiting discharge that were attended by matrons, senior nurses, wards managers and discharge co-ordinators.

Seven-day services

Key services were not all available seven days a week to support timely patient care.

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

We reviewed staff rotas on wards and saw that wards achieved safe staffing levels for nurses consistently, including at evenings and weekends.

Physiotherapy was provided on a Saturday and Sunday for the management of high priority patients on the wards, at all other times there was an on call service. Occupational therapy was provided Monday to Friday. Occupational therapists were available on a Saturday for supporting the discharge of some patients.

There was sufficient out-of-hours medical cover provided to patients in the surgical wards by junior and middle grade doctors as well as on-site and on-call consultant cover. There was on-site consultant presence across most surgical specialties on weekends along with on-call cover and consultant-led ward rounds took place seven days per week.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards/units. We saw information leaflets and posters displayed on wards and in theatres that including how patients could access dietetic support, alcohol and smoking cessation services and mouth care information.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Patient who were assessed as requiring further support were signposted by staff to relevant specialist support staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Surgery

Staff we spoke to on the wards and in theatre areas understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. We reviewed six patient consent records and saw that staff gained consent from patients for their care and treatment in line with legislation and guidance and when patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff clearly recorded consent in the patients' records.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The surgical care and critical care group at this hospital had achieved the trust's mandatory training completion target of 95% for mental capacity act and deprivation of liberty safeguards for staff over the last 12 months.

During our inspection we spoke to a member of the trust's safeguarding team who told us that managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them and monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. We were told that the number of Deprivation of Liberty Safeguards forms completed by staff had increased since our last inspection and that staff implemented Deprivation of Liberty Safeguards in line with approved documentation.

Is the service caring?

Good ➔➔

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed interactions between staff and patients and saw that staff took the time to speak to patients and used easily understandable language that met the patients' needs. We saw that staff maintained patients' privacy and dignity by drawing curtains around beds when they spoke to patients at bedsides. We saw that when patients were transferred between the ward and theatre areas that their dignity was maintained by staff who used blankets and dressing gowns to cover patients.

Patients said staff treated them well and with kindness. Patients we spoke with told us that staff were caring, compassionate and supportive. Managers told us that during the covid-19 pandemic that the response rate of the NHS Friends and Family Test (FFT) had decreased, however we were told that this had started to increase now that patients were contacted to complete the survey after their discharge from the hospital. The NHS FFT is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. The NHS FFT test data between October 2020 and April 2021 showed the surgical wards at this hospital achieved an overall satisfaction score of 95.13% with a response rate of 25%. This demonstrated that the majority of patients were positive about recommending the hospital's surgical wards to friends and family.

Surgery

Staff we spoke to understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs and provided examples of how they had respected and adapted to these when they had provided care to patients.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. There was a day room available on the wards we visited for patients to use, the day rooms were dementia friendly and included objects, signage and decorations from the past.

The wards we visited had posters about the Butterfly Scheme, which is a system of hospital care for people living with dementia. The trust used the Butterfly Scheme to identify patients living with dementia and we saw this used in the care of patients living with dementia on the wards we visited.

The hospital had a multi-faith chaplaincy service and a bereavement service which staff could access to provide support to patients and relatives.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We observed the care of a patient living with dementia on a surgical ward, and saw that staff provided comfort and reassurance to this patient who had become distressed and agitated in a way that maintained the patient's dignity and protected other patients around them from harm and distress.

Understanding and involvement of patients and those close to them

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

Staff supported patients to make informed decisions about their care. Patients that we spoke to told us that they felt informed about their care and were included in decisions that had been made. Patients gave positive feedback about the service and were complimentary of the staffs' caring manner and had told us that they were happy with the care and treatment provided.

Staff told us that during the covid-19 pandemic when visiting restrictions were in place, they had used digital technology to allow patients and relatives to maintain relationships. Staff also told us that a dedicated ward liaison team was set up during the covid-19 pandemic. The staff in this team contacted the relatives and friends of each patient daily to provide them an update of their loved one's care and to offer support.

Is the service responsive?

Requires Improvement 

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

Surgery

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the needs of the local population. The senior leadership team told us that surgical service plans were included in the annual trust business plan. Managers described working with business managers, the clinical director and matrons to plan services. The senior management team was aware of the logistical and recruitment issues posed by the trust's geography and had a workforce recruitment and retention strategy in place to address the workforce issues.

The surgical wards operated a colour-coded Covid-19 designation. At the time of our inspection all four surgical wards at this hospital were assigned as green Covid-19 free wards. Due to the covid-19 pandemic the wards at this hospital were mixed surgical specialty wards.

We were told by the senior leadership team that they planned to undertake a review of the surgical wards as part of the services post-pandemic recovery plan to determine the most appropriate use of the surgical wards going forward.

Patients underwent Covid-19 screening and testing prior to admission to wards and theatres. Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach.

Meeting people's individual needs

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

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. We saw in patient records that staff used holistic care plans for patients with a complex need such as patients living with dementia or patients with a learning disability. Staff had access to the trust's safeguarding team who provided advice and support for how to meet the needs of patients with complex needs.

The service had information leaflets available and we were told that these could be translated into other languages if required. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Access and Flow

People could not always access the service when they needed it or receive the right care promptly. The service performed worse than national standards for waiting times from referral to treatment. The average length of stay for patients having trauma and orthopaedics surgery was worse than national average. Whilst the services had plans in place to improve this, these measures had not been fully implemented and had not yet led to any significant improvement in the services.

Patients could be admitted for surgical treatments through a number of routes, such as pre-planned day surgery, through accident and emergency or through a GP referral. Patient records showed that patients were assessed upon admission to the wards or prior to undergoing surgery.

Surgery

Managers and staff told us that patient extended length of stay was an issue for this hospital. During the inspection, we saw that some patients on wards had been waiting over seven days to be discharged, however staff told us patient's length of stay was impacted by awaiting appropriate community or nursing home care placements for patients and some complex requirements of patients with social care needs.

A report submitted to the trust wide Quality Committee in February 2021 in relation to trauma and orthopaedics length of stay identified planned remedial actions such a review of the clinical operating model and care pathways to identify areas for improvement and to work with physiotherapy leads, trauma leads and trauma co-ordinators to explore areas for further improvement.

The trauma and orthopaedics service improvement plan for length of stay was also in progress and included a number of actions to improve patient length of stay. However, the planned improvements to patient length of stay had not yet been fully implemented so the impact of these measures on improving patient length of stay could not be verified at the time of inspection.

Cancellations

The proportion of patients whose operations were cancelled and were not treated within the 28 days across the trust was better than the England average between October 2017 and September 2018. There were 26 patients whose operations were cancelled and were not treated within the 28 days during this period. However, this included 14 patients for the period between January 2018 and March 2018. There had only been seven instances reported in the following six months which indicated an improving trend.

Referral to treatment times (RTTs)

From February 2020 to January 2021 the trust's referral to treatment time (RTT) for admitted pathways for surgery was worse than the England average. During this period, one specialty (oral surgery) was above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery and five specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

Referral to treatment time performance for ophthalmology (31.1% compared to England average of 50.5%) and trauma and orthopaedics (23.2% compared to England average of 41.2%) was significantly worse than the England average.

The trust reported in their April 2021 surgery management board that in March 2021 each surgical speciality was not achieving the 92% RTT performance target and that the surgical care group's overall RTT performance across all surgical specialities was 54.4%. The national England average RTT performance in March 2021 was 54%. At the time of our inspection this hospital had decommissioned one theatre and all other theatres were operational due to the covid-19 pandemic.

Waiting lists

NHS England data showed the total number of patients on the waiting list for the trust was 49,196. The largest number of patients on the waiting list were for trauma and orthopaedics (8,718), followed by general surgery (6,714) and ear, nose and throat surgery (6,014).

Recovery plan

Surgery

The elective recovery plan 2021/22 outlined the trust's proposals to reduce waiting times. The trust submitted baseline elective capacity plans for 2021/22 to inform recovery plans for the NHSE/I North West regional team.

The trust reported in the elective recovery plan that current performance (February 2021) was below the trust's Phase 3 Covid response plan targets. The trust reported day case activity was 75% and elective activity was 38% (compared with target of 90% of pre-pandemic activity levels). This was due to the impact of using theatre and recovery space for critical care surge capacity. There were 2,365 patients waiting over 52 weeks, compared with target of zero patients by end of the year.

The elective recovery plan 2021/22 included proposed trajectories for reducing waiting lists for cancer patients, elective inpatient and day case patients and those waiting over 52 weeks.

The recovery plan trajectories from April 2021 to March 2021 showed the trust could achieve zero (waiting list prioritisation 2) patients waiting over 28 days by March 2022 with additional funding. The recovery plan showed that without additional capacity, the number of patients waiting over 52 weeks would increase to 4,178 by March 2022 and even with additional capacity and funding, there would still be 210 patients waiting over 52 weeks by March 2022.

The recovery plan also showed that without significant additional capacity and funding, the elective and day case performance would equate to 88% to 89% of 2019/20 activity levels.

The director of operations for the critical care and surgery group told us the trust had agreed to fund additional capacity for April to June 2021 through outsourcing (patients treated by independent sector) and insourcing models (use of trust theatre space by independent providers) elective and day case patients.

There was an agreement in place with an external health provider to utilise the trust's existing theatre space during weekends to provide surgery for elective and day case ear, nose and throat (ENT) surgery patients. The trust also had arrangements with a number of independent health providers to support breast surgery, elective orthopaedic surgery and ophthalmology (cataract procedures).

