University Hospitals of Morecambe Bay NHS Foundation Trust

Royal Lancaster Infirmary

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out a follow up inspection between 11 and 14 October 2016 to confirm whether University Hospitals of Morecambe Bay NHS Foundation Trust (UHMB) had made improvements to its services since our last comprehensive inspection, in July 2015. We also undertook an unannounced inspection on 26 October 2016.

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

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

There were seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations. These were in relation to staffing, supporting staff, safety and suitability of premises, safe care and treatment, and assessing and monitoring the quality of service provision.

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

We found that the trust had made the required improvements and rated Royal Lancaster Infirmary as good overall, with caring and end of life services rated as outstanding and safe rated as requires improvement.

Our key findings were as follows:

- There had been significant improvements across most services at this hospital since our last inspection in July 2015.
- In critical care and end of life care services, there were a number of outstanding examples of compassionate care and emotional support shown by all levels and disciplines of staff who did not hesitate to go the extra mile to make a difference for patients and their loved ones.
- Leadership of the hospital was good, managers were available, visible, and approachable; staff morale had improved significantly, and they felt supported. Staff spoke positively about the service they provided for patients.
- There had been significant investment in leadership within end of lfe services.
- Staff knew the process for reporting and investigating incidents using the trusts reporting system. They received feedback from reported incidents and felt supported by managers when considering lessons learned.
- The hospital had infection prevention and control policies in place, which were accessible, understood, and used by staff. Patients received care in a clean, hygienic, and suitably maintained environment.
- The trust reported no incidences of MRSA between September 2015 and May 2016. Eight cases of clostridium difficile were reported in the same period.
- We saw that patients were assessed using a nutritional screening tool, had access to a range of dietary options, and were supported to eat and drink.
- Nursing and medical staffing numbers had improved since the last inspection. However, there were still several nursing and medical staffing vacancies throughout the hospital, especially in medical care services and the emergency department. There were also nurse staffing concerns in the neonatal unit. The trust had robust systems in place to manage staffing shortfall, as well as escalation processes to maintain safe patient care.
- The hospital had improved compliance against mandatory training and appraisal targets in most services. Local support and supervision of junior staff had improved, and many areas had developed their own unit-specific competencies for training and development purposes.
- There had been an improvement in record-keeping standards throughout the hospital, however, we identified some ongoing areas for improvement around legibility and trigger levels for early warning of deterioration, particularly in in medical care services and the emergency department.

Summary of findings

- The trust's referral to treatment time (RTT) for admitted pathways for surgery services had improved since the last inspection. Information for September 2016 showed an improvement in the trust's performance, with 75% of this group of patients treated within 18 weeks against the England average of 75%.
- Access and flow, particularly in the emergency department and medical care services, remained a challenge. The emergency department performance had been deteriorating over the preceding 12 months. 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 last month that the trust delivered the 95% ED 4-hour performance standard was in August 2015. Lack of beds in the hospital resulted in patients waiting longer in the emergency department. Delays in obtaining suitable community care placements were causing access and flow difficulties, particularly in medical care services.

We saw several areas of outstanding practice including:

- The medicine division delivered outstanding Referral to Treatment (RTT) outcomes across all specialisms despite pressures on the service overall.
- The Listening into Action programme had delivered some clear, effective, and significant quality improvements for the organisation and for patients across the hospital.
- The service was one of only three trusts which were successful in securing funding to pilot a maternity experience communication project. This was a patient-based, communication-improvement training tool for multi-professional groups in maternity services. The project had the potential to be adopted nationally if learning outcomes and measurable improvements could be made for women who were using maternity services.
- The bereavement team, Chaplaincy, and specialist palliative care team worked together to promote compassionate care at the end of life. A particular innovation relating to this had been the development of death cafés. A death café provided an opportunity for people to talk more openly about death and dying. The trust had held death cafés for the public as part of 'dying matters week', and also had used them to support staff to talk more openly about death and to promote better communication with patients and relatives at the end of life.
- There were a number of innovations relating to compassionate care for patients at the end of life. This included the use of canvas property bags with a dragonfly symbol so staff knew that those collecting them had been recently bereaved. In addition, bereavement staff sent out forget-me-not seeds to family members following the death of a loved one. Families were also able to get casts of patient's hands. Thich was a service provided by an external organisation, with funding for this provided by the trust.
- The trust had adopted the dragonfly as the dignity in death symbol. This was used as a sign to alert non-clinical staff to the fact that a patient was at the end of life or had died. A card with the symbol could be clipped to the door or curtain where the patient was being cared for. By alerting all staff this meant that patients and family members would not have to face unnecessary interruptions, and non-clinical staff knew to speak with clinical staff before entering the room. An information card had been produced for non-clinical staff explaining the difference between the dragonfly symbol (dignity in death) and the butterfly (dementia care).
- A remembrance service was held by the Chaplaincy every three months for those bereaved. We were also told that 'shadow' funeral services had been delivered within the trust when patients had been too unwell to attend funerals of loved ones.
- Relatives were sent a condolence letter by the bereavement service a few weeks after the death of a loved one and support was offered at this time.

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

Importantly, the trust must:
In urgent and emergency care services:

- Monitor performance information to ensure 95% of patients are admitted, transferred, or discharged within four hours of arrival in the emergency department .

Summary of findings

- Ensure patients do not wait longer than the standard for assessment and treatment in the emergency department.

In services for children and young people:

- Ensure there are sufficient nursing staff to ensure compliance with British Association of Perinatal Medicine (BAPM) and Royal College of Nursing (RCN) guidance.

Action the hospital SHOULD take to improve

In urgent and emergency care services:

- Ensure observations are recorded appropriately to allow the assessment and early recognition of the deteriorating patient
- Ensure nursing documentation is completed in accordance with trust policy.

In medical care:

- Ensure all risk assessments (particular reference to venous thromboembolism and multi-factorial falls risk assessments) are completed for all patients where appropriate, and evidence of the same is documented consistently.
- Ensure medicines documentation records patient allergies, venous thromboembolism risk, and oxygen prescribing.
- Ensure National Early Warning Score (NEWS) triggers are followed or, in the event of deviation, ensure trigger levels are adjusted, with clinical rationale documented to evidence.
- Ensure all nursing and medical clinical documentation is completed in full and in accordance with recognised professional standards.
- Where medicines are stored in fridges, ensure temperature ranges are recorded in accordance with policy to ensure the safety and efficacy of the medicine is not compromised.
- Ensure all staff complete all elements of their mandatory training requirements, and ensure accurate compliance figures are maintained.
- Ensure all staff benefit from the appraisal process and these are completed on an annual basis in accordance with local policy.
- Ensure there is a reasonable and proportionate induction process, or access to relevant induction information, for all locum medical staff attending the hospital on an ad-hoc or short-term basis.
- Ensure action plans put in place to address shortfalls in local and national patient outcome audits are monitored and reviewed in a timely manner to ensure compliance is measured.
- Ensure there is a review of patient comments and Patient Led Assessment of the Care Environment (PLACE) findings regarding food quality, and consider measures which may be implemented to improve nutritional care;
- Ensure staff awareness and knowledge of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) is underpinned by consideration of procedural competence in making such applications, to avoid potential legislative breaches.
- Ensure where family attendance is required at care meetings sufficient notice is given;
- Ensure the patient and family members are given appropriate time and opportunity, in the right arena, to voice opinion on care and treatment plans.
- Ensure that, where external staff are required to support in 1:1 observation of patients, they are suitably trained to perform the task.
- Ensure the number of patient bed moves after 10pm is kept to a minimum, to avoid patient and family anxiety and distress;
- Ensure the effectiveness of the new governance framework is measured and adapted accordingly.
- Ensure the effectiveness of current staff engagement themes, and consider other formats which will support divisional strategy.

Summary of findings

- Ensure reasonable measures are put in place to support staff wellbeing, and ensure all staff know what is available to them.

In surgery:

- The trust must ensure care pathways are reviewed in accordance with the trust policy.
- The trust should ensure hand hygiene audits take place monthly and that improvements are made.
- Nursing documentation should include whether a patient has had food or drinks whilst in the emergency department.
- Continue to improve Referral to Treatment Times (RTT) for patients and continue to implement trust-wide initiatives to improve response.
- Increase orthogeriatrician's input on surgical wards.
- Ensure all transfers between locations are performed in line with best practice guidance and policy. Where practice deviates from the guidance, a clear risk assessment should be in place.
- Continue to engage staff and encourage team working, to develop and improve the culture within the wards and theatre department.
- Continue with staff recruitment and retention.
- Ensure medicines reconciliation is completed in a timely way.
- Ensure medication fridge temperatures are checked within trust policy timescales.

In critical care:

- In 2015 we reported that the unit had limited space and during this inspection we noted again that the unit was over twenty years old and would not meet current national standards for new buildings and environment. The trust should continue to monitor environmental standards and challenges in critical care and continue with strategic plans for refurbishment and expansion.
- Take action to improve physiotherapy staffing and be clear in how it supports rehabilitation for patients in line with GPICS (2015).

In maternity and gynaecology:

- Ensure that outcome measures are developed to monitor the effectiveness of the strategic partnership with Central Manchester University Hospitals NHS Foundation Trust and Lancashire Teaching Hospitals NHS Foundation Trust.
- Ensure that care records, including cadiotocograph (CTGs), are legible, complete, timed, and dated.
- Continue to monitor the cultural assessment survey for obstetrics and gynaecology, and improve values around organisational culture.

In services for children and young people:

- Ensure that all children with an acute medical problem are seen by a consultant paediatrician within 14 hours of admission.
- Ensure the environment of the children's unit and neonatal unit are fit for purpose.
- Ensure there is a review of all children and young people's mortality and morbidity.
- Ensure that documentation refers to Gillick competency and ensure that staff are properly trained and confident to assess Gillick competency.
- Continue to ensure that communication takes place with partner agencies about the placement of CAMHS patients.

In outpatients and diagnostic imaging:

- Continue to build relationships and develop closer team working for medical staff in radiology and breast services across all locations, to develop a one trust culture.

Summary of findings

- Continue to ensure sufficient numbers of suitably qualified, competent, skilled. and experienced persons are deployed in order to meet the needs of the patients. This is particularly in relation to radiology, dermatology, and allied health professionals.
- Continue work started to ensure that all premises used by the service provider are suitable for the purpose for which they are being used, properly used, properly maintained, and appropriately located for the purpose for which they are being used. This is particularly in relation to services provided from medical unit one.
- Ensure it meets referral to treat targets in outpatient clinics and address backlogs in follow- up appointment waiting times.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	We rated the emergency and urgent care service as 'requires improvement' because: • The emergency department performance had deteriorated over the last 12 months. The last month that the Trust delivered the 95% ED 4-hour performance standard was in August 2015. Whilst there are multiple factors that impact upon patient flow it was recognised the most important factor was bed occupancy. Lack of beds in the hospital resulted to patients waiting longer in the emergency department. • Guidance issued by the Royal College of Emergency Medicine (RCEM) states a face to face assessment should be carried out by a clinician within 15 minutes of arrival or registration. The median time from arrival to initial assessment was worse than the overall England median in all months over the 12 month period. • Staffing levels and skill mix was below the actual planned levels at times despite the use of bank, agency and locums • The department was not meeting the trust's target for staff completing mandatory training. The target for appraisal rates was not being met. Following our previous CQC inspection in July 2015 an action that the hospital must take to improve was to ensure that staff receive appropriate support, training, supervision and appraisal. Appraisal rates and mandatory training remains below the trust target for completion. • The outcomes of people's care was not always monitored regularly or robustly, using the national early warning score which could prevent early recognition of a deteriorating patient • Nursing assessments were not always completed. • Patient group directives were overdue a review in January 2016. Prescription pads were not stored securely. • Care pathways were not regularly reviewed.

Summary of findings

- Emergency equipment was not always checked daily.
- Hand hygiene audit results were poor.
- The trust's unplanned re-attendance rate to the emergency department within seven days was generally worse than the national standard of 5% and generally better than the England average.
- Between September 2015 and August 2016 there was an upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes. A 'black breach' occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. Between August 2015 and July 2016 the trust reported 1210 black breaches. The trust reported 157 black breaches in July 2016. There was an upward trend in the monthly number of black breaches reports over the period.
- In the previous CQC inspection in July 2015, an action that the hospital should take was to improve the ambulance turnaround times. The department was continuing to fail to meet the standard.
- Between August 2015 and September 2016 the trust's monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was worse than the England average.
- Between August 2015 and July 2016, the trust's monthly median total time in A&E for admitted patients was consistently similar to the England average.

Medical care (including older people's care)

Good

The service was inspected as part of our comprehensive visit in July 2015. Overall, medical care at RLI was rated as 'requires improvement'. During this inspection we found the service had made significant improvements.