The trust reported the recovery plan to utilise the independent sector and additional theatre activity sessions for elective and day case patients would mean the trust could achieve over 100% of 2019/20 activity levels by July 2021.

There was a theatres improvement programme in place aimed to improve theatre utilisation, reduce late start times for theatre lists and to reduce cancellations. The programme was in progress and the March 2021 progress update showed the plan was on track with progression of identified workstreams.

NHS England data over the past two years showed the percentage of patients whose operation was cancelled and were not treated within 28 days at the trust was better than the England average. During this period, the percentage of cancelled operations as a percentage of elective admissions at the trust were similar to the England average. (Cancelled operations as a percentage of elective admissions only includes short notice cancellations.)

The surgical services had introduced a clinical review of all operations cancelled on the day to identify reasons and look for improvements. A review was also under way around data quality and coding issues due to cancellations identified as reported in error or duplicated.

Surgery

We identified concerns around patient length of stay and performance against referral to treatment waiting times as part of our previous inspection in November 2018. We found during this inspection that no significant improvements had been made in relation to waiting times and length of stay. The Covid-19 pandemic also had an adverse impact on the hospital's performance measures such as length of stay and referral to treatment wait times.

The services had put in place a number of measures and plans to improve waiting time performance and patient length of stay; however, these had not yet been implemented and had not led to a significant improvement at the time of the inspection.

Learning from complaints and concerns

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

The service clearly displayed information about how to raise a concern in patient areas. We saw in the ward and theatre areas information leaflets displayed for patients detailing how to raise a complaint with staff and Patient Advice and Liaison Service leaflets (PALS) were also available for patients should they wish to make a formal complaint to the trust. The patients, relatives and carers we spoke to knew how to complain or raise concerns.

Staff we spoke with understood the policy on complaints and knew how to handle them should a patient make a complaint or raise concerns. Managers shared feedback from complaints with staff and learning was used to improve the service. Staff told us that information about complaints was shared in ward handovers and with all staff in the services encrypted social media messaging application to share any learning.

Managers investigated complaints and identified themes. The ward and theatre managers were responsible for investigating complaints in their areas. The timeliness of complaint responses was monitored by a centralised complaints team, who notified individual managers when complaints were overdue.

The trust complaints policy stated that complaints would be acknowledged and responded to within 35 working days for routine formal complaints.

From April 2020 to March 2021 there were 16 complaints about the surgical services at this hospital and the trust reported these were responded to within the timescales specified in the trust complaints policy.

Is the service well-led?

Good ➔➔

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

Leadership

Surgery

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

The surgical services at the hospital formed part of the trust's critical care and surgery care group. The care group was led by a clinical director, who was supported by a triumvirate leadership team made up of the associate director of operations and the associate director of nursing along with the governance business partner. The clinical director had been in post for two years. The remaining triumvirate team had been in place less than 12 months but had a clear understanding of the risks to the surgical services and how to address these.

The surgical specialties were spilt into six specialty care groups and each specialty was led by a clinical lead and clinical manager with a surgical matron supporting across a number of specialties. Each surgical ward was managed by a ward manager with support from senior nurses. There was a theatre matron responsible for overseeing the surgical theatre services.

The majority of staff spoke positively about the leadership and organisation structure. The theatres and ward-based staff told us they understood their departmental reporting structures clearly and described their line managers as approachable, visible and who provided them with good support.

Vision and Strategy

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

The trust's brand statement was 'better care together'. The trust's vision was 'We will consistently provide the highest possible standards of compassionate care and the very best patient and colleague experience. We will listen to and involve our patients, service users, colleagues and partners.' These were underpinned by a set of five priorities; our patients, our people, in partnership, making progress and improving performance.

The vision and values had been cascaded to staff across the surgical services and staff we spoke with had a good understanding of both.

The strategy for the critical care and surgery care group was outlined in the care group business plan 2021/22, which was based on the overall trust vision and priorities.

The business plan included a number of objectives for the year, including the improvement of cancer pathways and referral to treatment waiting time performance, focus on positive working cultures, staff recruitment and developing extended roles, such as trained advanced nurse specialists and surgical care practitioners, participation and collaborative working in a range of integrated care systems (ICS) programmes, use of digital technology to support new models of care (such as virtual clinics) and to utilise 'get it right first time (GIRFT) right care and model hospital data to drive cost improvements.

Progress against the business plan priorities and objectives was monitored as part of monthly surgical management board meetings.

Surgery

Culture

Most staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an improved culture and was working towards embedding an open culture where patients, their families and staff could raise concerns without fear. Improvements identified following an external review around culture within the trauma and orthopaedic specialty had not yet been fully implemented.

The staff we spoke with were dedicated to meeting the needs of patients and were passionate about the care and treatment they provided. Staff told us there was a friendly, supportive and open culture on wards and in theatre areas. Staff we spoke with told us that the culture had improved since our last inspection and the external reviews.

The medical and ward staff we spoke with told us they received regular feedback to aid future learning and that they were supported with their training needs by their line managers. Junior doctors and newly recruited nurses told us they received good training and learning opportunities.

Staff we spoke with reported increasing confidence to raise issues and concerns with line managers and felt managers responded positively when concerns were shared. All staff we spoke with were aware of the trust's whistleblowing policy and understood how to contact the freedom to speak up guardian if needed.

The medical teams in the urology and trauma and orthopaedics specialties underwent external reviews during 2020. These reviews highlighted a number of areas for improvement in relation to leadership, culture and clinical practice. Medical staff in the surgical theatres that we spoke to during our inspection told us there had been significant improvements made in relation to the leadership and culture within the urology services, this included regular engagement and input from staff around how to improve the services. The introduction of a separate on-call consultant during weekdays at this hospital and Royal Lancaster Infirmary was also received positively by staff. Medical staff also reported that there were improved positive relationships between staff working in trauma and orthopaedic services. The clinical director and associate director of nursing told us that they were still in the process of implementing recommendations from an external review of the service during 2020 and this was in progress at the time of the inspection.

Governance

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

The surgical services at the hospital had clear governance structures in place that provided assurance of oversight and performance against safety measures. There were monthly specialty level and care group level governance meetings in place to discuss governance and risk. Each surgical specialty had routine monthly governance meetings and governance and operational performance was reviewed at monthly surgery governance and assurance group and surgery management board meetings.

We reviewed the minutes of recent monthly speciality meetings, group level surgery governance and assurance group and surgery management board meetings. These included key discussions around workforce, current risks, clinical effectiveness and performance issues in relation to each speciality area.

Surgery

The trust had an existing ward accreditation programme to assess the quality of care delivered in the surgical wards. This programme had been suspended during the Covid-19 pandemic. The ward accreditation programme had restarted recently with a plan to assess each surgical ward by July 2021.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care. However, staff had not identified and escalated all relevant risks and issues and identified actions to reduce their impact.

The trust used an electronic risk register system to record and manage key risks. The critical care and surgery care group maintained a risk register to document key risks relating to the overall surgical services across the trust and also incorporated the individual departmental / ward risks.

The governance business partner told us key risks were identified and control measures were put in place to mitigate risks. Identified risks had a review date and an accountable staff member responsible for managing that risk.

Staff were aware of how to record and escalate key risks on the risk register. A risk scoring system was used to identify and escalate key risks to care group and trust level.

Staff were supported by governance leads within each specialty to review open risks and identify mitigations and controls to reduce or eliminate risks. Meeting minutes showed key risks were reviewed at routine specialty level meetings and at the monthly care group level surgery governance and assurance group meetings.

In each area we inspected, there were routine staff meetings to discuss day-to-day issues and to share information on complaints, incidents and audit results.

We saw that routine audit and monitoring of key processes took place to monitor performance against objectives. Information relating to performance against key quality, safety and performance objectives was monitored and cascaded to staff through team meetings, safety huddles, performance dashboards and newsletters.

The surgical specialty leads produced a monthly ‘safer today’ report which included performance indicators around patient safety, staffing, operational performance and finances. This was presented at monthly surgery governance and assurance group meetings.

During our inspection we identified on some wards that staff did not consistently carry out daily safety checks of resuscitation trolley equipment and medicines were not always consistently stored in line with trust policy, including the escalation of medicine storage conditions in rooms and in medicine fridges. We raised these issues at the time of inspection with ward managers and the matron who was not aware of this concern. We reviewed the wards’ harm free care checks documentation tool and noted that a weekly oversight check of daily recording and action was to be undertaken by the ward manager that covered ensuring required safety assurance checks were completed and actions taken by staff where required. However we spoke to three ward managers, the surgical ward matron and the senior leadership team for the surgery care and critical care group who were all unaware of the required wards’ harm free care checks documentation weekly manager check, and we found on one ward that this check was last completed in October 2019.

We also found that the matron's safety assurance monthly audit did not identify the non-compliance with the completion of the resuscitation trolley daily check logbook by staff on DSU and EOU as it had not been completed in January 2021 and February 2021. We were told by managers that the matron's safety assurance monthly audit was presented weekly at the executive care nursing meetings (ECN) where reports are shared by exception reporting and are not reported to any wider governance committees.

We also saw that the matron's safety assurance monthly audit demonstrated good levels of compliance with escalating fridge temperatures, however this was due to the audit using data from the daily check by the senior sister daily check and not the primary data source and did not identify that staff had documented and not escalated that the medicine fridges and ambient room temperature were out of expected range on some wards. We spoke to the lead pharmacist that told us they were aware of the concern that staff on wards had not escalated fridge temperatures that were out of range and that this was identified through a spot audit check in February 2021 and a subsequent action was assigned through the trust's governance system to the Associate Director Nurse for surgery. However, we spoke to the Associate Director Nurse for surgery and we were told that they were unaware of this concern and had not taken action to address this matter.

This meant that there was a risk that the trust's resuscitation trolley equipment safety assurance daily check would not be completed and appropriate action would not be identified or taken if required due to the ineffective safety check process in place and that medicine on wards would not be stored safely in line with trust's policy.

Information Management

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

Staff completed information governance training as part of their core skills mandatory training. The surgical services had achieved the trust target of 95% of staff to have completed this training.

Staff files and other records (such as audit records, staff rotas, files) were held electronically.

Computers were available across the wards and theatre areas and staff access was password protected. Electronic patient records were also password protected. The staff we spoke did not identify any concerns relating to accessing IT systems or any connectivity issues.

Each ward had a visual display screen with live patient information such as admission, length of stay, current status and whether observations were due. The ward and theatre areas also had a number of notice boards that displayed information such as staffing levels, patient safety and infection control.

Staff could access policies, procedures and clinical guidelines through the trust intranet site. Staff told us they could access patient information and up to date national best practice guidelines and prescribing formularies when needed.

Engagement

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

Staff told us they received good support and regular communication from their line managers. Staff routinely participated in team meetings across the areas we inspected. The trust also engaged with staff through newsletters and through other general information and correspondence that was displayed on notice boards and in staff rooms.

The associate director of operations and associate director of nursing told us the findings from the NHS staff survey 2020 had been reviewed and draft action plans were currently being developed to cascade across the surgical teams.

The medical and nursing staff participated in specific events and training days that included engagement, training and discussions around improvements to clinical processes. The care group leads told us they carried out regular walk rounds to engage with staff across the surgical ward and theatre areas.

The trust had developed a staff booklet detailing the support available during the covid-19 pandemic. This included guidance for staff and details of support available for staff in relation to emotional health and well-being.

Staff across the surgical services told us they routinely engaged with patients to gain feedback from them. This was done informally and formally through participation in the NHS Friends and Family. Feedback from NHS Friends and family survey was mostly positive across the surgical wards.

Public engagement had been impacted due to the Covid-19 pandemic; however staff told us there was still engagement through patient focus groups and general engagement through the trust's website.

Learning, continuous improvement and innovation

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

The culture across the services was based on quality improvement. There were a number of quality improvement projects and work streams in place across the surgical services, such as theatre improvement and elective surgery quality improvement programmes.

Staff across the services were involved in research, innovation and clinical trials to improve patient care and treatment; for example, new funding applications and collaborative working with an external university for new surgery imaging for orthopaedics. Staff participated in local clinical audits to improve the services; for example, local audits for clinical note taking and anaesthetic record documentation had led to improvements in staff compliance.

As part of the perioperative wellness programme, the surgical services developed the patient charter with involvement from patients, staff and other stakeholders. The patient charter aimed to support patients to be fit for surgery, help patients decide is surgery is the right option for them and to offer alternative treatments such as physiotherapy or pain management to manage their health condition.

Maternity

Inadequate ↓↓

Is the service safe?

Requires Improvement ↓

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

Mandatory training

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

Staff told us that in addition to attending the NHS 10 core skills training, they completed training in incident reporting and fetal monitoring. Staff also attended three mandatory training days each year, one of which was for PROMPT training. PROMPT stands for Practical Obstetric Multi Professional Training and is training for professionals across disciplines in maternity services for responding to obstetric emergencies. During the pandemic this training was moved to online modules to ensure staff could continue to keep up to date with training. Community midwives told us they had protected time for learning. Service leaders told us that there were three maternity mandatory training days in 2020. However, midwives on the unit said they did not have protected time for learning and we heard this could sometimes be a challenge to complete.

Managers told us that during the COVID-19 pandemic compliance with mandatory training had been reviewed at each 'SITREP' call between matrons, ward managers and senior managers and these were held three times a week

Midwifery staff received but were not always up to date with their mandatory training. Training had been reduced during the COVID pandemic, particularly face to face, but this was now being re-instated. At the time of inspection, the trust data showed training compliance for midwives as follows for required training : GAP Theory Midwives – 85.3%; Growth Assessment Protocol Theory 56.3%; Core skills (Face to Face) – 75%; Covid Prompt – 80%; Basic Life Support (Face to face) 89.4%; Newborn Life Support(Face to face) 82.8%; Safeguarding level 3 children -86%; K2 (Including community data)– 82.1% ; Smoking Cessation– 84%; Skills / Drills (Face to Face) 97.7%.

Following the inspection further information was provided which showed completion for Growth Assessment Protocol at the time of inspection was over 75%, which met The Gap Service Specification and Agreement (Perinatal Institute) and the target which was 75%.

Medical staff received but were not always up to date with their mandatory training. Mandatory training compliance in core skills did not meet trust targets– particularly for Medical staff. At the time of inspection, the trust data showed training compliance for medical staff as follows:

Growth Assessment Protocol Theory -38.5%, COVID- PROMPT – 52%; Basic Life Support (Face to Face) -80%; Newborn Life Support (Face to face) 42.1%; K2 - 72.7%; smoking cessation – 20.8%; Skills / Drills (Face to Face) 73.9%.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff we spoke with told us they were encouraged to attend the mandatory training days. Matrons audited compliance with mandatory training as part of the matron audits.

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities, and autism. The trust's lead for learning disability had delivered a programme of training for midwives regarding this during 2019.

Safeguarding

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

Nursing and midwifery staff received training specific for their role on how to recognise and report abuse. Staff compliance with level three safeguarding adults and children training was 94%, which was above the trust's target of 90%.

Medical staff received training specific for their role on how to recognise and report abuse, however compliance for medical staff in safeguarding children level three training was 60%, which was below the trust's target of 90%.

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

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. There were four enhanced support midwives who worked across the service, to provide additional resource and specialist support for any identified safeguarding concerns.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The safeguarding team included a Named Midwife for Safeguarding, Named Nurse for Safeguarding Children and Named Nurse for Safeguarding Adults, together with clinical midwife safeguarding specialists. Four enhanced support midwives were available across the service to provide further safeguarding advice and support for staff.

Staff followed trust safeguarding policies and procedures where any safeguarding concerns were identified. The Safeguarding Team operated a duty line Monday to Friday, with team members available to provide safeguarding advice and support. In addition, outside of weekday working hours staff could access safeguarding advice from the trust's safeguarding team. Maternity records included a form to alert staff where any safeguarding concerns were identified. Staff we spoke with were confident about safeguarding issues which may present in the service and could appropriately describe how to respond to these.

Staff followed safe procedures for children visiting the ward. Entrances to the unit were accessed by security keypad, with continuous CCTV recording. Reception staff and midwives maintained oversight of entry to the unit.

The service had a current baby abduction policy providing details of actions for staff to follow in the event of a suspected baby abduction. A baby abduction drill had taken place for staff in August 2020.

Safeguarding training had continued during COVID-19, with safeguarding supervision available either face to face or virtually via Teams for staff. At the start of the pandemic, colleagues had been advised to complete the Safeguarding Children Level 3 training through the e-learning for Health Care, to ensure colleagues were kept updated whilst the Safeguarding Team created a bespoke course. This new course 'Think Family' was now available for colleagues to work through as part of their Children and Adult Safeguarding training. Face to face training was being resumed at the time of inspection.

Maternity

Monthly safeguarding supervision had continued to be provided to midwives during the COVID-19 pandemic, although this had been adapted from face to face, and more usually by telephone or through online meetings.

Cleanliness, infection control and hygiene

The service mostly controlled infection risk well. However, staff did not follow consistent approaches for keeping birth pool equipment clean. The premises were visibly clean and staff used equipment and control measures to protect women, themselves and others from infection.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. Throughout inspection we observed housekeeping staff completing regular routine cleaning tasks. Where we checked these, we saw cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff cleaned equipment after patient contact, however we observed in pool rooms that green stickers were on trolleys, but not on individual pieces of equipment, to show when items were last cleaned.

Staff followed infection control principles including the use of personal protective equipment (PPE). The trust has been able to access testing, PPE, and COVID-19 vaccines for staff in a timely manner. Staff have been encouraged to have their COVID-19 vaccination and were also encouraged to complete lateral flow tests twice weekly. Community midwives had been able to access PPE continuously during the Covid-19 pandemic. COVID-19 swabbing was offered to all women and their partners on admission. We observed during inspection that although notices were displayed to limit the numbers of staff in one room at the same time, in accordance with COVID-19 social distancing guidance. However we frequently observed larger numbers of staff in ward office areas. The trust confirmed following inspection that under their guidance 'Covid secure room occupancy limits are for prolonged working or working without PPE. It is acceptable for larger numbers of staff wearing PPE to be in the room for short periods.

The service had a 'Waterbirth guidance' document for cleaning waterbirth pools, but this did not include any policy or specific direction for pool cleaning. The guidance directed staff to run the pool taps daily, but there were no records maintained for this being completed. Staff were directed to clean pools with 'Chlorclean', but instructions were unclear, confirming no details of the strength to be used or the length of time for soaking. The waterbirth guidance document made reference to the 'water safety policy& plan, but this was not included in the guidance document. None of the staff we spoke with were aware of the water safety policy.

Environment and equipment

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

Staff carried out daily safety checks of specialist equipment. We reviewed the adult and neonatal resuscitation trolleys on the birth unit and saw these were stored in line with Resuscitation Council (UK) guidelines with the drawers sealed with a tamper evident tag. We found the adult resuscitation trolley casing was past its maintenance date; however, all the resuscitation equipment and supplies contained in the trolley were in date. With the exception of one missed signature for an item on one date, we saw daily and weekly checklists for resuscitation equipment were completed.