- There had been a reduction in patient harm related incidents, particularly around pressure ulcers and falls.
- There had been significant improvements made in the clinical environment to support better care delivery;

Summary of findings

- Although there was still a number of nursing and medical staffing vacancies, the trust had robust systems in place to manage staffing shortfall and had extended their recruitment reach with the appointment of a number of international nurses.
- The service had improved compliance against mandatory training and appraisal targets which had seen an increased uptake in Safeguarding (incorporating Mental Capacity Act 2005) training. Local support and supervision of junior staff had improved with the implementation of 'Professional Forums'. The features of this covered facilitated group sessions, reflective practice and a redeveloped preceptorship programme for newly qualified nurses.
- Overall, medicines management was good.
- There had been a marked improvement in record keeping standards following a continued programme of training. The division scrutinised audit figures and targeted areas of lower compliance with support from matrons and practice educators.
- The service had developed an action plan to address and progress areas for improvement highlighted in the 2015 inspection.
- Staff understood their responsibilities to raise concerns and report incidents. The division had reported a reduction in patient harm related incidents. Senior staff managed nurse staffing shortfalls proactively and there were robust escalation processes in place to deal with nurse staffing concerns.
- Staff delivered evidence based care and the division were actively involved in local and national audit. There were some positive patient outcomes recorded in a number of national audits and there was good evidence of collaborative and effective multi-disciplinary team working.
- The division were passionate to deliver quality compassionate patient care and we observed this care being delivered. Patients were complimentary about the care they received and felt informed about treatment and management plans.

Summary of findings

- The division reported excellent referral to treatment time figures across all specialisms. The division was responding to the internal and external demands placed upon it by developing a number of services and care pathways to reduce unnecessary hospital admissions. There was a positive drive to engage with partner organisations to maintain and further services for the benefit of the population in the short, medium and long term. Staff made reasonable adjustments in response to individual patient needs and to accommodate vulnerable patient groups.
- Managers led the service well. The divisional strategy reinforced with the trust vision and aligned with the on-going work with partner organisations. Staff felt a real and palpable shift in divisional culture referring to a 'new energy', an openness and a team approach in dealing with issues faced. Organisational governance structures had been encompassed within the division and there was evidence to show how this supported divisional governance processes.
- There were many excellent examples of improvement projects and innovative strategies which brought about changes in clinical practice, work efficiencies, improved patient care and delivered organisational benefits.

At this inspection we rated medical care (including older people's care) as 'good' overall, with safe as 'requires improvement', because:

- Fall related incidents remained a concern despite reducing numbers of patient related harms. The process of capturing the multi-factorial falls risk assessment was unclear and inconsistently applied. This was compounded by the recent transition of the core safety bundle from paper records to the electronic patient record.
- Some medicines related record keeping standards required improvement, in particular, around the recording of patient allergies and oxygen prescribing.
- There remained a significant number of nursing vacancies and there was a reliance on senior

Summary of findings

locum medical cover across many sub-specialisms at RLI. The division were actively recruiting to vacant posts however many remained unfilled.

- The division had some static patient outcome measures in stroke services at RLI. These findings were across a number of domains and the division had action plans in place to address areas for improvement.
- Seven day services were not fully embedded and the division fell below national averages on a number of key metrics in the NHS Services, Seven Days a Week Four Priority Clinical Standards. The division was involved with the trust task group looking at seven day working across the organisation.
- A combination of factors including extended length of stay, increasing bed occupancy levels and delays in obtaining suitable community care placements were causing access and flow difficulties at RLI. This had led to significant numbers of patient moves after 10pm and a number of medical outliers encroaching into other services. Divisional managers were working with partners looking at all variables affecting patient flow.
- To achieve the divisional strategic objectives, the service identified staff engagement as one of the key priorities. Clinical leaders recognised there was a risk of staff becoming fatigued and less resilient to deal with the pressures of working demands in the current climate. Staff considered the division managers could do more in terms of recognition and support for their wellbeing.

Surgery

Good

The overall surgery rating from the 2015 inspection was 'requires improvement'. During the 2016 inspection we found that action had been taken to address the issues identified. There were systems in place to identify themes from incidents and near miss events. We saw improved audits for the 5 steps to safer surgery and had discussions with staff about the process and procedure for raising safeguarding referrals. There were risk assessments and escalations plans in place for situations where practice deviated from guidance.

We rated surgical services as 'good' because:

Summary of findings

- Staff knew the process for reporting and investigating incidents using the trusts reporting system. They received feedback from reported incidents and felt supported by managers when considering lessons learned. All wards used the national early warning scoring (NEWS) system for recording patient observations and systems for recognition and management of deteriorating patients. Infection prevention and control was managed effectively.
- Wards and theatre skill mix was variable during shifts, but measures were in place to ensure the safety of patients. Generally, nursing staff to patient ratio was one to eight. We reviewed the nurse staffing levels on all wards and theatres and found that numbers and skill mix appropriate at the time of inspection.
- The hospital had an escalation policy and procedure to deal with busy times and staff attended bed meetings in order to monitor bed availability on a daily basis. Staff treated patients in line with national guidance and used Enhanced Recovery (fast track) pathways.
- Local policies were written in line with national guidelines. Staff told us appraisals were undertaken annually and records for Royal Lancaster Infirmary showed that 82% of staff across surgical wards, and theatres had received an appraisal against the trust target of 95%. Appraisals were on going to the year end.
- Allied health professionals (AHP's) worked closely with ward staff to ensure a multi-disciplinary team approach to patient care and rehabilitation.
- Evidence based care and treatment national audits identified mixed outcomes for all audits. The National Bowel Cancer Audit Report (2015) showed better than the England average for four measures.
- The National Emergency Laparotomy Audit (NELA) report (2015) showed Royal Lancaster Infirmary achieved a rating over 70% for five measures and had a good rating for nine out of 10 elements of the audit. The element which was worse than required related to orthogeriatricians input for patients over 70 years old.

Summary of findings

- The Patient Reported Outcomes Measures (PROMS) for groin hernia metrics and knee replacement metrics were about the same as the England average whilst hip replacement metrics had mixed performance. We saw that orthogeriatricians had contributed to the development of the care pathway of elderly patients.
- Staff received Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training as part of staff induction. All the staff we spoke with received training in and knew about safeguarding policies and procedures
- The trust's referral to treatment time (RTT) for admitted pathways for Surgery has been worse than the England overall performance between October 2015 and August 2016. However, the latest figures for September 2016 showed an improvement in the trust's performance, with 75% of this group of patients treated within 18 weeks against the England average of 75%.
- We saw staff treating patients with compassion, dignity, and respect throughout our inspection.
- Ward managers and matrons were available on the wards so that relatives and patients could speak with them
- Complaints were dealt with informally at ward level in the first instance and where necessary escalated to ward managers and matrons in line with trust policy. Complaints were discussed at monthly staff meetings where training needs and lessons learning were discussed. The directorate risk register was updated at governance meetings with action plans monitored across the division.

Critical care

Good

Following our last inspection in July 2015, we found that overall the critical care service provided at the Royal Lancaster Infirmary required improvement. During this inspection we rated this service as 'good' overall, with 'good' ratings in safe, effective, responsive and well-led, and a rating of 'outstanding' for caring because:

- Patients were at the centre of decisions about care and treatment. The weight of positive comments gave evidence of a caring and

compassionate team. Staff were positive and motivated and without exception delivered care that was kind and promoted peoples dignity, and focused on the individual needs of people.

- During our inspection we found that nurse staffing was good with sufficient staffing levels for provision of critical care. Recruitment was underway to provide a supernumerary coordinator and practice educator in line with Guidelines for the Provision of Intensive Care Services (GPICS) (2015). Supernumerary induction for new nursing staff was good with an organised approach to nurse appraisal and nursing achievement of competence in critical care skills. This was an improvement to findings in 2015 where we found that although nurse staffing levels had improved from the 2014 inspection findings, there was no supernumerary coordinator or funded practice educators in post.
- Medical staff we spoke with discussed the historical shortfalls in anaesthetic staffing levels for out of hours cover. We had noted in 2015 that the intensive care services, obstetrics, anaesthetics and emergency surgical services across the trust did not have enough anaesthetic staff to meet the required national recommendations and standards. However, this was well understood by the executive team and clinical staff. An additional five consultants at RLI and three consultants at FGH have been funded to ensure safe staffing levels and mitigate risks. A recruitment strategy was in place.
- Pharmacy cover was good at RLI and met the standards outlined in GPICS (2015) with a critical care pharmacist and senior technician support. We had reported in 2015 that medicines were not stored securely in the unit; however this had improved with provision of new storage cabinets and performance of a regular safe storage of medicines audit.
- The emergency resuscitation equipment and patient transfer bags were checked daily with a good system in place as per trust policy. There was good provision of equipment in critical care

Summary of findings

with robust systems for medical device training. The risks associated to loss of service if equipment was broken and needed replacement were on the risk register.

- The unit was visibly clean; standards of infection prevention and control were in line with trust policy. Staff we spoke with told us that isolation of patients was risk assessed and documented. Liaison with the infection control team supported assurance that patients with infections received best practice and the small proportion of patients that may need specialist ventilated isolation facilities would be transferred if required. Patients with infections were isolated as per policy, however the two isolation rooms were not designed in line with Health Building Note (HBN 04-02) and did not have ensuite shower rooms or ventilated lobby areas.
- There was on-going progress towards a harm free culture. Incident reporting was good with low incidence of harm and infection. There was a proactive approach to the assessment and management of patient-centred risks and staff took responsibility for driving improvement to reduce risk of patient harm or acute deterioration. The programme for care of patients with tracheostomy across wards was comprehensive.
- In 2015 we reported there was no Critical Care Outreach Team across both units at UHMB. The trust did not have a dedicated CCOR team and this continued to be on the risk register, however during our inspection we noted good provision of principles in line with GPICS (2015), NICE CG50 and against the seven core elements of Comprehensive Critical Care Outreach,(C3O 2011). Staff we spoke with told us that there was an 'educational model' of outreach embedded across the trust. We observed three occasions of a rapid response to acute emergencies by the team.
- The team in critical care services were well-led. A genuine culture of listening, learning and improvement was evident amongst all staff we spoke with. Staff we spoke with across the team

Summary of findings

were passionate about their roles and proud of the trust. The investment in leadership programmes was good and it was clear the learning was shared, staff had a shared purpose and made an impact in practice. Governance arrangements were embedded in the directorate.

- We found that ICNARC data showed that patient outcomes were comparable or better than expected when compared with other units nationally, this included unit mortality.
- Follow up clinics were in place at the RLI for critical care patients, as recommended by NICE CG83 and GPICS (2015), who had experienced a stay in critical care of longer than 4 days. Emotional support was given as part of the follow up appointment, post critical care admission and additional psychological support was assessed on an individual basis. The use of patient diaries had been embedded in practice since our last inspection.
- Patients received timely access to critical care treatment and consultant led care was delivered 24/7. A low number of critical care elective admissions were cancelled and there was a low number of readmissions to the unit. Patients were not transferred out of the unit for non-clinical reasons. Staff worked hard to not discharge patients to wards during the night with low number of out of hours discharges, comparable with other similar units.
- Over half of all discharges to ward areas were delayed beyond 4 hours due to the pressures on hospital beds, however this did not prevent the patient from receiving the care and treatment they needed and staff paid attention to patient dignity when single sex accommodation breaches occurred. ICNARC data did indicate that the unit position was comparable nationally with other units against the 8 hour reported target in the CMP.
- Staff we spoke with in critical care and theatres did not express concern about risk to patients when 'outlier' admissions took place and staff had not reported any incidents of harm as a consequence. This was an improved

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arrangement since our last inspection, with a 50% reduction in annual admissions, (from 46 to 24). Critical care training had been increased for staff in theatres. Nurse skill mix in the critical care unit was not compromised to cover the theatre recovery activity, as had been previously reported.

However:

- In 2015 we reported that the unit had limited space and during this inspection we noted again that the unit would not meet current national standards for new buildings and environment. There was an estates strategy which outlined the plans for unit upgrade and expansion. Issues around estates and environment were on the directorate risk register and had been identified as a 'not met' against National D16 commissioning service specifications for critical care services, during an assessment by the LSCCCN.
- We observed good compliance with hand hygiene by all nursing staff, with regular 100% audit results of compliance. However there was poor access to sinks in the unit, which did not comply with health building note HBN 00-09, (infection control in the built environment; hand hygiene facilities, clinical wash-hand basin provision).
- Patients discharged from critical care should receive a ward follow up visit by critical care nurses within 36 hours of discharge, it was reported that this could not be provided consistently by staff in the unit and was affected by activity and staffing resources. Staff we spoke with were planning improvement as part of the appointment of a supernumerary coordinator.
- We observed that physiotherapy cover in the unit did not provide enough opportunity to be involved in unit activity, deliver care to eight patients that was in line with GPICS (2015) and reduced opportunity to develop standards of patient rehabilitation in critical care.