Staff we spoke with told us they frequently needed to move large equipment such as beds; we heard during inspection that there were 64 such equipment moves during one week.

We saw that the external and internal doors to the unit were keypad controlled, which could impact on time critical transfers in an emergency. This had been raised at the last inspection and is not recommended in Health Building Note 09-02 (2013): Maternity care facilities which states that “digital code locks should be avoided”

Service leaders advised us that external keypads had been added to the risk register in March 2019, with mitigating actions including a security review and Standard Operating Procedure. However no further plans had been identified or progressed to remove the keypad locks and we observed the continuing impact of this during inspection.

We heard plans had been identified to replace these with swipe card access, but that progress had been interrupted due to COVID-19. We also heard plans for a link corridor had been identified and discussed since the birth centre opened, although this also had not progressed. Also, the transfer route from the day case assessment unit in case of emergencies was complicated by issues of the design of the building and environment, since the date the birth centre opened. Midwives described how women would be transferred via a dedicated lift, in cases where needing to transfer to the birth unit. We were told there had been two instances since the unit opened where women had needed to be transferred to the birth unit from the day case assessment unit, and two instances of women having babies in the day case unit. Following inspection, service leaders confirmed that , all staff attended a skills drill to transfer a patient in the lift with staff escorting to ensure this could be achieved safely.

Indoor access to intensive care or mortuary facilities required women to access the main hospital through the gynaecology ward.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each woman or take action to remove or minimise risks. Staff identified but did not always act quickly upon women at risk of deterioration

The service used a nationally recognised tool, modified obstetric early warning score (MOEWS), to monitor vital signs and any changes in women’s condition. Midwives in the birth centre used MOEWS to identify any possible underlying infection or need for escalation.

We saw however, that in the day assessment unit, midwives did not use MOEWS, or any recognised and available triage and assessment tool, and risk assessments were not always fully completed or reviewed at each attendance. We also saw in one of the MOEWS records we reviewed, that the woman had not been escalated for review after having triggered a score which indicated a need for medical review, and who later required urgent surgery. We found that staff still had difficulty with the electronic record system and the MOEWs scores did not show with the Red Amber Green RAG rating on the system as they would do with a paper version.

The service reported two incidents of sepsis between January and March 2021. We saw the service had presented an audit of sepsis in June 2020 and they told us the next audit was due in July 2021. The audit did not break down performance by each site so was for the whole of the maternity service. We reviewed the audit and saw that of 17 records analysed, six cases of amber flag sepsis were identified, of which two women were not prescribed antibiotics within three hours. Twelve cases of red flag sepsis were identified of which four women did not receive antibiotics within one hour. Only eight of the 12 red flag women had full sepsis six bundle completed within the first 60 minutes after being identified.

Ward managers monitored completion of the MOEWS tool through regular audits. In January 2021 compliance with full completion was 70% and in February 2021 it was 69%, however this had improved in March 2021 to 93%. Managers told us there had been a gradual improvement in compliance with MOEWS completion since late 2019, with the main areas of concern being staff signing and countersigning the records.

Staff did not always complete and update risk assessments to mitigate potential risks to women and staff. The risk assessment proforma identified 'mother alerts' such as risks for infection, abnormal bleeding or hypertensive disorders, administration of postnatal anti D and history of past mental health concerns. In the records we reviewed, we saw cases where specific risks had been identified, for which no follow up actions had been identified. Risk assessments were completed at the time of booking, to assess the level of risk for the woman during the pregnancy. These considered factors, including previous history; risk of venous thromboembolism; and growth plan as part of 'gap and grow'. The level of risk identified determined any needs for referral or review by an obstetrician. During COVID-19, Pre appointment calls were being made to risk assess for COVID-19. Community midwives used a risk assessment bundle which included all key risks including body mass index, gestational diabetes, smoking status and pre-eclampsia.

In birth pool rooms we saw a laminated pool evacuation checklist for action to follow in the event of a woman in labour requiring evacuation from the pool during an emergency. This guidance advised only two or three people would be needed to assist in this, whereas in practice the procedure would require more than three people to support the procedure.

Targeted communications on the trust's social media platforms supported contact with women from ethnic minorities backgrounds. At booking appointments, the trust reported that data capture rates for ethnicity was 98%- 99%. This allowed for targeted support and identification of any additional risks which may present to women, on the basis of their ethnicity, such as pre-eclampsia or diabetes.

Midwifery Staffing

The service did not always have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Although managers regularly reviewed staffing levels, there were frequent staff shortages which affected skill mix. However, managers gave bank and agency staff a full induction.

The service did not always have enough nursing and midwifery staff to keep women and babies safe. Service leaders told us there had been a review of the midwifery staffing establishment, completed six months ago, prior to the current Deputy Head of Midwifery being in post, with recommendations for revised staffing levels being progressed at the time of inspection.

Whilst the service had faced unprecedented staffing challenges during the COVID-19 response, and followed escalation policies when needed, the staffing shortages had been a frequent and continuing experience in the service.

Managers calculated and reviewed the number and grade of midwives, midwifery support workers and healthcare assistants needed for each shift in accordance with national guidance. The service used the 'Birthrate plus' tool to monitor staffing levels every four hours. The usual planned staffing was six midwives on the early shift; five on the late shift and five on the night shift. The matron told us the staffing ratio and numbers had remained the same since before

the new unit opening three years ago. During our inspection we saw on one early shift there were only three midwives present, resulting in the service needing to follow the trust's escalation process to divert any new admissions to other maternity services within the trust's locations, and to NHS hospitals wider across the region if needed. However, within two hours the staff shortages were covered, such that there was only one midwife short on the shift.

The ward manager could not always adjust daily staffing levels according to the needs of women and the staffing tool did not always reflect the acuity of women on the unit who were at different stages of their pregnancy. If there was a shortage of midwives on any shift, cover would first be requested from bank and agency staff and then to community midwifery services. We were told the unit was generally one midwife down per shift and that bank staff were usually known staff in the service. During inspection we saw at the start of one shift there was a shortage of three midwives and the co-ordinator,

The number of midwives and healthcare assistants did not always match the planned numbers. Data provided by the trust showed in the last six months from October 2020 to March 2021 there were a total of 126 Registered Midwife shifts and eight Clinical support workers' shifts not filled. From the start of 2021, for Registered Midwives, there were 15 unfilled shift requests in January; 25 for February; 29 for March, and 28 in April. Staff we spoke with said that although there were frequent staffing challenges in the service, the team worked together to ensure women received safe care.

The service had five current vacancies for band five midwives, with interviews proceeding at the time of inspection. It was anticipated any new staff would commence in post from September 2021.

The service had moderately high and increasing sickness rates. Data provided by the trust indicated staff sickness rates for the South Lakes Birth Centre of 5.1% in January 2021; 5.4% in February 2021 and 7.8% in March 2021, against a trust target of 4.6%. Sickness absence rates in community midwifery services were notably lower than this, at 2.7% in January 2021; 1.8% in February 2021; and 0.3% in March 2021.

Managers informed us there were had been several incidences of staff absence due to musculoskeletal injuries, however we did not see evidence confirming this. We heard during inspection that staff were involved in frequent moves of large equipment, with 64 bed moves during one particular week.

Although the service made frequent use of bank and agency staff, managers ensured they completed a full induction to the unit and understood the service.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep women and babies safe. Seven consultants provided 24-hour consultant on-site cover Tuesday to Friday, with ongoing provision from six middle grade doctors. Four consultants were local, fulfilling the requirement for consultants to be able to attend in 30 minutes. At weekends senior registrars were resident to cover, with consultants off-site for support if needed. The service always had a consultant on call during evenings and weekends.

The medical staff matched the planned number. Consultant obstetricians led twice daily ward rounds in the birth centre, and once daily ward rounds at weekends.

The service had reducing vacancy rates for medical staff. The trust had appointed a seventh consultant obstetrician to ensure sustainable rotas, with recruitment of an additional consultant post at the time of inspection.

Medical staff described that although women were booked under named consultants, all clinicians would be aware of individual women's care needs during admission to the birth centre and care would be managed continuously at the time. Due to the number of deliveries in the unit there was no separate antenatal or postnatal ward – all inpatients were cared for in individual on suite rooms which have beds for antenatal and postnatal care, which were swapped with beds for delivery. The time that individual "on call" consultants cover in-patients, including those in labour, was often a morning or afternoon which resulted in multiple changes of on call consultant cover for a woman in the unit. Medical staff described that the middle grade doctors provided continuity as the periods for their on call cover for the unit was often longer during Monday – Friday 9-5 periods. Two of the consultant obstetricians were resident during their nights on call.

Records

Staff kept records of women's care and treatment. Although records were stored securely and were clear, they were not always up to date, or easily available to all staff providing care.

Records we reviewed showed women's notes were not always up to date. Different systems were used to record different types of activities, and we saw that staff could not always access these systems easily, or in a timely way. When women were actively in labour, intra-partum records were completed on paper, then electronic systems were used to record post-natal care. We saw in three out of four records reviewed, risk assessments were incomplete or had not been reviewed.

If staff on the birth unit had any difficulties locating information, they would liaise with community midwives for any clarification needed. The electronic record system had a red flag to indicate where a woman had a particular need, such as a safeguarding concern or learning disability. When reviewing records during inspection, we found the electronic system was complex to navigate and, not all staff were aware of how to access specific details within a particular record. The service was planning to implement a new electronic record system, anticipated to be in place in July 2021. We were told proposals for the new system were shared with the board in December 2020.

Computers on wheels were available on the birth centre for staff to use, however, these were not easy to manoeuvre into women's rooms, meaning there could be a delay in updating records. Staff also commented on the difficulty in timely access to computer terminals at midwives' stations and the office; we also observed this during the inspection Community midwives had laptops for accessing electronic patient records when working in the community.

The service had implemented a communication tool in theatre, used for both elective and emergency cases. This comprised a whiteboard, used as a visual prompt alongside the World Health Organisation Surgical Safety Checklist (WHO checklist) and theatre time out check. The boards support the verbal handover from maternity staff to theatre

Women did not bring their own records when attending the birth centre but when women transferred to a new team, there were no delays in staff accessing their records. Records were stored securely, with electronic records accessed by individual staff through password log-in. We reviewed four women's records and saw these were completed to an appropriate standard, with completed entries signed and dated by clinical staff. Due to the difficulties in accessing the different systems used we were limited in the numbers of women's records we were able to review.

Medicines

The service used systems and processes to prescribe, and store medicines, however we saw there were different systems used for administering and recording medicines.

Staff followed systems and processes when prescribing and storing medicines in line with the trust's policy. However, we saw during inspection there were different electronic and paper-based systems used for administering and recording medicines. An electronic prescription system recorded any medicines which doctors on the birth centre had prescribed, but anaesthetists in theatre could not access this. Any medicines prescribed or administered in theatre would be documented in paper records, for later updating in the electronic systems. Staff told us this meant there was a reliance on verbal handover, and staff checking of paper records, to ensure safe medicines management. Leaders also advised the risk of double dosing had been identified in the service's risk register; a request had been made for the anaesthetists to have access to the electronic prescribing system. There was awareness of the risk of 'double dosing' on the ward, due to delays in updating medicines administered into the electronic prescription record.

We saw during inspection that medicines were stored securely and where required, in fridges at appropriately maintained temperatures. Fridge temperatures were monitored daily, and where we checked these, records we saw confirmed all temperature checks were completed, signed for and within range.

Controlled drugs were separately stored, with stock checks correctly recorded, in accordance with trust policy. Registers for controlled drugs had been signed by two staff members when these medicines had been administered.

The service had systems to ensure staff knew about safety alerts and incidents, so women received their medicines safely. National safety alerts were circulated to staff using the electronic prescribing system.

Incidents

The service managed safety incidents. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service, although systems for sharing important safety information day-to-day were not well embedded. When things went wrong, staff apologised and gave women honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Midwifery staff received training on how to recognise and report incidents. There was a list of triggers and types of incidents for staff to follow so they knew which incidents to report. Staff were aware of the types of incident which could occur in the service and reported these using the trust's electronic incident reporting system, describing the details of incidents fully and any initial follow up actions taken. Staff raised concerns and reported incidents and near misses in line with trust policy. Midwives reported shortage of staffing as an incident when this occurred.

Midwives described how they would also discuss any incidents with the midwife in charge as soon as possible following the incident, and that they received feedback on any incidents they had reported. This feedback was also shared with the matron who provided any support where immediate learning had been identified. Midwives could also access further support from practice midwifery advocates. Staff received feedback from investigation of incidents, both internal and external to the service, and staff generally said they had increased confidence in the incident reporting system and that systems for sharing learning had improved since the last inspection.

Local managers described how important information and learning relating to incidents was shared with staff. An example was given of a programme of learning delivered by the lead midwife for diabetes, following an incident related

to maternal diabetic keto-acidosis. Managers also described how key information was shared in a '3 minute briefing' circulated to all staff, as well as shared in daily handovers. During the inspection however, we observed there was a limited focus on the three-minute briefing and we heard from several staff that these had only recently been introduced and were not regularly established in practice. There was no routine practice of signing handover attendance, so managers could not always be assured all staff had been informed of key safety messages.

The service had no never events on any wards since our last inspection of the service.

Staff reported serious incidents clearly and in line with trust policy. The service had not identified any relevant incidents for reporting to the Health Service Investigation Board (HSIB), however learning was shared from these incidents reported at the trust's other hospital locations. Staff we spoke with were able to describe improvement actions that had been implemented following serious incidents reported. Following one serious hypovolaemic incident, actions identified included: increased skills and drills training; review of guidance for post-partum haemorrhage; increased observational audits; and a fluid balance training package to address when to initiate a fluid balance chart. 82% of staff had completed this across the service.

All serious incidents were investigated using a root cause analysis approach and this was overseen and reviewed by the divisional Care Group Governance Assurance Group.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation if and when things went wrong. Managers told us duty of candour letters sent as a result of perinatal mortality reviews were individually tailored to each woman and her family. We reviewed the service action log as a result of perinatal mortality reviews. There were five cases reviewed for the service, which had clear actions identified and were completed or in progress at the time of our inspection.

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, women and visitors.

The service did not use the maternity safety thermometer but collected different data to monitor safety performance. Some information, including C difficile and MRSA rates, was displayed at the entrance to the birth centre for staff and women to see. The maternity dashboard was available on all computers as staff logged in so they could keep up to date with safety performance. The service had developed a monthly safety summary infographic for all staff. This had been developed with staff and gave information on key safety performance data and performance against targets.

Managers reviewed the safety monitoring data to further improve services.

Is the service effective?

Inadequate 

Our rating of effective went down. We rated it as inadequate.

Evidence-based care and treatment

Maternity

The service did not always provide care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed trust guidance.

Staff did not always have up-to-date policies to follow in planning for delivery of high-quality care according to evidence-based practice and national guidance**.** We saw during inspection that several guidelines used in the service were out of date or did not have related proformas available. Among these, we noted the guideline for still birth, which had expired November 2020, appeared to be a generic form, and not identified with the trust's corporate branding. The trust advised us following inspection that the The maternity service follows the North West Coast Regional Stillbirth Guideline. This was updated regionally in March 2021 and was ratified by the Trust in April 2021. We found the guidelines for post-partum haemorrhage, and incidents complaints and claims had passed their review date of December 2020.

In view of the relatively small number of deliveries in the SLBC per annum there was no guidance or policy describing for maternal conditions that should prompt consideration for transfer of mothers to another unit, apart from low gestational age. In view of the relatively long transfer times between units such guidance and an escalation policy would be important for ensuring the safety of mothers and their babies.

The service had a protocol for transfer of any babies from the bereavement suite after they had died. Staff described how there would be a decision made at the time, with midwives transferring babies usually along a route through the gynaecology ward.

At handover meetings, staff routinely referred to the psychological and emotional needs of women, their relatives and carers. Women's records we reviewed contained information on specific risk factors including body mass index, comorbidities, mental health and domestic abuse.

Nutrition and hydration

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

Staff made sure women had enough to eat and drink, including those with specialist nutrition and hydration needs. Women told us that they had enough choice of food and drinks available to them during their stay.

Staff fully and accurately completed women's fluid and nutrition charts where needed.

Specialist support from staff such as dietitians was available for women who needed it. Midwives assessed and made onward referrals where women required dietary advice for conditions such as diabetes, or a high BMI. Breastfeeding advice and support was available for women and further development of roles for breastfeeding champions were being identified in the service to promote this. The service did not have accredited status in the Baby Friendly Initiative at the time of our inspection.

Pain relief

Staff assessed and monitored women regularly to see if they were in pain but did not always give pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed women's pain using a recognised tool but did not always give pain relief in line with individual needs and best practice.

However, we reviewed the audit of maternity early obstetric warning scores (MOEWS)which was completed in January 2020 and saw only 60% of women had their pain score completed according to their clinical condition. This had deteriorated from the 2019 audit which showed 70% compliance.

Women did not always receive pain relief soon after requesting it. We reviewed the cross-trust audit of pain relief in labour conducted by the anaesthetic department which covered two weeks in December 2020. This showed that across Royal Lancaster Infirmary and South Lakes Birth Centre 81% of women received their epidural within the 30-minute timeframe, in line with national recommendations. In two out of 16 cases there was no documentation of quality of pain relief made at 45 minutes. The Anaesthetic department was looking into their policy to improve the epidural in labour service, however at the time of inspection, no further detailed actions had been identified from this.

Patient outcomes

Staff monitored the effectiveness of care and treatment. However, they did not always use the findings to make improvements and achieve good outcomes for women. The service was not accredited under relevant clinical accreditation schemes, such as Baby Friendly Initiative.

The service participated in relevant national clinical audits, such as MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries). We asked the service to provide any reports or action plans against MBRRACE outcomes, but the information supplied was not specific to this maternity service and did not reference any local learning or action plans. We reviewed the trust response to the national maternity and perinatal audit 2018-2019 and saw there was little detail in the action plan of how the service intended to meet key actions.

Outcomes for women were not always positive, consistent nor met expectations, such as achieving national standards. The service had an ongoing audit of Elective Caesarean Section, comparing common practice at the birth centre to the national standards set by The National Institute for Health and Care Excellence (NICE) and the Royal College of Obstetricians and Gynaecologists (RCOG). Between October and December 2020 Between October and December 2020 of all live births at South Lakes Birth centre, 39.5% were by Caesarean section. Performance in three out of 10 standards audited had dropped in comparison to the same audit report of 2019. Whilst improvement actions were stated, the recommendations included only suggestions for improvement, rather than clearly identified action plans.