Summary of findings

Maternity and gynaecology

Good

At the last inspection in July 2015, we rated maternity and gynaecology services as 'requiring improvement' for being safe and well-led, particularly in relation to checking of equipment, medicine management, assessing and responding to risk, embedding governance and risk processes, joint working, and culture. During this inspection, we found good progress had been made in these areas and rated maternity and gynaecology servicse at Royal Lancaster Infirmary as 'good' because:

- Staff understood their responsibilities to raise concerns and record patient safety incidents. There were processes to ensure reviews or investigations were carried out and action taken.
- Staff were aware of the procedures for safeguarding vulnerable adults and children, the infant abduction policy had been tested.
- There were processes for checking equipment and arrangements for managing medicines.
- Medical, nursing and midwifery staffing levels were similar or better than the national recommendations for the number of babies delivered on the unit each year.
- Systems were in place for assessing and responding to risk. Staff received training that enabled them to identify and act in the instance of a critically ill woman. There was improvement in the use and completion of the surgical safety checklist compared to the last inspection.
- Women's care and treatment was planned and delivered in line with current evidence-based practice, which was audited to ensure consistency of care and treatment pathways.
- Care outcomes were meeting expectations in most areas, and where improvements were required the service had identified action.
- Women were positive about their treatment by clinical staff and the standard of care they had received. They were treated with dignity and respect.
- Services were planned, delivered and co-ordinated to take account of women with complex needs, there was access to specialist support and expertise.
- The leadership team understood the challenges to the service and actions needed to address

Summary of findings

these. Improvement had been made to ensure staff and teams were working together to promote a culture of learning and continuous improvement. A culture of openness was evident.

- There were many examples of how people's views and experience was used and acted on to develop and delivery maternity care.

However:

- Not all care records were fully completed, dated and signed. This included inconsistent recording on cardiotocographs (CTG) which was not in line with the trust fetal monitoring policy. These areas were audited and recommendations made.
- Although there was a plan, which set out the principles and governance arrangements for a strategic partnership with Central Manchester University Hospitals NHS Foundation Trust and Lancashire Teaching Hospitals further work was required to effectively capture

Services for children and young people

Good

Following our previous inspection in 2015, children and young people's services were rated as 'requires improvement'. Issues were identified with the reviewing of incidents, medical staffing levels, the design and layout of the neonatal unit, insufficient resuscitation trolleys on the children's unit and the abduction policy had not been tested.
At this inspection we found that the majority of these issues had been resolved with the exception of the design and layout of the neonatal unit. Incidents were reviewed appropriately, medical staffing levels had improved, although we found that not every child was seen within 14 hours of admission, there were sufficient resuscitation trolleys and the abduction policy had been tested. Overall, we rated the services for children and young people at RLI as 'good'. Effective, caring, responsive and wellled were rated as 'good'. We rated safe as 'requires improvement'.

Summary of findings

- Staff were aware of their responsibility to report incidents and appropriate systems were in place. Staff received feedback about incidents and learning was shared.
- Staff were clear about their responsibilities if there were concerns about a child's safety. Safeguarding procedures were understood and followed. Staff had completed the appropriate level of training in safeguarding and received safeguarding supervision.
- A paediatric early warning system was used for early detection of any deterioration in a child's condition and appropriate transfer arrangements were in place for those children requiring more specialised care.
- Staff had access to evidence based policies which were compliant with national guidance.
- There was a programme in place for local and national audit.
- Feedback from children, young people and their parents was positive.
- Services were planned to meet people's needs. Facilities were provided for parents.
- There were governance systems in place to ensure that quality, performance and risks were managed and information could be cascaded between senior management and clinical staff.

However:

- Not all children were seen within 14 hours of admission in line with Royal College of Paediatric and Child Health (RCPCH) standards.
- Staffing was not always compliant with British Association of Perinatal Medicine (BAPM) and Royal College of Nursing (RCN) guidance.
- The layout of the children's unit meant that staff could be isolated when working in the assessment unit.
- The Neo Natal Unit (NNU) had insufficient space and there was not always a member of staff present in the special care room.

End of life care

Outstanding ☆

In the last inspection of Royal Lancaster Infirmary, in July 2015, we rated end of life care services as 'good'. During this inspection we rated the end of life care service as 'outstanding' because:

Summary of findings

- The trust had clear leadership for end of life care services that was supported at a senior level within the organisation. There was active involvement strategically from the deputy chief nurse and executive leadership at board level.
- End of life care services were very well led. There was a clear vision and strategy that focused on all people are treated with dignity, respect and compassion at the end of their lives.
- We saw evidence of proactive executive involvement in terms of the development of the end of life care strategy.
- There was very good public and staff engagement
- There was a commitment by the trust and this was underpinned by staff that patients were cared for in a dignified, timely and appropriate manner
- There were examples of innovation across the service. Leading Dying Matters week, the trust had introduced death cafés with an aim to raise the profile end of life care. This included the development of the bereavement service.
- Patients were cared for holistically and there was strong evidence of spiritual and emotional support being recognised for its importance within the trust. This was apparent through the development of 'death cafés' where issues relating to death and dying were talked about openly.
- The staff throughout the hospital knew how to make referrals and people were appropriately referred to and assessed by the specialist palliative care team in a timely manner, therefore individual needs were met.
- Staff had access to specialist advice and support 24 hours a day from a consultant on-call team for end of life care.
- The chaplaincy and bereavement service supported families' emotional needs when people were at the end of life, and continued to provide support afterwards.
- The mortuary was clean and well maintained, infection control risks were managed with clear reporting procedures in place.

Summary of findings

- The bereavement palliative care service had been nominated for a compassionate care award in 2015.
- The survey of bereaved relatives results were positive in relation to dignity and respect afforded to patients.
- The trust had recently introduced a Hospital Home Care Team service, where patients could be transferred to their own homes and supported by trust staff where care packages were difficult to access in the community.
- An 'ease of access to hospital' group had been developed by the trust which included representation from the bereavement and chaplaincy service where initiatives were in place to improve access to the mortuary.
- DNACPR (do not attempt cardio-pulmonary resuscitation) records were generally completed well and the trust was making use of audits and learning from incidents to drive improvements.
- Mandatory training was in place and attendance by the specialist palliative care nurses exceeded the trust target.
- The care of the dying patient (CDP) document in use throughout the trust.
- The trust had introduced EPaCCS (electronic palliative care co-ordination system). This enables recording and sharing of people's care preferences and details about their care at the end of life.

Outpatients and diagnostic imaging

Good

We rated this service as 'good' because:

- During our last inspection we noted that space was limited and working areas were cramped in breast and physiotherapy services. We noted this time that space remained limited in some areas and the service provision was physically constrained by the existing environment. The trust had made plans for structural and estate changes.
- During our last inspection we identified concerns with the timely availability of case notes and test results in the outpatients department. At this inspection staff and managers confirmed that the trust had reduced the use of paper records and implemented an electronic records system

Summary of findings

for most outpatient areas. This was still being rolled out across all departments but we found there had been significant improvements in the availability of case notes.

- Since the last inspection we found that there had been some improvements in staffing. CT scanning staff had previously raised concerns about shortage of staff and their access to knowledge and skills competencies. When we inspected this time the department continued to work with vacancies but a new rota system enabled the department to make improvements.
- During our last inspection we noted that there was no information available in the departments for patients who had a learning disability or written information in formats suitable for patients who had a visual impairment. We saw this time that there was a range of information available in different formats and staff had involved the public and groups including vulnerable people in producing information for use by patients.
- The service had previously experienced issues with effective team working and had challenges in building team resilience and communication. We found examples of strong local and senior leadership and staff from all departments commented on management improvements. Staff were proud of opportunities they had been involved in to drive forward service improvements and innovation.
- Outpatient and diagnostic services were delivered by caring, committed and compassionate staff.
- Patients were overwhelmingly positive about the way staff looked after them. Care was planned and delivered in a way that took account of patients' needs and wishes. Patients attending the outpatient and diagnostic imaging departments received effective care and treatment. Care and treatment was evidence based and followed national guidance. We found that access to new appointments throughout the departments had improved.

Summary of findings

- The Breast Screening Service at this hospital had been the subject of an external review by an independent body. During this inspection we observed that recommendations from the review had been implemented and maintained

Royal Lancaster Infirmary

Detailed findings

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

Detailed findings

Contents

Background to Royal Lancaster Infirmary

Royal Lancaster Infirmary (RLI) is situated in the centre of the city of Lancaster and has around 426 beds. It provides a wide range of services including accident and emergency, medicine, surgery, maternity, critical care, end of life care, outpatients and diagnostic imaging, and a children and young people's service, including a special care baby unit.

The emergency department at RLI provided a 24-hour, seven-day a wee, service to the local population. The emergency department was a designated trauma unit. However, the most severely injured trauma patients were taken by ambulance or helicopter to the nearest major trauma centre, if their condition allowed them to travel directly. If not, they were stabilised within the emergency department and either treated or transferred as their condition allowed.. Self-presenting patients with minor illnesses or injuries were assessed and treated in the 'minors' bays. One of the major cubicles had doors rather than curtains and this could be used for patients who need to be isolated due to an infection. One of these cubicles was specifically designed for patients with dementia. There was a waiting area for adults and a separate waiting room for children. Patients with a serious injury or illness, arrived by ambulance through a dedicated entrance. Patients were assessed in an area with a triage room . There was a resuscitation room, near the ambulance entrance, which had four bays, one of which was equipped for children. All four resuscitation bays could be used flexibly as needed.

Medical care services at RLI provided treatment for patients requiring cardiology, gastroenterology, general medicine, medical oncology, respiratory medicine stroke and older persons care. There were 198 medical beds located at RLI across the division; Acute Medical Unit ("AMU"), Cardiac Care Unit ("CCU"), Ward 20, Ward 22, Ward 23, Ward 37, Ward 39 (now "The Lancaster Suite") and the Acute Frailty Unit ("AFU"). The division also provided care on the oncology unit, dermatology unit, ambulatory care unit, endoscopy suite, the day treatment centre and the clinical investigations unit ("CIU").

The hospital provided a range of surgical services including urology, ophthalmology, trauma and orthopaedics and general surgery (such as colorectal surgery). There were four surgical wards, a day case ward, and an acute surgical unit (ASU). There were four general theatres that carry out emergency and elective surgery procedures, two gynaecology and obstetrics theatres and two day case theatres. There were 165 inpatient and 17 day case beds.

The critical care unit (ward 38) can flexibly admit six level 3 and two level 2 patients, two bed spaces of the eight in total are single rooms. The service provides intensive and high dependency care for patients who have had complex surgery. It also provides care for emergency admissions.

This hospital offered midwife-led and obstetric consultant-led care for high risk and low risk women and

Detailed findings

a range of gynaecology services. There were 28 maternity beds and 10 gynaecology beds, a labour ward, an early pregnancy assessment unit and day assessment unit. The central delivery suite had seven delivery rooms (including the birthing pool room), one dedicated maternity theatre and one gynaecology theatre used for multiple deliveries if required.Services for children and young people at the Royal Lancaster Infirmary (RLI) consisted of a children's unit, which included a 21 bedded inpatient ward, a six bedded day care unit and a five bedded assessment unit; a children's outpatient department and a 10 cot neonatal unit (NNU). The neonatal unit was a Level 2 unit providing high dependency care and short term intensive care.

The Specialist Palliative Care service (SPC) works across University Hospitals of Morecambe Bay NHS Foundation Trust (UHMB) on two main hospital sites at the Royal Lancaster Infirmary in Lancaster (RLI) and Furness General Hospital in Barrow (FGH). Patients at the end of life were nursed on general hospital wards. The SPC delivered a Monday to Friday 9am-5pm service, with an out of hours advice line service available from St Mary's and St John's Hospice. The SPC team was made up of 1.7 whole time equivalent (WTE) consultants in palliative medicines postsand there were four SPC clinical nurse specialists across the trust as a whole, two of which were based at RLI .The lead nurse was based at FGH and held managerial responsibilities across the trust as a whole, including for those SPC nurses at RLI. The trust had a bereavement team which consisted of a bereavement nurse and a bereavement officer at both FGH and RLI.

The University Hospitals of Morecambe Bay NHS Foundation Trust provided outpatient and diagnostic services at the Royal Lancaster Infirmary. Outpatient services were part of the core clinical services directorate. There were nurse led clinics for dermatology, diabetes, lung clinics, gastroenterology clinics, respiratory and rheumatology clinics. Outpatients offered 'one-stop' clinics for Breast, Cardiology, Respiratory, Thyroid and Urology. The outpatient service was responsible for the management of room scheduling and staff support to clinicians to enable the running of outpatient based treatment functions within the trust.

Diagnostic imaging at Royal Lancaster Infirmary provided plain film x-rays, ultrasound, CT, MRI, Nuclear medicine, breast screening, interventional treatments and a radio pharmacy. The acute clinical work including fluoroscopy ; offered a range of diagnostic imaging, image intensifiers in theatres, and interventional procedures at the two main sites.

Our inspection team

Our inspection team was led by:

Chair: Ellen Armistead, Deputy Chief Inspector of Hospitals, CQC

Inspection Lead: Amanda Stanford, Head of Hospital Inspections, CQC

The team included CQC inspectors and a variety of specialists: Nurse Manager, A&E Doctor, A&E Sister, Critical Care Nurse, Advanced Paramedic, Doctor, Matron, Consultant General Surgeon, Lead Nurse Post Anaesthetic care unit, Critical Care Matron, Risk Midwife, Midwife Matron, Consultant Obstetrician & Gynaecologist, Neonatal Consultant, Locum Doctor, Paediatric Nurse, Consultant in Clinical Oncology, EOLC Matron, Outpatients Matron, Board Level Director, Director of Nursing and Quality, and Medical Director.

How we carried out this inspection

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

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

The inspection team inspected the following core services at Royal Lancaster Infirmary:

Detailed findings

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

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

We staffed public engagement stalls at the hospital sites on 20 and 21 September 2016 to hear people's views about care and treatment received at the hospitals. We used this information to help us decide which aspects of care and treatment to look at as part of the inspection.

We carried out the announced inspection visit from 11 to 14 October 2016 and undertook an unannounced inspection on 26 October 2016.

Facts and data about Royal Lancaster Infirmary

The Royal Lancaster Infirmary is one of three locations providing care as part of University Hospitals of

Morecambe Bay NHS Foundation Trust. There are 426 beds in total at this hospital.

Between July 2015 and July 2016 the hospital had 53,974 emergency department attendances. This equates to an average of 148 patients per day. 18% of emergency department attendances between April 2014 and June 2016 were children up to 16 years old. This has been a consistent percentage for the last three years.

Hospital episode statistics data for 2015/2016 showed that 16,590 patients were admitted for surgery at this hospital.

Between April 2015 and March 2016, there were 1,974 births at RLI. Across the trust, the percentage of births to mothers aged 20-34 and the percentage of births to mothers aged 20 and under was slightly higher than the England average.

Between April 2015 and March 2016 there were 8,378 admissions to the children and young people's service across the trust.

Between April 2015 and March 2016 there were 25,360 inpatient admissions and 1,438 inpatient deaths across the three hospital sites within the trust. Between April 2015 and March 2016 there had been 960 referrals to the specialist palliative care team (SPC). Of those referrals, 36% were for patients with a non-cancer diagnosis and 64% were for patients with cancer.

Between April 2015 and March 2016 Royal Lancaster Infirmary provided 303,496 outpatient appointments.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Urgent and emergency services

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

Information about the service

University Hospitals of Morecambe Bay NHS Foundation Trust has emergency departments at its two main hospital sites: Furness General Hospital (FGH) in Barrow; and the Royal Lancaster Infirmary (RLI) in Lancaster. The location of the hospitals covers a large geographical area, and journey time between Barrow and Lancaster is approximately one hour and 15 minutes by car.

The emergency department (ED) at RLI provides a 24-hour, seven-day a week, service to the local population. Between July 2015 and July 2016 the hospital had 53,974 emergency department attendances. This equates to an average of 148 patients per day. Between April 2014 and June 2016 18% of RLI ED attendances were children aged under 16 years. This had been a consistent percentage for the preceding three years.

Between April 2015 and March 2016 25.1% of attendances resulted in an admission, which was higher than the England average of 24.7%.

The emergency department was a designated trauma unit. However, the most severely injured trauma patients were taken by ambulance or helicopter to the nearest major trauma centre, if their condition allowed them to travel directly. If not, they were stabilised within the emergency department and either treated or transferred as their condition dictated. There was a protocol to inform the medical team which patient injuries would require treatment at a major trauma centre. The department had a nearby helipad within the hospital grounds.

Emergency department patients receive care and treatment in three main areas: 'minors', 'majors' and resuscitation bays. Self -presenting patients with minor illnesses or injuries were assessed and treated in the 'minors' bays. One of the major cubicles had doors rather than curtains and this could be used for patients who need to be isolated due to an infection. One of these cubicles was specifically designed for patients with dementia.

There was a waiting area for adults and a separate waiting room for children. Patients with a serious injury or illness, arrived by ambulance through a dedicated entrance. Patients were assessed in an area with a triage room . There was a resuscitation room, near the ambulance entrance, which had four bays, one of which was equipped for children. All four resuscitation bays could be used flexibly as needed.

In order to make our judgements we spoke with 10 patients, six carers, and 21 staff from different disciplines including nurses, doctors, managers, support staff, and ambulance staff. We observed daily practice and viewed 30 sets of records. Prior to and following our inspection, we reviewed performance information about the trust and reviewed information provided to us by the trust.

Urgent and emergency services

Summary of findings

We rated the emergency and urgent care service as 'requires improvement' because:

- The emergency department performance had deteriorated over the last 12 months. The last month that the Trust met the 95% ED 4-hour performance standard was in August 2015. Whilst there are multiple factors that impact upon patient flow it was recognised the most important factor was bed occupancy. Lack of beds in the hospital resulted to patients waiting longer in the emergency department. Bed occupancy levels are were 115 -130% on each site. The aim was to achieve an 85% average occupancy
- Guidance issued by the Royal College of Emergency Medicine (RCEM) states a face to face assessment should be carried out by a clinician within 15 minutes of arrival or registration. The median time from arrival to initial assessment was worse than the overall England median in all months over the 12 month period.
- Staffing levels and skill mix was below the actual planned levels at times despite the use of bank, agency and locums
- The department were not meeting the trust's target for staff completing mandatory training. The target for appraisal rates was not being met. Following our previous CQC inspection in July 2015 an action that the hospital must take to improve was to ensure that staff receive appropriate support, training, supervision and appraisal. Appraisal rates and mandatory training remains below the trust target for completion.
- The outcomes of people's care was not always monitored regularly or robustly, using the national early warning score which could prevent early recognition of a deteriorating patient
- Nursing assessments were not always completed.
- Patient group directives overdue a review in January 2016. Prescription pads were not stored securely.
- Care pathways were not regularly reviewed.
- Emergency equipment was not always checked daily
- Hand hygiene audit results were poor
- The trust's unplanned re-attendance rate to the emergency department within seven days was generally worse than the national standard of 5% and generally better than the England average.
- Between September 2015 and August 2016 there was an upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes A 'black breach' occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. Between August 2015 and July 2016 the trust reported 1210 black breaches. The trust reported 157 black breaches in July 2016 There was an upward trend in the monthly number of black breaches reports over the period.
- In the previous CQC inspection in July 2015 an action that the hospital should take was to improve the ambulance turnaround times. The department was continuing to fail to meet the standard.
- Between August 2015 and September 2016 the trust's monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was worse than the England average.
- Between August 2015 and July 2016, the trust's monthly median total time in A&E for admitted patients was consistently similar to the England average.

However:

- The management team had strengthened the 'cross bay' working since our last inspection and learning from incidents, sharing best practice and cross sight working had improved.
- One of the actions the hospital should take to improve from the last CQC inspection was to improve staff engagement, knowledge and awareness of the strategy of the service, we found staff were more engaged, and staff were provided with information via WEESEE, newsletters, internet updates and email on trust developments, clinical issues, patient themes and staff recognition.

Urgent and emergency services

- The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. RLI met the medain standard for all months over the 12 month period.
- Between August 2015 and July 2016 the trust's monthly median percentage of patients leaving the trust's urgent and emergency care services before being seen for treatment was better than to the England average for the entire period. The trust's performance followed a similar trend to the England average.
- There were governance, risk management, and quality measurements and processes in place to enhance patient outcomes and openness, and transparency about safety was encouraged.
- Staff provided care to patients based on national guidance, such as the National Institute for Clinical Excellence (NICE) guidance and the Royal College of Emergency Medicine (RCEM) guidance.
- Safety of the department was being regularly reviewed through investigation incidents and local audits that encompassed both local and national audits.
- Feedback from patients, relatives, and carers was consistently positive. We saw that staff were caring and compassionate in their dealings with patients. Patients felt well informed and engaged in their care
- Staff were qualified and had the skills they needed to carry out their roles effectively, in line with best practice. Staff are supported to maintain and further develop their professional skills and experience.
- Policies and procedures had been developed in conjunction with national guidance and best practice evidence.
- There was evidence of good multidisciplinary working. A 'frail elderly' team and a rapid enhanced assessment clinical team attended ED liaising with the community teams.
- Services were planned in conjunction with a number of other external providers, commissioners and local authorities to meet the needs of local people.
- There was clear evidence of learning shared and improvements made as a result of listening to complaints and concerns.
- Staff described the culture within the service as open and transparent. Staff were able to raise concerns and felt listened to and leaders were visible and approachable.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

We rated the emergency department as 'requires improvement' because:

- Guidance issued by the Royal College of Emergency Medicine (RCEM) states that a face-to-face assessment should be carried out by a clinician within 15 minutes of arrival or registration. The median time from arrival to initial assessment was worse than the overall England median in all months over the 12 month period.
- Staffing levels and skill mix were below the actual planned levels at times despite the use of bank, agency, and locums. Fill rates were between 53% and 74% for registered nurses and between 88% and 91% for emergency nurse practitioners shifts.
- The department was not meeting the trust's target for staff completing mandatory training. None of the eight main training elements had been completed at above 95% by medical staff and only two of the elements had been completed by nursing staff Only 36% of medical staff had advanced paediatric life support (APLS). Nursing staff band 6 and above should be trained in APLS according to trust policy. 65% had completed this training. Band 5 nurses should be trained in paediatric life support (PLS) according to trust policy. 65% had completed this training
- The outcomes of people's care was not always monitored regularly or robustly, using the national early warning score which could prevent early recognition of a deteriorating patient
- Record keeping was variable. Nursing assessments were not always completed.
- Patient group directives overdue a review in January 2016. Prescription pads were not stored securely.
- Care pathways were not regularly reviewed.
- Resuscitation and difficult airway trolleys had not been checked daily.
- Hand hygiene audit results for February 2016 to June 2016 showed between 58% and 63% compliance.

However:

- When something goes wrong, people receive a sincere apology and are told about any actions taken to improve processes to prevent the same happening.
- Openness about safety was encouraged and staff understood their responsibilities to raise concerns and report incidents. We saw that systems and processes worked together to keep people safe from harm and abuse and where areas for improvement were identified, this was acted upon.
- There was a strong culture of reporting incidents, which were reported using an electronic system. Incidents were investigated swiftly. Feedback and lessons learnt from incidents was shared amongst the staff.
- The department was visibly clean, well organised and the equipment was maintained in line with trust policies.
- There were safe systems for the storage and handling of medicines. The department used an electronic dispensing system for dispensing medicines which was accessed using finger print technology. This also provided an audit pathway and improved inventory control.
- There were clear systems and processes in place to protect children and vulnerable adults from abuse. Safeguarding vulnerable adults and children were given sufficient priority and there was active and appropriate engagement in local safeguarding procedures.
- Plans were in place to respond to emergencies and major situations. Staff understand their role and the plans were tested and reviewed.

Incidents

- There was a strong culture of reporting, investigating and learning from incidents.
- To report incidents, staff used an electronic system. Staff were confident about using the system and were encouraged to report incidents. Incidents were appropriately graded in severity from low or no harm to moderate or major harm.
- Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Between November 2015 and October 2016, the trust reported no incidents which were classified as Never Events for Urgent and Emergency Care.
- In accordance with the Serious Incident Framework 2015, the Royal Lancaster Infirmary reported 12 serious incidents (SIs) in Urgent and Emergency Care which met

the reporting criteria set by NHS England between November 2015 and October 2016. There was no particular theme to the serious incidents however, long wait was the most common category of incidents reported and these were reported as a near miss.

- There was clear evidence that these serious incidents were robustly investigated. Following investigations of incidents of harm or risk of harm, staff told us they always received feedback. Learning from incidents was discussed and cascaded through several forums. They were discussed individually, displayed on a notice board in the staff area, and discussed in the clinical governance group meetings.
- Staff were aware of the statutory Duty of Candour principles. The department had a system in place to ensure patients were informed and given an apology when something went wrong and were told of any actions taken as a result. 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. Examples of duty of candour were given and we saw staff were open and honest with the patients and their family.
- Any unexpected deaths or potentially avoidable deaths that occurred in the emergency department (ED) were reviewed within the divisional mortality meetings with medicine. These were attended by a member of the ED who reported any findings or lessons learned at the department meetings.

Mandatory training

- There was a trust mandatory training policy in place. This referenced eight statutory training requirements, mandatory training requirements and training in essential skills. They included such topic areas as equality and diversity, health and safety, infection prevention and control, information governance, basic life support, conflict resolution, general fire safety awareness and manual handling.
- For each training element, staff groups were identified together with the frequency of each training element. Employees had a personal training account, which reflected the mandatory training needs required by them as an individual and reflected if their training was up to date and when it would expire.
- The trust set a target of completion at 95%. None of the eight main training elements had been completed at above 95% by medical staff and only two of the elements had been completed by nursing staff which were manual handling and health and safety.. The others ranged between 92% and only 48% of medical staff had completed conflict resolution training. However, from the training figures received it was difficult to ascertain as there were different level modules for some of the topics.
- In addition, sepsis training was part of the mandatory training for emergency department staff. 85% of staff had completed sepsis training. There was a sepsis champion in the department.
- Staff completed most mandatory training using e-learning however, there were some clinical skills that resulted in competency based classroom sessions.
- Time was allocated in the off-duty for face to face mandatory training although staff did e-learning in their own time or at work, if time was available.
- New staff received a corporate induction programme that included some face to face mandatory training.
- We were told all medical staff looking after children were trained in advanced paediatric life support (APLS), however training figures supplied indicated only 36% of medical staff had advanced paediatric life support. Nursing staff band 6 and above should be trained in APLS according to trust policy. 65% had completed this training with a plan in place to have 100% completion by December 2016. Band 5 nurses should be trained in paediatric life support (PLS) according to trust policy. 65% had completed this training with a plan in place for 100% completion by December 2016.
- All nurses band 6 and above should have completed advanced life support adult training. Compliance was 89%. There was a plan to be 100% compliant by December 2016.
- The department had a clear system and process in place for the identification and management of adults and children at risk of abuse.