During inspection we noted in information displayed that 53% of total births were by unassisted vaginal delivery, and 46% by Caesarean section, with induction of labour rates of 41%. We spoke with service leaders about the apparently relatively high rates for emergency Caesarean section, at the South Lakes Birth Centre and the rate of instrumental deliveries. Managers told us caesarean section rates had been static over many years. In March 2021 the maternity dashboard showed 42.86% of deliveries were by caesarean section, 29.76% emergency and 11.90% elective. The lowest caesarean section rate was 17.35% in February 2021 and highest 45.83% in December 2020. Managers carried out regular caesarean section audits but recognised these could be improved to aid learning. They told us the emphasis was on the appropriateness of a caesarean section for each woman rather than their rates – suggestions such as maternal choice following induction of labour were proposed. Senior staff we spoke with were unable to describe how they had used this data effectively to make improvements in the service for women.

Following our inspection, the Health and Social Care committee recommended percentages should not be used to measure caesarean section rates in maternity services.

However, managers and staff used other audit results to improve women's outcomes. An audit of reduced fetal movements was carried out in 2020, specifically for women who attended the Day Assessment Unit, linked to the Saving Babies Lives initiatives. Actions identified and implemented included adding a field in the electronic record to document the number of attendances the woman had in her pregnancy with reduced fetal movements. A checklist proforma was also identified as part of this monitoring. At the time of inspection, no further update on the audit was available. The day assessment unit was open during the day with no extended hours. We were told by staff that women attended the labour ward directly outside these opening hours for assessment and that this had caused pressure in the labour ward rooms and for staffing. We saw no evidence that data on this had been recorded and analysed in order to consider improvements to this service for women and staff.

In another example, the service had recognised they had a higher than expected number of post-partum haemorrhages between August and November 2020. They worked with the education team to include targeted work on responding to post-partum haemorrhages in skills and drills training and made improvements to the post-partum haemorrhage trolleys. This had led to a reduction in post-partum haemorrhages to 2.1% in March 2021 against a target of achieving less than 2.5% of women having a post-partum haemorrhage with blood loss of more than 1500 ml.

Competent staff

The service made sure all staff were competent for their roles. Although managers appraised staff's work performance and held supervision meetings with them to provide support and development, completed appraisal rates for medical staff were low.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. During the COVID-19 pandemic, staff had continued to attend core skills training online and monthly skills and drills training sessions. Increased training sessions has been identified to provide staff with opportunities to attend face to face training.' Skills and drills training ensured clinical staff maintained their skills for managing a range of obstetric emergencies, including shoulder dystocia, postpartum haemorrhage and cord prolapse. Cross- bay' training sessions, involving staff from across the trust's main hospital sites, allowed for shared learning in a multi - disciplinary approach. Compliance for Skills Drills and Covid PROMPT training was above 90.9% during inspection.

Maternity and medical staff completed training in cardiotocography (CTG), with CTG champions established within the service. Staff with CTG training was 75.4% Trustwide in April 2021, which had improved from March, but was below trust target. Lead midwives were identified in the service, providing specialist advice and support for women and midwives regarding learning disabilities; teenage pregnancy, substance and alcohol abuse, and perinatal mental health.

Band three midwifery clinical support workers had completed training to enhance their skills. These included competencies for recording maternal observations ante and postnatally; such as Modified Obstetric Early Warning System (MOEWS); venepuncture and fluid balance charts. We were also told there were more limited development opportunities for maternity support workers, with an 'in-house' training pathway equivalent to National Vocational Qualifications no longer available interim.

Managers gave all new staff a full induction tailored to their role before they started work. New staff we spoke to said that they had completed a three-day induction in emergency protocols and suturing. Due to COVID-19 restrictions the main induction had taken place on the unit. Staff reported being supernumerary for two weeks during their induction period.

Managers informed us that only midwives who were experienced, qualified and had the right skills and knowledge to meet the needs of women would be deployed to the day case assessment unit on rotas.

Managers supported staff to develop through yearly, constructive appraisals of their work. However, compliance rates did not meet trust targets and were particularly low for medical staff, at 87% completion rate for midwives and 59% for medical staff.

Managers supported nursing and midwifery staff to develop through regular, constructive clinical supervision of their work. Staff could access regular clinical supervision and ad hoc support from a Professional Midwife Advocate (PMA). PMAs offered regular drop-in sessions that midwifes could attend.

The clinical educators supported the learning and development needs of staff. They were working with a local university to set midwife apprenticeships.

Practice educators were based at Lancaster and although they could be accessed remotely for advice, many staff said they had not been a frequent presence at South Lakes Birth Centre. Service leaders told us following inspection that a SLBC based education midwife commenced in post 12th April 2021 to increase presence at this site. Prior to this, it was a cross bay service.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Newly qualified midwives participated in a rotational placement within the services, in which they gained experience and had opportunity to develop skills between the different hospital and community locations.

Staff had the opportunity to discuss training needs with their line manager but were not always supported to develop their skills and knowledge. Although training in core midwifery skills was ongoing, managers did not always make sure staff received any specialist training for their role. Development opportunities had reduced during the COVID-19 pandemic, and particularly, access to leadership development programmes. Band six midwives commented that the model of ward handover, with one to one co-ordinator handovers now limited the opportunity for skills development, in leading ward handovers. A simulation suite was available at the birth centre offering facilities for specialist training in midwifery and obstetric care. However, staff said this wasn't in frequent use, although they had made repeated suggestions and requests for this training environment to be more accessible.

Multidisciplinary working

Doctors, midwives and other healthcare professionals worked together as a local team to benefit women. They supported each other to provide good care. However, the process for medical handovers did not have a clear and consistent process.

Staff held regular multidisciplinary meetings to discuss women and improve their care. We observed different shift handovers, including those between midwifery staff. These began with a one -to-one handover between ward co-ordinators to share details of all women's care needs on the unit. This was followed by a midwife to midwife handover, in which detailed care updates were shared about individual women receiving care.

Medical staff met to share information in handovers about women receiving maternity care. However, this did not follow a standardised SBAR process. SBAR stands for situation, background, assessment and recommendation and is a way of ensuring all key elements of care and treatment are discussed in a structured way so everyone in the team has the information needed to provide safe care and treatment. We heard from staff that this was not used as a routine

procedure in medical handover, also that it was' loosely' used during phone calls where any escalation was identified. Some medical staff commented that the system was not clearly or consistently used, and the process was not embedded. We saw there was a video call with other maternity units in the trust to share details of any escalated staffing and medical issues as part of the handover. However, there appeared to be limited engagement in this, and we observed no clinical discussion during the brief call. There were unclear plans of how the obstetric service at South Lakes Birth Centre worked collaboratively with the trust's other hospital sites, particularly at Lancaster Royal Infirmary.

In view of the low number of deliveries in the SLBC and the number of middle grade and consultant obstetric staff working there, we note that the "cross Bay" working did not extend to opportunities for medical staff to rotate for periods of time between the units.

Staff worked across health care disciplines and with other agencies when required to care for women. Midwifery staff we spoke with told us there were positive working relationships with other colleagues in the multi-disciplinary team, both in hospital and community services as well as wider multi agency services. There was effective external team working. Specialist safeguarding midwives liaised with social workers when necessary. Records reviewed showed that information was shared appropriately with GPs, and health visitors as well as midwives in the community.

Staff referred women for mental health assessments when they showed signs of mental ill health, depression. They referred women to a qualified perinatal mental health midwife who provided additional support to women experiencing mental ill health.

Seven-day services

Key services were not always available seven days a week to support timely care.

Consultants led daily ward rounds on the birth centre. At weekends, there was only one consultant ward round in the morning. Women were reviewed by consultants depending on the care pathway.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Medical and anaesthetic cover was provided outside of normal working hours, with on-site emergency surgery services and Caesarean section team available during working hours. At nights an on-call team was available for emergency Caesarean section, however midwives said there could be waiting times for this response, although we did not see any evidence to confirm this during inspection. Staff logged an incident report if there were instances of any delays. In the day case assessment unit, we heard there could be difficulties accessing portering support for transfer of blood samples to clinical sciences units for analysis.

The day case assessment unit was available between 9.00am and 5.00pm, Monday to Friday. Outside these hours, women were directed to attend the birth centre for assessment. We saw that between October 2020 and March 2021 nine shifts were unfilled, resulting in the day case assessment unit needing to close, with any women attending being directed to the birth unit for review

Administrative staff on the birth centre reception were not full time at weekends, usually finishing their shift at 1.00 pm on Saturdays. When the reception was not staffed, midwives would respond to anyone who was waiting, as and when they could. We saw during the inspection a woman who appeared to be in labour and was waiting outside the birth centre for response, until a midwife could attend to them.

Health Promotion

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

The service had relevant information promoting healthy lifestyles and support on the unit.

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

Staff focus for health promotion was on breast feeding support and smoking cessation, although midwives told us dietary advice was not routinely discussed with women. Referrals could be made to a dietician if the woman had a body mass index (BMI) over 35. We heard that Vitamin D status was not routinely recorded on the antenatal electronic system. and we were told that 'a better approach to this was needed to identify these protocols' and this work was in progress. Women may be at risk of vitamin D deficiency during pregnancy and Midwives recommended vitamin D supplements in line with best practice guidance.

The service participated in a Local Maternity System work programme starting in February 2021, to focus on vitamin D provision for pregnant women.

Clear advice on safe sleeping for babies was provided to mothers before they left the birth centre.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care. Women with a learning disability were supported in the service by the enhanced safeguarding team. They would be accompanied by a support worker, to assist in completing a capacity assessment, where this need was identified. In an acute episode, such as a mental health illness, where a woman was identified as potentially lacking capacity to consent, a capacity assessment tool was available on the electronic patient record for staff to use.