Safeguarding

- We reviewed ten children's records. All the children had been assessed regarding safeguarding.
- Nursing, medical and administration staff we spoke with was able to explain the process of safeguarding a patient and provide us with specific examples when they would do this.

- We observed staff accessing the trust safeguarding guidelines, which were readily available in a file at the nurses' station. This provided information of how to make referrals when staff had concerns about a child or adults' safety.
- Any safeguarding concerns were escalated to the senior nurse and doctor.
- There was a safeguarding team for adults and children and a robust referral system in place.
- A domestic violence independent adviser could be contacted 24 hours a day, 7 days a week, for advice and support. A folder was available for staff, with information on domestic violence. Staff told us all domestic violence incidents involving adults with children would trigger the generation of a safeguarding alert.
- Safeguarding audits took place weekly by randomly checking ten paediatric ED records were checked. If anything is missed, the paediatric nurse would speak with the staff. We saw evidence of the audits which showed 96% completion for August 2016.
- Staff were aware of the assessment for child exploitation and female genital mutilation (FGM).
- The ED had a Child Protection Information Sharing System in place which allowed the trust to share and receive information from other authorities responsible for safeguarding children. When children presented to ED the system generated a specific sign on the patient's records if they had already been identified as 'at risk' or had a specific care plan in place if they had presented to ED a specific amount of times.
- There was a file at the nurses station which the specialist midwives kept up to date. This contained details of vulnerable babies who were due in the next nine months.
- The trust set a mandatory training target of 95% for completion of mandatory safeguarding adults and children training level one and two. Completion rate was 94% of nursing staff and 67% of medical staff had completed safeguarding children and young people training. All medical staff and senior nurses should receive level three training. This means that on every shift a senior member of staff was on duty with the appropriate safeguarding competencies in line with national guidance set out by the RCPCH. However, only 25% of medical staff and 65% of nursing staff had received level three training.

Cleanliness, infection control and hygiene

- The emergency department was visibly clean and tidy. We saw cleaning in progress during the visit. Some of the equipment had 'I am clean' labels attached documenting the time and date when it was last cleaned.
- We reviewed areas including the sluice, administration stations and relatives waiting areas and found them clean and tidy.
- Needle sharp bins in the areas 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).
- Staff adhered to the infection control policy and used personal protective equipment (PPE) when delivering personal care.
- We observed medical and nursing staff following the trust policy for hand washing and 'bare below the elbows' guidance in clinical areas. There were adequate hand washing facilities throughout the department and hand gel dispensers were available in each cubicle.
- In the CQC's 2014 A&E survey, the service scored 8.6 out of 10 for the question: "In your opinion, how clean was the A&E department?" This was about the same as other trusts.
- Hand hygiene was audited on a monthly basis. The audit results for February 2016 to June 2016 showed between 58% and 63% compliance. In April 2016 there was no recording of the audit taken place.
- Staff did routinely carry out mattress audits. We were told they were checked and cleaned between patients. On inspection, we checked six mattresses and found they were clean and they had no tears in them.
- The majors and minors areas had appropriate facilities for isolating patients with an infectious condition. They were nursed in a cubicle which had a door on it rather than one with disposable curtains.
- In the children's waiting areas, toys were visibly clean. There was no cleaning check list.
- The bays had a cleaning checklist in place and we saw these had been completed daily.
- We spoke with domestic staff whose main role was to assist with the hygiene and cleanliness of the department and they spoke of the importance of infection control and how they contributed to patient safety by ensuring that they followed trust infection control policy. We looked at the cleaning stock room and saw that equipment such as coloured mops and

buckets were available and stored correctly. The cleaning chemicals had the appropriate instructions for storage and usage in line with Control of Substances Hazardous to Health national guidelines.
- Waste was managed in line with effective infection control practices.
- We saw evidence of a sepsis screening tool for the trust. However, the notes we checked did not include a patient with sepsis and during our inspection we did not observe the treatment of a patient with sepsis
- A retrospective audit had taken place however, the date of it was not clear and a re-audit was planned for July 2015 which we did not see evidence of. Staff were aware of the signs and symptoms of sepsis and had received sepsis training.93% of ED nursing staff had up to date training in infection control.

Environment and equipment

- The hospital department pre-dated current national guidance for compliance in facilities for accident and emergency departments (HBN 15-01: Accident and Emergency Departments 2013)
- In the Estates Strategy 2015 to 2025, it acknowledged that there are insufficient cubicles at busy periods. The trust planned to explore the possibility of using another space within the building as an assessment area for patients who had been seen in the ED but required ongoing review prior to discharge. The Ambulatory Medical Unit (AMU) was located in a rented modular building and needed a permanent location nearer the ED. There was a future plan to expand the Centenary building to provide more space as part of the area devoted to acute medicine services.
- There was a helipad within hospital grounds, near the emergency department.
- The waiting area was adequate and we did not observe any patients standing whist waiting to be seen. There was a separate children's waiting area, with a toilet and baby changing facilities, and a television on the wall.
- Staff in reception sat behind a screened area and had access to panic buttons. Staff were aware of how to raise a security alert and said they felt safe. Security arrangements were in place from 7pm to 6am. During the day, security was not available. Staff told us that they would call the police if they had concerns or they could book security from an external provider if needed.
- Closed circuit television (CCTV) was in operation.There was a resuscitation room, near the ambulance entrance, which had four bays, one of which was equipped for children. All four resuscitation bays could be used flexibly as needed. The resuscitation area was visibly clean and well organised.
- The resuscitation bays were similarly set up which helped staff care and treat patients in a timely and efficient manner.
- Equipment trolleys were labelled and some were matched with an equipment checklist. We saw evidence resuscitation trolleys and the difficult airway trolley had not been checked daily as per trust policy.
- There were adequate stocks of equipment and we saw evidence of good stock rotation to ensure that equipment was used before its expiry date.
- Safety testing of electrical equipment had been carried out in the department by the medical engineering department on a rolling programme basis. Stickers on the equipment confirmed servicing and maintenance had been completed.
- In the CQC's 2014 A&E survey, the service scored 9.7 out of 10 for the question: "While you were in the A&E Department, did you feel threatened by other patients or visitors?" This was about the same as other trusts.

Medicines

- Staff followed systems that demonstrated adherence to relevant legislation
- The department used an electronic dispensing system for dispensing medicines which used finger print technology to control access and provided an audit pathway and improved inventory control. Staff told us they felt this system had improved patient safety.
- Medicines, including intravenous fluids, were appropriately stored and access was restricted to authorised staff.
- Controlled drugs were managed appropriately and accurate records were maintained in accordance with trust policy, including regular balance checks.
- Medicines requiring refrigeration were stored securely, however maximum and minimum temperatures had not been recorded in accordance with national guidance. We checked fridge thermometers and found maximum and minimum temperatures outside of the recommended range for storing medicines; in addition it was unclear whether staff had reset thermometers correctly.

- Patient Group Directions (PGDs) were in use to support patient access to medicines in a timely way. PGDs are written instructions which allow specified healthcare professionals to supply or administer a particular medicine in the absence of a written prescription. The paper copies held on the ward were overdue for review in January 2016.
- Blank FP10 prescription pads were stored securely, however staff did not keep records of serial numbers in accordance with national guidance. We found blank hospital prescription pads were not stored securely. We discussed this with the ward manager during our visit, and she took immediate action to move them to a more suitable location.
- We found that two out of 20 adult patients' notes had medication prescribed but not signed as administered.

Records

- Paper records (ED cards) were used within the department. If the patient was admitted a copy was sent to the ward.
- A discharge letter was generated through the IT system. A copy was sent to the patients GP through the post.
- Access to patients' previous electronic notes was timely, and they could be accessed via the medical records department 24 hours a day, seven days a week.
- The IT system could interface with the GP's system and doctors could view a GP summary.
- We reviewed 20 sets of adult patients' records fully, and found completion of documentation was variable. For example, we could not tell whether nursing care had actually been given because the record of nursing care was inconsistent. Assessment of pressure ulcers, pressure care given and falls assessment were not recorded fully on eight out of the 20 records.
- We found dementia or cognitive assessment was not completed on the over 75's.
- We noted pain scores were not completed in 16 out of the 19 applicable; therefore, we could not tell if patients were given timely pain relief.
- Writing was legible in all of the records, and they were dated and timed in 18 out of the 20 adult records. Out of the 10 paediatric notes we checked all were legible and one was not dated and timed.
- The frequency and documentation of the recording of patients' observations was not in line with best practice guidance in 15 out of the 30 sets of records.
- We found six out of the 10 paediatric records had not had allergies recorded, and one out of the 20 adults notes had not had allergies recorded. This increased the risk that patients may be given inappropriate medicines that could have a harmful effect.
- The electronic system alerted staff to any patient specific concerns or risks. For example, if a patient had a previous infection or a safeguarding concern.
- Reception staff collated and filed the patient notes at the end of the visit and arranged for safe storage of notes.

Assessing and responding to patient risk

- All patients booked into the ED received a full, appropriate triage based upon their presentation, which was undertaken by an appropriately qualified nurse.
- Patients who walked into the department were registered by the receptionist and directed to the waiting room where a nurse triaged them.
- The trust used a recognised triage system in the 'minors' area which categorised the severity of the patient's condition and level of risk. This reflected the order in which patients were seen.
- Once triaged, the walk in patients received an initial assessment by a doctor or nurse.
- Patients arriving by ambulance entered through a dedicated entrance specifically for ambulances. There was an assessment room where patients had an initial assessment by a nurse. The initial assessment included commencing investigations that would assist with diagnosis and treatment. For example, bloods were taken, electrocardiograms (ECG) carried out, analgesia prescribed and x-rays ordered. A nurse then triaged the patient into the appropriate area (unless the patient required immediate access to the resuscitation bay).The nurse triaging the patients arriving by ambulance was on duty between the hours of 10am and 2am. Between 2am and 6am triage was undertaken by a nurse working in the majors area.
- A National Early Warning Score (NEWS) system for acutely ill patients was used, which supported the process for early recognition of those patients who were becoming unwell. This ensured early, appropriate intervention from skilled staff. We checked records and six out of 20 adults, and four out of 10 paediatric records had evidence of the NEWS recorded. The NEWS system had been recently introduced to the department and replaced a similar system used to assess patients.

- Guidance issued by the Royal College of Emergency Medicine (RCEM) states a face to face assessment should be carried out by a clinician within 15 minutes of arrival or registration. The median time from arrival to initial assessment was worse than the overall England median in all months over the 12 month period. In July 2016 the median time to initial assessment was 16 minutes compared to the England average of seven minutes. The trust's performance has worsened over time with the median time increasing.
- During the inspection, the records we examined informed us that the target was met for 14 out of 16 patients notes we checked who arrived by ambulance. These times were between one and 66 minutes.
- We checked 14 patients notes who had walked into the ED. They waited between three and 43 minutes for an initial assessment by the triage nurse. Seven of these patients were assessed by the triage nurse within 15 minutes.
- During the inspection we tracked the journey of seven patients through the ED from their arrival until they were discharged from the department. Of those, four received a initial assessment within 15 minutes of their arrival at ED this ranged from two and 12 minutes. One patient waited 20 minutes and two patients did not have an initial assessment time documented.
- Failure to triage within 15 minutes was on the departments risk register.
- The emergency department was a designated trauma unit and provided care for all trauma patients. However, the most severely injured trauma patients were taken by ambulance or helicopter to the nearest major trauma centre, if their condition allowed them to travel directly. If not, they were stabilised at Royal Lancaster Infirmary and either treated or transferred as their condition dictated. There was a protocol to inform the medical team which patient injuries would require treatment at a major trauma centre. The department was served with a nearby helipad were the helicopter could land and a protocol was in place for the transfer of the patient into the emergency department.
- A handover process to the wards was used known as SBAR. (This is used to describe the patients' medical Situation, Background, Assessment and Recommendations). This allowed staff to communicate assertively and effectively, ensuring key information was passed to relevant staff and reducing the need for repetition.
- The trust performed 'about the same' as other trusts in the 2014 CQC A&E Survey questions for the five questions relating to assessing and responding to patient risk.

Nursing staffing

- The department completed a nurse staffing audit using 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 tool analysed the volume and pattern of nursing workload and tracked this against the rostered staffing level, calculating the whole time equivalent workforce and skill mix that would be required to provide the nursing care needed in the department during the audit period.
- As a result of the audits and the NICE consultation paper which gave minimum core nursing staffing in emergency departments a business case was put forward in April 2014 and agreed.
- However, the full complement of staff was not recruited due to recruitment difficulties. There was a rolling advert for recruitment and the trust had recruited from oversees.
- The department used bank and agency nurses. Often the same nurses were used, providing familiarity to the department and many of the bank nurses were substantive staff. We were told the agency nurses were experienced emergency department nurses. Some were booked as a block contract.
- The department used a text messaging system to ask staff if they were available for overtime shifts when the department was short staffed.
- Between April 2016 and August 2016, the planned number of whole time equivalent establishment of registered nurses was 55.8. The actual number of staff in post was between 44.5 and as low as 29.5 in July 2016. This meant there was a lack of 26.3 nurses. Fill rates were between 53% and 74% leaving shifts with low numbers of nurse staffing The emergency nurse practitioners planned was five whole time equivalent and in post was between 4.4 and 4.5. Fill rates were between 88% and 91%, therefore emergency nurse practitioners shifts were unfilled at times. Unqualified staff planned was 17 whole time equivalent with 21.7 been in post in April 2016, and reducing down to 15.7 in

July 2016. Fill rates for unqualified staff was between 92% and 128%, therefore at times there were less than planned unqualified staff on duty and times when more were on duty to try and mitigate the risk of the low number of trained staff on duty.

- These figures excluded the paediatric ED cover which is covered as part of the children's ward establishments.
- We reviewed four weeks of nursing off duty between 29th August 2016 and 25th September 2016. The percentage of filled qualified nurse shifts 38%. The unqualified (clinical support workers) filled shifts were 16%. This included the use of bank and agency. There were 15 shifts (9%) were there was an additional Band 4 clinical support worker on duty to mitigate the risk and some agency shifts had a shift pattern of 6pm to 4am to part cover the night shift and the busier periods.
- At the time of the inspection we were told the nursing vacancy rate was eight registered nurses and no vacancies for clinical support workers as they had recently recruited.
- To mitigate risk, nurse staffing was discussed the bed management meetings which occurred at least four times a day. Senior staff would move staff from other areas to help cover if they were available.
- Nurse staffing was on the departments risk register.
- The trust's sickness levels between June 2015 and April 2016 were higher than the England average for all months except September 2015. The trust's sickness trend is not following the England average and is increasing over time. The trust was unable to provide sickness rates for the emergency department
- In accordance with the safer staffing initiative put in place as part of the NHS response to the Francis enquiry, we saw displayed for each shift the actual versus planned numbers of nursing staff on duty.
- The department had the skill mix and flexibility to deploy staff as demand and workload dictated across the different parts of the department
- The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency settings (2012) identifies that there should always be a registered children's nurse in the emergency department, or trusts should be working towards this. Staff told us that there were one full time paediatric nurse who was the lead paediatric nurse for the emergency department and the ward paediatric staff nurses covered the emergency department providing two paediatric nurses daily, one working between 9am and 10pm, and the other 7.15am to 8.15pm. The lead nurse was trialling a twilight shift on the busy days (Mondays and the weekend) from 5pm to 2am.
- All nursing staff had received training regarding the care of children.
- The department was overseen by a matron who provided managerial support, and clinical support when necessary.
- Nursing and medical handover occurred separately at the beginning of each shift.
- The handover included discussions around number of patients in the department and waiting times, a handover of each patient, any issues that had occurred, any deaths and any shortfalls in nursing or medical staffing.
- We did not observe a board round and there was no evidence of regular board rounds which include a discussion with the multidisciplinary team regarding patients.

Medical staffing

- We examined the medical staffing rota and talked with consultants and junior doctors.
- According to the College of Emergency Medicine (CEM) (2015), an emergency department should have at least 10 whole time equivalent consultants to provide a sustainable service during extended weekdays and over the weekend.
- There were eight whole time equivalent (WTE) consultants employed for the ED. This is therefore, below the CEM recommendations. However, the consultants were employed on 12 PAs to cover this. Four of the eight posts were locums, but there was a plan in place to fill three of these locum posts in January 2017.
- In July 2016 the proportion of consultant staff reported to be working at the trust were lower than the England average and the proportion of junior (foundation year 1-2) staff was lower.
- There were 10 WTE middle grade doctors. Eight were substantive posts and two were long term locum posts.
- Medical staffing was on the departments risk register.
- Consultant rotas demonstrated that a consultant presence in the department was between 8am and 11pm , seven days per week. CEM guidance states services should ensure there is 16 hours of consultant presence a day, except in Major Trauma Centres which should have 24 hour cover. At Royal Lancaster Infirmary

they provided consultant presence for 15 hours a day. Outside these hours, a consultant was available on call and attended the department if there was a clinical need to do so. In the absence of a consultant, middle grade cover was available.

- National guidelines for emergency departments seeing 16000 or more children a year state that there should be at least one consultant with sub-specialist training in children's emergency medicine. The department saw 12097 children aged 0 to 16 between April 2014 to June 2016. A paediatric consultant provided paediatric cover if needed and was on site 24 hours a day, 7 days per week.

Major incident awareness and training

- The trust had a major incident policy; this was accessible to staff on the trust intranet.
- The department had a major incident plan with clear guidance and action cards for individual roles in the event of specific incident.
- Staff had an understanding of their roles and responsibilities with regard to any major incidents. Staff could describe processes and triggers for escalation. They described to us the arrangements to deal with casualties contaminated with hazardous materials (HAZMAT) such as chemical, biological or radiological materials.
- There was a designated store for major incident equipment that contained specialist suits, which staff were trained to wear in the event of dealing with casualties contaminated with hazardous materials, such as chemical, biological or radiological materials.
- There was a link nurse in the department for major incidents and the emergency planner checked the equipment every three months.
- Staff had undertaken training and practice that included rehearsal in wearing the protective suits in July 2016. There was an agreed programme of training in place for 2017.
- The department had a decontamination room, which was next to the ambulance entrance. This contained a shower. This room was also used as an ambulance triage room.
- Staff had received training on how to care for someone who may have symptoms of Ebola.
- The department could be locked down easily to ensure the safety of patients should the need arise
- There was appropriate security arrangements to keep staff and others safe and protected from violence during the night from 7pm to 6am. During the day security was not available. Staff told us that they would call the police if they had concerns or they could book security from an external provider if needed. Closed circuit television was in place.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We rated the emergency department as 'good' for effective because:

- Care and treatment was delivered in line with national guidance and best practice
- The department had an ongoing audit programme that encompassed both local and national audits.
- Staff are qualified and have the skills they need to carry out their roles effectively in line with best practice. Staff are supported to maintain and further develop their professional skills and experience.
- Policies and procedures had been developed in conjunction with national guidance and best practice evidence.
- A mentor or preceptor supported new staff, and a supernumerary period of time was given that varied depending on their previous experience and learning needs. A clinical educator was due to commence in post.
- There was evidence of good multidisciplinary working. A 'frail elderly' team and a rapid enhanced assessment clinical team attended ED liaising with the community teams.
- The department offered a 24-hour seven-day service however; some services were available out of hours as an on call service.
- Staff were clear about their responsibilities in gaining consent from people including those who lacked capacity to provide informed consent to care and treatment

- Between August 2015 and July 2016, the trust's unplanned re-attendance rate to A&E within seven days was generally worse than the national standard of 5% and generally better than the England average.

However:

- Documentation of pain scores were not always completed.
- The target for appraisal rates was not being met
- Care pathways were not reviewed regularly.

Evidence-based care and treatment

- There were a range of pathways that complied with the National Institute for Health and Care Excellence (NICE) guidelines and the Royal College of Emergency Medicine's (RCEM) clinical standards for emergency departments.
- We saw evidence that care was delivered in line with recommended national guidance for emergency departments and medicine. This included specific pathways for patients presenting with stroke, sepsis and fractured neck of femur. We looked at the pathways and found that some did not have review dates, and those that did had passed their review dates. Care pathways aimed to promote early treatment and improve patient outcomes.
- We did not see any evidence of pathways being used.
- The ED provided an acute service for patients who had a stroke. A specialist nurse attended ED to advice and support the care of the patient. A stroke pathway was in place 9am to 5am Monday to Friday. Out of hours, the stroke specialist doctor on call was contacted and the care of the patient discussed via telemedicine which is a video conferencing service.
- The trust participated in the national RCEM and Trauma Audit and Research Network (TARN) audits so it could benchmark its practice against other emergency departments.
- All guidelines were accessible on the trust's intranet page. Junior doctors were able to demonstrate ease of access to guidelines, and found them clear and easy to use.
- We spoke with nursing and medical staff that had a good understanding of the Mental Health Act (MHA) and code of practice. Staff were able to explain how patients detained under the MHA were being treated for their mental disorder and if they required treatment for a physical illness consent would still have to be sought in line with current legislation.

Nutrition and hydration

- Patients were offered food and drinks. Snack boxes were available 24 hours a day. Hot food was available from the hospital canteen if requested.
- There was no set mealtime regime. Patients told us they were offered food and drinks and we observed patients eating.
- We noted out of the 30 patients notes, eight had documented that food and/or drinks were given.
- We saw evidence on patient's records that there was a section on nutritional status and body mass index. This was only completed on patients being admitted.
- Within the waiting room there were vending machines which contained cold and hot drinks, chocolate and crisps.
- Baby food could be accessed from the children's ward if needed.
- In the CQC's 2014 A&E survey, the service scored 7.08 out of 10 for the question: "Were you able to get suitable food or drinks when you were in the A&E Department?" This was about the same as other trusts.

Pain relief

- A pain score tool was used to assess if a patient had pain. Pain was scored as zero for no pain, up to 10 for severe pain.
- We reviewed 20 sets of adult patients' notes for the completion of pain scores. Only four records had documented the patient pain score. However, we did find evidence that pain relief was given on 12 of the 20 adult patient's prescription charts and five out of 10 paediatric prescription charts. We were not able to establish if the remaining patients had pain and required pain relief.
- Patients told us staff asked about their pain; nearly all of those patients who had pain said they were treated quickly. Patients were happy with the pain relief they had received.
- In the CQC's 2014 A&E survey, the service scored 6.40 out of 10 for the question: "How many minutes after you requested pain relief medication did it take before you

got it?" and scored 7.50 out of 10 for the question: "Do you think that the hospital did everything they could to help control your pain?" Both scores were about same as for other trusts.
- The paediatric notes we checked received pain relief within 20 minutes of arrival and those in severe pain reassessed every hour (RCEM management of pain in children 2013).

Patient outcomes

- The Royal College of Emergency Medicine (RCEM) has a range of evidence based clinical standards to which all emergency departments should aspire to achieve to ensure optimal clinical outcomes.
- The emergency department had participated in a number of audits to benchmark their performance against the CEM standards. The RCEM invites emergency departments to take part in national clinical audits annually which evaluate care based against agreed standards.
- In the 2015 to 2016 RCEM vital signs in children audit, the Royal Lancaster Infirmary was in the lower quartile compared to other trusts in two of the six measures, and in the upper quartile for none of the six measures.
- In the 2015 to 2016 RCEM audit procedural sedation in adults the Royal Lancaster Infirmary was in the lower quartile compared to other trusts in none of the seven measures, and in the upper quartile for two of the seven measures
- In the RCEM audit 2015 to 2016 Venous thrombotic embolism (blood clot) risk in lower limb immobilisation in plaster cast, the Royal Lancaster Infirmary was in the lower quartile compared to other trusts in one of the two measures, and in the upper quartile for none of the two measures.
- Recommendations were made as a result of the audits and these were discussed in the governance meetings, emailed to staff and displayed on the notice boards in the department.
- There were several audits on going at the time of the inspection which included asthma, sepsis, paracetamol overdose, consultant sign off and unplanned re-attendance within seven days.
- There was a clinical audit and effectiveness steering group which was held monthly were the doctors responsible for the audits discussed their findings
- The department closely monitored its performance against a range of clinical indicators. This presented a detailed and balanced view of the care delivered by the emergency department. It also reflected the experience and safety of the patients and the effectiveness of the care they received.
- Between August 2015 and July 2016, the trust's unplanned re-attendance rate to A&E within seven days was generally worse than the national standard of 5% and generally better than the England average. In latest period, trust performance was 6.8% compared to an England average of 7.9%. The trust has been higher than the standard for the entire period and the unplanned re-attendance rate has shown a steady increase almost in-line with the England average.

Competent staff

- Medical and nursing staff had an annual appraisal and staff spoke positively about the process.
- 53% of nursing staff had received an up to date appraisal.
- All medical staff had received an up to date appraisal.
- New nursing staff received a trust induction and trust wide competency based assessments for procedures such as venepuncture and administrating intravenous drugs.
- New staff worked through an emergency department introduction booklet. A preceptor supported their learning, and they had a supernumerary period of time that varied depending on their previous experience and learning needs.
- Revalidation is the new process that all nurses and midwives in the UK will need to follow from April 2016 to maintain their registration with the Nursing and Midwifery Council (NMC) and allow them to continue practicing. Staff were aware of the requirements and how to register online.
- Medical staff have been required to undergo a revalidation process with the General Medical Council (GMC) since 2012. The trust had a process in place to support medical staff in revalidation procedures.

Multidisciplinary working

- We observed very good working relationships between medical and nursing staff in the department. Staff appeared to communicate and work cooperatively between all areas of the emergency department.