Staff gained consent from women for their care and treatment in line with legislation and guidance. When women lacked capacity to give consent, staff made decisions in their best interest, taking into account women's wishes, culture and traditions. During the inspection staff were able to describe the processes which were followed to support best interest decisions, where a woman could not give consent.

Staff made sure women consented to treatment based on all the information available.

Staff clearly recorded consent in the woman's records. We saw evidence that staff clearly recorded consent in the records based on information available and that women's wishes were respected and listened to.

Midwifery staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. All applications for Deprivation of Liberty Safeguards (DoLS) were reviewed and processed by a member of the safeguarding team, to ensure that all the correct procedures have been followed.Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. The trust lead for learning disabilities had delivered a programme of learning for all midwifery staff during 2019.

Maternity

Is the service caring?

Good

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

Compassionate care

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

Women said staff treated them well and with kindness and told us 'I am really happy with the care I have received; we have been well looked after.' Cards displayed on the walls thanked staff for their 'kindness', being 'supportive' and for their 'passion for being caring and helpful'. There was a caring culture fully embedded across the service.

Staff followed policies to keep women's care and treatment confidential.

Staff understood and respected the individual needs of each woman and showed understanding and a non-judgmental attitude when caring for or discussing women with mental health needs. We saw evidence that appropriate referrals were made to the enhanced support midwives and multidisciplinary working where required.

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

Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way.

Women told us that their privacy and dignity were respected.

Emotional support

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

Staff gave women and those close to them help, emotional support and advice when they needed it. Staff were able to describe situations which demonstrated how they showed insight and empathy for women receiving care in the service.

Staff supported women who became distressed in an open environment and helped them maintain their privacy and dignity. All rooms in the birth centre were en-suite rooms, providing a private environment for women and their families

Staff were aware of the changing emotional states women experienced antenatally, perinatally and postnatally. Staff undertook training on breaking bad news and spoke of how they would communicate with empathy when having difficult conversations. Staff described how they were sensitive and supportive to parents after the loss of their baby, providing direction for bereavement care.

Maternity

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

Staff offered debriefing to women and families following difficult births through the 'listen with mother' initiative and could refer women directly for this support through the electronic patient record system.

Understanding and involvement of women and those close to them

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

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

Staff talked with women, families and carers in a way they could understand, using communication aids where necessary. We were given examples of when staff had used additional communication tools to aid people with a hearing impairment and a portable translator where English was not the persons first language.

Women and their families could give feedback on the service and their treatment and staff supported them to do this. In addition to seeking feedback from women directly whilst on the unit, information was provided to women about listening groups so that feedback can be provided later. Women were also signposted to PALs where required.

Staff supported women to make advanced decisions about their care.

Staff supported women to make informed decisions about their care.

Women gave positive feedback about the service. Staff supported women and their families to give feedback on the service and their treatment. We saw evidence in the records that women were encouraged to complete the Friends and Family test prior to discharge. Prior to COVID-19 we were told that there was a 40% feedback rate to the Friends and Family test. Over the last few months, the response rate had been 10-15% via the electronic app, with feedback consistently 100% positive in response.

The trust performed similarly to other trusts for all 19 questions in the CQC maternity survey (January 2020).

Is the service responsive?

Good  

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

Service delivery to meet the needs of local people

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

Maternity

Managers planned and organised services so they met the needs of the local population. Women were offered choice of maternity care and as far as possible, depending on the level of risk, the service aimed to accommodate women's preferences in this. Community midwives provided antenatal care in local clinics as an alternative to hospital attendance.

They had also worked with the maternity voices partnership to produce videos in different languages to reach out to women in diverse communities and share information and encourage women to access services during the COVID-19 pandemic.

Facilities and premises were appropriate for the services being delivered. The South Lakes Birth Centre had been purpose built, opening in February 2018. The centre provided a ground floor ante natal unit, with the birth centre on the first floor above. This had 14 individual rooms, providing facilities for labour, delivery, recovery and post-natal care. Each room had a bed for women's partners to stay and be able to provide support. A Rainbow room was available to provide bereavement support for women who needed this, also including en-suite kitchen and sitting room facilities. This was situated in a quieter part of the unit, having its own entrance and corridor, to allow for some privacy.

There were two obstetric theatres in the birth centre suite for elective and emergency obstetric procedures. Women remained in theatre recovery area immediately following their surgery, before transferring to the birth centre for post-natal care. An anaesthetist was based in theatre, with consultant obstetrician on call.

The service relieved pressure on other departments when they could treat women in a Day Assessment Unit. The centre did not have a dedicated area for high dependency care. If women required this during their admission, they would be transferred to the main hospital services for critical and high dependency care.

Staff could access emergency mental health support 24 hours a day seven days a week for women with mental health problems and learning disabilities.

The service had systems to help care for women in need of additional support or specialist intervention.

Managers ensured that women who did not attend appointments were contacted.

Meeting people's individual needs

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

Staff made sure women living with mental health problems and learning disabilities received the necessary care to meet all their needs. Staff described how they had been able to provide timely support for women who were experiencing mental health issues, or who had been detained under section of the Mental Health Act. We saw in one case that a woman had been transferred to a mother and baby unit in a neighbouring NHS Trust, to receive specialist support for their mental health needs. This transfer had been completed in around two hours following the need being identified.

Staff supported women living with learning disabilities by using 'This is me' documents and patient passports. Easy read information and advice folders were available for service users who had a learning disability. Community midwives were able to complete learning disability passports where a new service user was identified who required this support.

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

The service had information leaflets available in languages spoken by the women and local community. Leaflets were provided in nine different languages. accessible via a smartphone 'QR' code.

Managers made sure staff, women, loved ones and carers could get help from interpreters or signers when needed. A portable translator had been purchased from charitable funds to provide interpreting and translation services. This included translation for British Sign Language, and frequently used languages, including Kurdish, Urdu, Polish and Bulgarian. The trust website offered a 'Browse Aloud' facility, enhancing access for people with sensory impairments.

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

Staff had access to communication aids to help women become partners in their care and treatment. Midwives described how they had been able to source appropriate support for a woman with a hearing impairment, who could not access a hearing loop system but could lip read. The wearing of face masks due to COVID -19 made this difficult, so use of COVID testing and clear face masks was implemented, to enable preparation of a detailed birth plan and effective communication for the woman and her partner.

A maternal network was being established, across the Integrated Care System, for management of women with co-morbidities.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge women were in line with national standards.

Managers monitored waiting times and made sure women could access emergency services when needed and received treatment within agreed timeframes and national targets. The number of bookings for delivery by 12 plus six weeks was monitored using the maternity dashboard. The dashboard for January 2021 showed 92.7% of women were booked for delivery by 12 plus six weeks, with 88.04% in February and 93.2 in March 2021.

Managers and staff worked to make sure women did not stay longer than they needed to. In March 2021 the average length of stay following unassisted vaginal delivery was five and a half hours.

Managers ensured that women who did not attend appointments were contacted. Staff in the day assessment unit contacted all women who did not attend planned appointments.

Staff planned women's discharge carefully, particularly for those with complex mental health and social care needs. The specialist support team liaised with community and other services to ensure women received continued support whenever this need was identified.

Staff supported women and babies when they were referred or transferred between services.

Managers monitored transfers and followed national standards.

Maternity

Learning from complaints and concerns

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

Women, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

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

Managers investigated complaints and identified themes. There were low levels of complaints in the service in general and only one formal complaint being followed up through trust procedures.

Managers shared feedback from complaints with staff and learning was used to improve the service. The matron completed 'intentional rounding' with women on the unit, to gain any positive feedback and deal with any potential concerns at an early stage. We saw thank you cards displayed on the wall, including women's comments about their care such as, "amazing", "supportive", "helped make our dream come true", "passion for helping and caring" and "kind".

The service has continued with the Friends and Family Test (FFT) through the COVID-19 pandemic; however, this has been entirely through the mobile phone app only. March results 100% positive There was no indication of the response rate for FFT, although this had been generally between 10 and 15%. Previously the response rate had been up to 40% when a paper version was available. The matron gives cards to staff specifically mentioned, from families including theatre teams).

Is the service well-led?

Inadequate 🔴 ↓↓

Our rating of well-led went down. We rated it as inadequate.

Leadership

Leaders did not have the skills and abilities to run the service. They did not understand the priorities and issues the service faced. They did not always support staff to develop their skills and take on more senior roles. and were not always visible and approachable in the service for women and staff.

Staff we spoke with told us local managers and leaders were visible, approachable and supportive. There was a weekly meeting with the Deputy Head of Midwifery and all maternity matrons.

Managers told us that access to executives had improved and they did conduct regular walk rounds. Staff gave examples of times that senior executives had been present at times of difficulty or crisis to offer support. However, some staff also told us executive leaders were not visible in the service. We also heard there were some limitations in staff's opportunities to develop, particularly in leadership skills.

Maternity

Leaders told us the senior team worked together well and attended a weekly formal catch up meeting. Leaders described good links and access to senior trust executives. However, the new non-executive maternity board champion had only recently been appointed and not all staff and managers knew who this was.

There had been a lack of continuity in midwifery leadership over time. Staff told us this had led to a lack of clarity about the future direction and expectations in midwifery. At the time of our inspection, the Deputy Head of Midwifery was interim as Head of Midwifery and received support and coaching from an external Head of Midwifery. They attended weekly meetings with other Heads of Midwifery across the local maternity system.