- Clinical nurse specialists came to the department to provide clinical expertise and review patients if needed, we observed a nurse specialist from the frailty team reviewing a patient.
- An advanced nurse practitioner for mental health patients was based within the department. This provided timely assessment to patients with mental health needs between 8am and 9pm seven days a week. Out of these hours, a crisis team was available. This was a community-based service and we was told patients often had a long wait to be seen.
- A Rapid Enhanced Assessment Clinical Team (REACT) visited the department that consisted of a nurse, a physiotherapist and an occupational therapist. The team assessed patients and was able to put in place support at home if needed. We observed the REACT team within the department.
- There were alcohol liaison workers who supported patients with alcohol misuse issues. They visited the department Monday to Friday between 9am and 5pm. Out of hours a referral form was completed and the patients were followed up.
- A GP out of hour's service was based in the hospital and links had developed with the department allowing the referral of appropriate patients to that service

Seven-day services

- The adults and children ED was operational 24 hours a day, seven days a week. Consultants provided on call cover for 24 hours a day, were present for 15 hours a day. A middle grade doctor was present 24 hours a day seven days a week. A paediatric on call consultant was available 24 hours a day seven days per week.
- The emergency department had x-ray facilities within the department, which could be accessed 24 hours, seven days a week. CT scans were available within one hour. The department had an ultrasound available.
- There was availability of pharmacy seven days a week and 'out of hours' an on call service was provided.
- Physiotherapy service and occupational therapy was provided six days a week and an ad-hoc service on Sundays. There was an on call physiotherapist available if needed.
- There was seven-day access to pathology services.

Access to information

- Patients' hospital notes were kept on site and were easily and quickly available from the medical records department.
- In the department, there were electronic screens that displayed the status and waiting times of all patients in the department. There were electronic screen outside of the department which displayed the waiting times. These did not always match the waiting time displayed inside the department.
- By using the trust's intranet, staff had access to relevant guidance and policies.
- A GP letter was generated from the IT system, printed off and posted to the GP practice.
- The IT system could interface with the GP's system and doctors could view a GP summary, which included a patients current problems, current medication, allergies and recent tests .This information could be accessed securely and verbal consent was gained from the patient .

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Where possible, 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.
- Doctors gained written consent from patients who required sedation.
- Training in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards was included within the mandatory safeguarding training. 59% of medical staff and 89% of nursing staff had completed the 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. Patients' consent was obtained as per trust procedures.
- Staff were clear about their responsibilities in gaining consent from people including those who lacked capacity to provide informed consent to care and treatment. Staff used Fraser guidelines and Gillick competency principles when assessing capacity, decision making and obtaining consent from children. The 'Gillick Test' helps clinicians to identify children

aged under 16 years who have the legal capacity to consent to medical examination and treatment. They must be able to demonstrate sufficient maturity and intelligence to understand the nature and implications of the proposed treatment, including the risks and alternative courses of actions. Fraser guidelines, on the other hand, are used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment.

Are urgent and emergency services caring?

Good

We rated caring as 'good' because:

- The emergency department provided a caring and compassionate service. We observed staff treating patients with dignity and respect. Patients told us staff were caring, attentive and helpful.
- Feedback from patients, relatives and carers was consistently positive. Patients told us staff in the emergency department kept them well informed and involved them in the decisions about their care and treatment.
- Care was person-centred, and staff were observed to provide care which maintained the dignity and privacy

Compassionate care

- We observed patients being treated with privacy and dignity. When patients had treatments or nursing care delivered, curtains were pulled round and doors closed.
- We observed a number of interactions between staff, patients and relatives. Staff were always polite, respectful and professional in their approach.
- We observed staff responding compassionately to patents pain, discomfort, and emotional distress in a timely and appropriate way.
- Confidentiality was respected in staff discussions with people and those close to them.
- In the CQC's 2015 A&E survey, the service scored seven out of 10 for the question: "Were you given enough privacy when discussing your condition with the receptionist?" and scored nine out of 10 for the question: "Were you given enough privacy when being examined or treated" Both scores were about same as for other trusts.
- In the CQC's 2015 A&E survey, the trust scored the same as other trusts for all of the 24 questions relating to caring. The question " Were you told how long you would have to wait to be examined?" had the lowest score (3.74) and the question "Did doctors or nurses talk to each other about you as if you weren't there?" had the highest score (9.16).
- In the CQC's 2015 A&E survey, the service scored nine out of 10 for the question: "were you treated with respect and dignity while you were in the A&E department and scored 7 out of 10 for the question: "if you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?" Both scores were about same as for other trusts.
- The trust's Urgent and Emergency Care Friends and Family Test performance (% recommended) was generally better than the England average between September 2015 and August 2016. In latest period, September 2016 trust performance was 87.9% compared to an England average of 85.7%. The trend for the percentage recommended follows the England average.
- We spoke with 10 patients and six carers. They were complementary of the staff. Comments included that staff were friendly, and they treated patients with dignity and respect.

Understanding and involvement of patients and those close to them

- Patients told us staff ensured they understood medical terminology and patients were given literature about their condition when required.
- Most patients who used the service felt involved in planning their care, making choices and informed decisions about their care and treatment.
- Staff generally communicated in a way that people could understand and was appropriate and respectful.
- We found medical staff generally took time to explain to patients and relatives the effects or progress of their medical condition and treatment options.
- We observed staff modifying their language, tone and pace of speech to communicate with patients and their relatives to help them understand their care and treatment.

Urgent and emergency services

- Patients and relatives told us they were generally kept informed of what was happening and understood what tests they were waiting for.
- We observed that patients were given a clear explanation at discharge and were advised what to do if symptoms re-occurred

Emotional support

- There was a room for relatives to use if needed. Access to a telephone and drinks were available.
- We observed staff offering emotional support to patients who were anxious. They spent time reassuring them and explaining what was happening and why.
- There was support available for the bereaved from the chaplaincy service and bereavement service.
- The spiritual needs of patients were provided by a 24-hour chaplaincy support that provided sacramental care in the trust chapel and at the bedside and through supporting patients at the end of life.
- Staff showed an awareness of the emotional and mental health needs of patients and were able to refer patients for specialist support if required.

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

(for example, to feedback?)

Requires improvement

We rated responsive as 'requires improvement' because:

- The emergency department performance had deteriorated over the last 12 months. The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the A&E. The trust breached the standard between October 2015 and September 2016.Whilst there are multiple factors that impact upon patient flow it was recognised the most important factor was bed occupancy. Lack of beds in the hospital resulted to patients waiting longer in the emergency department. Bed occupancy levels are were 115 -130% on each site. The aim was to achieve an 85% average occupancy
- Between June 2015 and May 2016, the trust's unplanned re-attendance rate to the emergency department within seven days was generally worse than the national standard of 5% and generally better than the England average.
- A 'black breach' occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. Between August 2015 and July 2016 the trust reported 1210 black breaches. The trust reported 157 black breaches in July 2016 There was an upward trend in the monthly number of black breaches reports over the period.
- Between August 2015 and September 2016 the trust's monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was worse than the England average.
- Between August 2015 and July 2016, the trust's monthly median total time in A&E for admitted patients was consistently similar to the England average. Performance against this metric showed a trend of decline. In July 2016, the trust's median time in A&E was 151 minutes versus the England average of 146 minutes.

However:

- During our inspection we did not witness long waits in the emergency department impacting on patient safety
- The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust met the standard for all months over the 12 month period.
- Between August 2015 and July 2016 the trust's monthly median percentage of patients leaving the trust's urgent and emergency care services before being seen for treatment was better than to the England average for the entire period. The trust's performance followed a similar trend to the England average.
- Services were planned in conjunction with a number of other external providers, commissioners and local authorities to meet the needs of local people.
- There was clear evidence of learning shared and improvements made as a result of listening to complaints and concerns.

- The department had a specific 'dementia friendly' cubicle and there were processes in place for patients who presented with a learning disability or mental health problem.

Service planning and delivery to meet the needs of local people

- Planning for service delivery was made in conjunction with a number of other external providers, commissioners and local authorities to meet the needs of local people. For example, the service worked with external partners including general practices in a programme named integrated care communities. The aim was to proactively plan care for both frail and vulnerable patients and frequent attendees to prevent unnecessary attendances to the emergency department. There were a number of schemes supported by community paramedics and a telehealth project.
- During our visit the department there was times when the department was overcrowded and there was not sufficient number of treatment rooms and cubicles were available. Ambulance staff were in the corridor with patients waiting for a cubicle.
- There was an ambulance triage room which had multiple uses. It was used as a decontamination room, in the event of a patient having had contact with hazardous material, it was also used as a viewing room for deceased patients. The environment was clinical with no comforting features that may help relatives and friends during a difficult time. In the event of it been used as a decontamination or viewing room, the triage had to take place in one of the other cubicles reducing the amount of majors cubicles available.
- Within the waiting room there were a number of notice boards. There was a 'you said we did' board. This contained information from complaints and what had been done to resolve the, for example there had been an increased number of complaints relating to discharges and as a result the discharge processes had been improved.

Meeting people's individual needs

- Separate male, female and disabled toilets and baby change facilities were available in the waiting room. The department was accessible for people with limited mobility and people who used a wheelchair.
- The reception area had a designated hearing loop.
- Within the waiting room there were plenty of seats and two vending machines which sold hot and cold drinks, plus snacks and a cold water machine. There was a large television screens displaying information on waiting times. There was an information boards with posters with contact details of support with drug or alcohol problems and details on how to contact the patient liaison advisory service information.
- There was notice boards which had information including photographs of the matron, unit manager and consultant. There was a description of the different coloured uniforms. A 'how we are doing' board which had results of friends and family tests, cleanliness and hand hygiene score. There was a 'you said we did board', which stated that there had been complaints regarding discharges, and the staff were looking at discharge procedures to try and improve them.
- There was a separate waiting area for children which had toys and books.. There were cubicles that were used for children with minor and major illness or injury, which had colourful pictures.
- The IT system had a flagging system. This included identifying patients with dementia or a learning disability.
- Staff told us if they had a patient with a learning disability they would encourage their carer to stay with the patient to help alleviate any anxieties and try and see the patient as soon as possible. During the time of inspection, we did not see a patient with a learning disability.
- There was a specific 'dementia friendly' cubicle. This was painted a different colour and had a picture on the wall and a clock with clear numbers to help the patient distinguish between night and day. These changes were aimed at reducing anxiety. However, during our inspection we saw patients nursed in this room who did not have dementia (when other cubicles were available), and patients with dementia nursed in another cubicle.
- There was a memory box containing reminiscent objects such as a ration book and old pictures. This was used to reduce patients' anxieties of being in an unfamiliar place. The staff told us this was a helpful tool and patients enjoyed looking through the items.
- We was told the 'Butterfly Scheme' was implemented, which at a glance created discreet identification via the

Butterfly symbol for patients who had dementia-related memory impairment and wished staff to be aware of it. However, we did not see this in use on the patient who had dementia.

- All the trolleys were able to be used for patients with a weight up to 35 stones. A hoist and bariatric wheelchair were available if needed. The department had an electric bariatric trolley which was used for the patients who arrive by helicopter, this could be used for patients up to 50 stone in weight.
- A range of information leaflets were available for patients to help them manage their condition after discharge however, leaflets were available in English only.
- Interpreting and translation services were available. These could be either face to face or by telephone. These could be accessed through two providers to ensure the service was accessible for Lancashire and Cumbria patients.
- A private room was available for relatives and those accompanying acutely unwell patients to discuss sensitive situations. Relatives could access a telephone. Hot and cold drinks were offered and available on request
- A mental health liaison team was based in the department from 8am to 9pm each day and provided assessment for patients with mental health problems. Out of these hours the community based crisis team was contacted. Nurses told us patients often had a long wait to be seen by the crisis team.
- There was not a dedicated cubicle or room used solely for patients with mental health issues. The nurses used the cubicle opposite to the nurses station as this cubicle was observed. The nurses told us they removed any ligature points including monitoring cables. The room was noisy as the main doctors and nurses station was opposite.

Access and 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 breached the standard between October 2015 and September 2016.
- The trust had been performing worse than the England average and the standard for all but three months of the 12 month period. Prior to June 2016 the trust's performance followed the England average trend, after June 2016 the trust's performance showed a downward trend, whereas the England average showed a slight increase.
- The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust met the standard for all months over the 12 month period.
- Between August 2015 and July 2016 performance against this standard showed a trend of improvement. In July 2016 the median time to treatment was 55 minutes compared to the England average of 62 minutes. Trends show that the time to treatment has been slowly increasing over the time period and is in line with the England average.
- Between August 2015 and July 2016 the trust's monthly median percentage of patients leaving the trust's urgent and emergency care services before being seen for treatment was better than to the England average for the entire period. The trust's performance followed a similar trend to the England average.
- Between September 2015 and August 2016 there was an upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes A 'black breach' occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. Between August 2015 and July 2016 the trust reported 1210 black breaches. The trust reported 157 113 black breaches in July 2016 There was an upward trend in the monthly number of black breaches reports over the period.
- Between August 2015 and September 2016 the trust's monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was worse than the England average. Trust's performance improved in May and June 2016 but declined from July 2016 onwards.
- Between August 2015 and July 2016, the trust's monthly median total time in A&E for admitted patients was consistently similar to the England average. Performance against this metric showed a trend of decline. In July 2016, the trust's median time in A&E was 151 minutes versus the England average of 146 minutes.