Vision and Strategy

The service did not have a clear vision for what it wanted to achieve nor a strategy to turn it into action, developed with all relevant stakeholders. It was not clear how the development of a vision and strategy would be focused on sustainability nor be aligned to local plans within the wider health economy.

Local managers and leaders told us the vision for the service was under development. They told us they had attended meetings to begin to design a vision statement and the plan was to align this with the wider trust vision. However, they acknowledged this was work in progress. Local leaders told us both the clinical operational model and maternity strategy were due for review.

Senior leaders were not able to clearly articulate a vision and strategy for the service overall or at each location. They described the key priorities as improving the governance process and incident investigation process.

During our inspection we did not see any posters or displays which outlined the vision and values of the service.

Following our inspection, we asked the trust for information on the vision and strategy for the service. They told us they recognised the need to develop the vision and strategy for the service, but they were focused on ensuring midwifery leadership was in place and improvement work underway before developing this.

Culture

Staff did not always feel respected, supported and valued. The service did not always promote equality and diversity in daily work and there were limited opportunities for career development. However, staff were focused on the needs of women receiving care. The service mainly had an open culture where women, their families and staff could raise concerns without fear, although we also heard experiences in contrast with this.

We heard mixed experiences of culture from staff we spoke with during inspection. We found there were contrasting experiences in different parts of the service and some staff told us that “managers do not respect staff”. We also heard from some others in the service who stated they did not respect managers, and that they didn’t demonstrate leadership for the service Some staff directly said they wouldn’t share confidential information with certain managers, who they perceived as not being confidential. During inspection we observed an apparent lack of engagement from a few individual staff at times. We were told of recent whistleblowing concerns which had been raised, which included some concerns in relation to equality and diversity. Staff frequently told us the continued pressures of staffing shortage were challenging, whilst in contrast, newer and junior staff generally appeared more optimistic and said they felt encouraged. There was a shared feeling of positive expectation in the service, with the anticipated recruitment of new staff imminently.

Some medical staff shared the view that there could sometimes be a resistance to change amongst colleagues, with the perception that any issues raised were not always progressed or responded to consistently.

We consistently heard from staff that there was a sense of greater support and teamworking in the community service, which we also saw was apparent during the inspection. However, most staff told us they felt positive and were proud to work for the service, and their focus was on providing a positive experience of care for women, their partners and their babies.

Staff told us they felt confident to raise concerns with managers at a local level as well as being aware of how to raise them with the Freedom to Speak Up Guardian. The trust had introduced a phone app called Freedom to speak app, which supported staff to share any concerns they had.

Governance

Leaders did not operate an effective governance process, throughout the service and with partner organisations. Not all staff were clear about their roles and accountabilities. Staff had regular opportunities to meet, however there were limited opportunities for staff at all levels to learn from the performance of the service.

Leaders told us they recognised the need to improve governance processes and described the model they were using to begin this improvement work. Improvements were focussed on ensuring information flowed from ward to board and was not just held at management level. They were also focused on improving the incident investigation process and sharing learning from incidents and complaints. At the time of our inspection, improvement work on the governance processes was ongoing and not completed.

Some staff we spoke to told us they were not given clear expectations for their work and roles by leaders.

There were systems in place to share learning with staff about the performance of the service. The service had developed a picture-based information poster called ‘safety summary’, for all staff to share performance data based on the maternity dashboard. However, this was a new system and not fully embedded. The ‘safety summary’ was trust wide and not tailored to maternity services at locations, which meant staff did not get information about specific performance to identify areas for learning in their areas or locations.

Although managers carried out a range of local audits there were no established and reliable mechanisms or systems for reporting these audits to senior managers and leaders.

The service lacked an embedded approach in implementing systematic quality improvement approach and none of the staff we spoke to could not describe such a model. Service leaders told us they hoped that giving opportunities to staff to make suggestions would lead to improvement projects, however we saw no proactive or detailed plans to identify how staff would be supported in leading and participating in quality improvement in the service.

The service had completed the maternity services assessment and assurance tool and submitted this to NHS England. The tool required services to complete a self-assessment against the seven immediate and essential actions arising from the Ockenden report. We reviewed the self-assessment and saw it was not fully completed. Some sections did not have a description of how the service was measuring and reporting compliance with the essential action and there was not an indication of how risks were to be mitigated in the short term for all actions. It was not clear how actions identified to improve compliance with the immediate and essential actions were broken into realistic and measurable action plans with clear lines of responsibility identified.

The service had identified a mechanism for reviewing progress against the Kirkup review recommendations. The trust shared a draft copy of the review. Of the 18 recommendations, the trust reported that 15 had been sustained fully and three were sustained partially.

Management of risk, issues and performance

Leaders and teams used systems to manage performance, but these were not always effective. Not all relevant risks and issues were identified and escalated, nor actions identified to reduce their impact. However, staff were given opportunities to contribute to decision-making to help avoid financial pressures compromising the quality of care. Leaders and teams did have plans to cope with unexpected events.

Information about service performance and outcomes were reported and reviewed in discussions at the Care Group Governance Assurance Group (CGGAG). This group was attended by the triumvirate and representatives of the whole women's and children's care group. However, we were not assured effective action was consistently taken to make improvements following quality audits, such as for the MBRRACE audit and for elective Caesarean section.

There was a lack of local oversight and ownership of risk. Managers we spoke with told us there were no location specific risks for the service and no local maternity risk register, only an overall risk register for maternity services.

During the inspection we consistently heard and observed the issue of midwifery staffing was the biggest risk in the maternity service at South Lakes Birth Centre. However, when we spoke with service leaders, they identified the access issues to the SLBC; storage of paper CTGs; and newborn life support training compliance as the key concerns. We noted the access issues had been present since the opening of the unit; whilst plans for improvement had since been identified, no progress had been made with these to date. We saw the lack of a high dependency area on the labour ward and witnessed the impact of this during the inspection. Although service leaders acknowledged in discussions that the lack of a high dependency care area was an issue, this was not reflected as a key risk or concern, or any actions identified regarding this.

Further information provided following the inspection stated, the facilities for a service of this size followed national guidance and women requiring a higher level of care would be transferred to intensive care.

The service achieved compliance with the 10 safety criteria for the NHS maternity safety strategy clinical negligence scheme and was allocated a rebate on the basis of this.

The service had identified actions in response to a letter from the Chief Midwife NHS England sent to all maternity services. This outlined the four actions to be taken to reduce the morbidity and mortality for lack and Minority Ethnic women who are pregnant as well as women from other ethnic minority groups who are also at higher risk as a result of COVID-19 infection during pregnancy.

Information Management

Although the service collected different data, leaders did not always analyse it to make improvements. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were not fully integrated; however, they were secure.

Managers told us they felt trust-wide quality assurance and audit systems did not always take account of maternity specific circumstances. The trust had introduced a new quality assurance system immediately prior to our inspection.

Maternity

The service provided details of the maternity dashboard but told us it was difficult to capture consultant versus midwife led birth in the current system. All births were recorded as consultant led for South Lakes Birth Centre, with none recorded for midwife led births.

In the South Lakes Birth Centre, staff could not always access computer terminals easily, and computers on wheels were could not always be taken into individual women's rooms.

In the ward coordinator's office, there was an interactive whiteboard which displayed symbols and information about the women who were receiving care in the unit. We saw this had potential to communicate live updates to assist midwives in providing timely care for women, however it was not routinely used. Several midwives we spoke with were unclear how this worked or what the different symbols meant, observing that the whiteboard 'made the room very hot'.

The service was planning to implement a new electronic record system, anticipated to be in place in July 2021.

Engagement

Leaders did not consistently engage actively and openly with staff. There was some engagement with women, the public and local organisations to plan and manage services. There was limited collaboration with partner organisations to help improve services for women.

There was limited working across the maternity services, between the hospital's other main locations. Staff principally maintained their association with the South Lakes Birth Centre, and there did not appear to be a proactive approach to working within the service as a whole. Where these were emerging, service developments appeared to be restricted to local contexts, rather than a service wide approach. Staff said they tried working with colleagues at Royal Lancaster and Helme Chase, but this was challenging due to the geographical limitations.

Following inspection, service leaders told us that care group meetings were across maternity services. There were also cross site development initiatives, including examples such as; Baby Friendly Initiative, Vulnerable Family Services and the Maternity App.

We heard there could be different challenges in working with external partners, particularly in the different local authority arrangements and related systems. In contrast, community midwives spoke of how they were being aligned as teams associated with specific GP practices and this would enhance communications across the different community professionals involved in care.

The service did collaborate and work with the local maternity voices partnership, with regular meetings between senior midwifery managers and the chair of the maternity voices partnership. The panel convened to review progress against recommendations in the Kirkup report included external partners, such as commissioners and maternity voices.

There was limited evidence of impact of collaboration with partner organisations to help improve services for women. Although service leaders told us of work with other agencies such as children's services , GPs and Local authorities, we heard limited information which was only apparent in parts of the service.

The matron represented the service at the local ethnic minorities steering group, within the Local Maternity System.

Learning, continuous improvement and innovation

Maternity

Staff were committed to continually learning and improving services. Leaders encouraged participation in research. However, staff and leaders did not have a good understanding of quality improvement methods and the skills to use them.

Safeguarding specialist midwives were participating towards a national research programme 'Born into care' regarding babies who were removed from mothers following their birth. This involved development of memory boxes and arranging access to ongoing support for women whose babies needed to be removed following their birth.

Safeguarding specialist midwives had also participated in the 'ICON programme' introduced in March 2020. This was a national programme to support families with effective interventions in the prevention of Abusive Head Trauma (AHT).