Urgent and emergency services

- In the CQC's 2014 A&E survey, the service scored eight out of 10 for the question: "Overall, how long did your visit to the A&E Department last?" This was about the same as other trusts
- During the inspection, we observed flow of patients and reviewed current information on waiting times. We observed the time patients waited in the waiting room. The longest the patients waited was 20 minutes.
- We observed ambulance handovers. There were no delays in ambulance handover times during our visit.
- The bed management team observed flow within the emergency department and meetings took place at least four times a day (more frequently if needed) jointly with Furness General hospital to understand the bed situation and enable planning for expected admissions and discharges, ensuring patient flow throughout the hospital was timely.
- An escalation process was in place that gave staff actions for how to manage the department during periods of extreme pressure. This would involve help from the wider hospital teams, including bed managers, matron and service manager improving the patient flow throughout the hospital and specialist teams reviewing patients in the ED..
- There was an escalation policy. This provided guidance on when and how to implement the escalation policy, to ensure safe working when the department was full or the hospital bed state was preventing flow of patients through the department.
- Patients who were referred by their GP with a medical problem, went straight the acute medical unit for assessment, this reduced the number of patients attending ED.

Learning from complaints and concerns

- The department had a complaints response process that addressed both formal and informal complaints, which were raised via the Patient Advocacy and Liaison Service (PALS). Complaints were investigated by either the matron, the unit manager or the clinical lead and discussed if appropriate with the concerned patient/ family as soon as possible after receiving the complaint with the aim of rapid resolution of the problem. All complaints were answered fully with an assessment of root causes made.
- Response letters to complainants included an apology when things had not gone as planned. This is what we would expect to see, and is in accordance with the expectation that services operate under a duty of candour.
- Between 27 October 2015 and 27 October 2016 there were 60 complaints about Urgent and Emergency Care services. The trust took an average of 23.02 days to investigate and close complaints; this is in line with their complaints policy that states that this should be done within 35 working days from receipt of the complaint, unless another timescale has been agreed with the complainant. At Royal Lancaster Infirmary emergency department there were 43 complaints. The overriding theme was patients being unhappy with the care and treatment they received.
- Learning from complaints was discussed individually, displayed on a notice board in the staff area, discussed in the clinical governance group meetings and departmental meetings.
- Patients and relatives we spoke with were confident about how to make a complaint to the trust although none of the people we spoke with complained about the department.

Are urgent and emergency services well-led?

Good

We rated well-led in the emergency department as 'good' because:

- The management team had strengthened the 'cross bay' working since our last inspection and learning from incidents, sharing best practice and cross sight working had improved
- There was a clear statement of visions and values across the trust, driven by quality and safety. These mirrored the aims and objectives of the trust.
- Divisional managers expressed their overreaching vision was to deliver a quality and safe service. They were aware of the challenges faced within the service and had strategies in place to help over come them.
- There were governance, risk management, quality measurements and processes in place to enhance patient outcomes.

Urgent and emergency services

- The emergency department had a clear management structure at both divisional and departmental level. The leaders within the department were knowledgeable about quality issues and priorities; they understood the challenges and were taking action to address them.
- Staff described the culture within the service as open and transparent. Staff were able to raise concerns and felt listened to and leaders were visible and approachable.

Vision and strategy for this service.

- Senior staff spoke positively about the board's vision and strategy 'Better care together' which outlined new plans of delivering health care. The strategy aimed to reduce the number of patients needing to attend hospital, by working collaboratively with GP's and local health and care providers to review how services were delivered.
- The vision and strategic goals for the division mirrored the aims and objectives of the trust, ' to constantly provide the highest possible standards of compassionate care and the very best patient and staff experience by involving patients, staff and partners.'
- Divisional managers expressed their overreaching vision was to deliver a quality and safe service
- The divisional strategy had short, medium and long-term projections. In the short to medium term, the division were keen to improve patient flow through a number of options by working with partner organisations. In the medium to longer term, the division were working with the collaborative to develop and further the 'Better Care Together' agenda aligned to the NHS Five Year Forward View.
- The division ambitions, service priorities and principles of working in the coming year were incorporated in the trust priorities for 2016//17 of strategy, engagement, quality and safety, partnership and performance.
- The majority of staff understood the vision and it was well presented around the trust and staff were able to tell us about trusts values.
- Staff were aware of the trust's values and felt that patient safety and quality care should be at the heart of everything they do; we heard this from staff at all levels.

Governance, risk management and quality measurement

- Urgent and emergency care was part of the medicine division. Each clinical division was headed by a clinical director, supported by a divisional general manager and an assistant chief nurse.
- The division had clear governance channels into the wider organisational management structure. The medical division governance was clinician driven with multi-specialism input.
- The governance and assurance framework permeated all levels within the division and was well embedded throughout despite the recent creation of the governance directorate.
- A governance system was in place and the agenda items of the emergency department governance meetings included discussions of incidents and complaints.
- A monthly emergency department senior team meeting took place that discussed, performance data, staffing and training.
- Staff were clear about the challenges the department faced and they were committed to improving the patients' journey and experience. These meetings reported into the divisional governance and assurance group, the divisional management board and the divisional performance meeting.
- The department risk register was available and was continually under review to ensure it reflected current risks relevant to the operational effectiveness of the department. Seven risks were recorded on the department register at the time of our inspection. Each risk was graded, dependent on severity. These included nurse staffing and failure to triage in 15 minutes. The risks present on the register reflected the views of the staff we spoke to at all levels
- There was a divisional risk register of which seven risks scored 16 to 20. These included staffing, missed fractures and patients staying in the department longer than four hours.
- When we spoke with the senior management team, they were able to clearly tell us about the risks posed to the department and how these were being addressed. For example, relating to the recruitment of nursing staffing and patient flow through the department to the rest of the hospital. There was consistency and alignment in what the division was concerned about and what appeared within the risk register. Senior managers were open and honest about those and their plans to address perceived shortfalls in areas of concern.

- The division monitored risk register key performance indicators. Managers completed 90% of risk reviews on time, 79% of risks had on-going or open actions and 98% of open actions had progress reported.
- The division were actively working to address areas previously highlighted for improvement and press was monitored in the CQC action plan. The division also had a 'journey ahead' plan which brought together the organisation objectives, divisional strategy, key priorities and governance framework.
- The department took part in RCEM audits and other locally agreed audits.
- The department had operational performance and quality dashboards .
- The department had a clear plan for internal audits in relation to continuously improving performance in key areas such as sepsis treatment and managing major trauma patients.
- The divisional dashboard was compiled monthly and reported key performance indicators which were discussed at performance review meetings
- The matron's dashboard was used to measure and monitor quality and safety performance on a monthly basis and was used as a basis for clinical governance meetings with the focus on continuous improvement of the service.

Leadership of service

- The management team had strengthened the 'cross bay' working since our last inspection and learning from incidents, sharing best practice and cross sight working had improved
- The division had a clear management structure defining lines of responsibility and accountability. The division was led by a clinical director, a divisional general manager and a chief nurse.
- The division had recently brought together medicine and acute medicine under one management structure cross-bay. A deputy chief nurse, deputy divisional general manager, six matrons, five service managers and a designated divisional governance lead further supported the divisional management structure.
- The emergency department had a clear management structure at both divisional and departmental level.
- The nursing team was established with experienced staff who provided clinical and professional leadership by supporting and appraising junior staff. Staff were given identified roles on each shift and there were clear lines of accountability. From our discussions with staff, the local leadership was strong, supportive and staff felt they were listened to and felt valued.
- The medical team had responsibility for audits in the department.
- Staff were motivated and described a supportive team-working environment
- Staff commented that the matron was visible and staff we spoke to said that their leaders were approachable and visible and they felt confident that they could voice concerns openly and they would be listened to.
- During our interview with the leaders of this service they displayed a thorough understanding of the improvements that were needed to strengthen the quality of their service.

Culture within the service

- We found the culture of the department open and inclusive. The majority of staff that we spoke to felt that they were valued and respected by their peers and leaders.
- The majority of staff told us it was a good place to work. They felt supported in their work and there were opportunities to develop their skills and competencies, which were encouraged by senior staff.
- There was a desire from all staff we spoke with to provide effective care and treatment to patients.
- We observed staff working well together and there were positive working relationships with the multidisciplinary teams
- We observed staff being flexible and helping in the different parts of the department which were busy to provide a better and more responsive service for patients
- We asked staff at all levels about the morale of the department and they all said that morale was generally good and they worked as a team. There was a consensus that morale tended to be lower when the department was full and staff were under pressure.
- We saw evidence of how the service is working towards meeting the requirements related to the Duty of Candour and examples of where this had been carried out. Staff we spoke to felt that identifying when something went wrong could help them to improve patient safety and that when this did occur individuals involved were well supported through reflection, supervision and training and learning was shared.

- The department's meetings and notice boards highlighted improvements and changes made through learning from complaints and incidents and also provided information to support the health and wellbeing of staff.
- Staff at all levels also told us that although achieving targets was important they were not afraid of breaching a target if it meant that the patient was safe and received the correct care including admission to an appropriate speciality.

Public and staff engagement

- Patients and those close to them were given the opportunity to provide feedback through the friends and family survey.
- The trust had an initiative were 'mystery customers' visited the departments and provided feedback on standards of care and service delivery
- There was a quality board in the waiting room which displayed information about the departments audits. This included ' you said we did,' giving examples of suggestions the public had made and what actions the department had taken as a result of the suggestions.
- Staff were encouraged to share experiences and comment on changes and ideas for improvement through the 'theme of the week' initiative. This allows staff to say how they think something may work better.
- We spoke to a patient flow coordinator which was a new role being trialled to improve the flow of patients through the department and enhance communication with the rest of the hospital. This was trialled as a result of listening to staff.
- We saw evidence of staff receiving recognition for their contribution to the service through internal annual awards ceremonies.
- The division provided staff with information via WESEE, newsletters, internet updates and email on trust developments, clinical issues, patient themes and staff recognition.
- In the NHS Staff Survey 2016, the trust performed worse than other organisations in the question 'staff experiencing harassment, bullying or abuse from other staff in the, last 12 months' (29% compared to England average of 26%). Staff we spoke with did not report any incidents of this nature to us during the inspection.

Innovation, improvement and sustainability

- There was much improved cross departmental working with Furness General Hospital since our previous CQC inspection, allowing the sharing of best practice, education and lessons learnt.
- A formalised handover process had been developed since our last CQC inspection for the medical staff which occurred at 8.30am and 2pm.
- Training was given using simulation equipment on an ad-hoc basis. This training included scenarios of resuscitations with learning points discussed at the end.
- There were 'listening into action' schemes where staff discussed issues and looked at resolutions. An example was blood samples were at times haemolysed and could not be analysed when they reached the pathology/haematology department, this delayed a patients time in the department.

Medical care (including older people's care)

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

Information about the service

The medicine division ("the division") incorporated acute medical services, emergency care, elderly care,and speciality medicine cross-bay,with a combined management team. The division provided 330 inpatient beds. There were no day case beds. The division reported over 36,500 admissions into the service from April 2015 to March 2016;an increase of 2% from the previous year. These admissions can be broadly broken down into emergency admissions (56%), day case (43%),and elective (1%). Admissions for the top three medical specialisms were general medicine (19,206), gastroenterology (5,393) and medical oncology (3,606).

Royal Lancaster Infirmary (RLI), situated in the city of Lancaster, has occupied its current site since 1896 and is the largest of the hospitals in the trust. The division at RLI provides treatment for patients requiring cardiology, gastroenterology, general medicine, medical oncology, respiratory medicine stroke and older persons care. At the time of our inspection there were 198 medical beds located at RLI across the division: Acute Medical Unit (AMU); Cardiac Care Unit (CCU); Ward 20; Ward 22; Ward 23; Ward 37; Ward 39 ("The Lancaster Suite"); and the Acute Frailty Unit (AFU). The division also provided care in the oncology unit, dermatology unit, ambulatory care unit, endoscopy suite, day treatment centre, and clinical investigations unit (CIU).

During our inspection we spent time at RLI visiting all wards and units. We spoke with 49 members of staff (including managers, doctors, nurses, therapists, pharmacists, and non-clinical staff). Where appropriate we considered care and medication records (including electronically stored information),and we completed 20 reviews. Our team met with 16 patients and relatives, and observed shift handovers, multi-disciplinary team meetings (MDT), safety huddles, meal times, and care being delivered at various time of the day and night.

Medical care (including older people's care)

Summary of findings

This servicehad been inspected as part of our comprehensive visit in July 2015. Overall, medical care at RLI wasthen rated as 'requires improvement'. A number of areas for improvement were highlighted, and the service was told to take action to:

- Ensure care and treatment was provided in a safe way through the assessment of risks to the health and safety of patients receiving care and treatment in accordance with the Mental Capacity Act 2005;
- Ensure staff understood their roles and responsibilities in relation to the Mental Capacity Act 2005;
- Ensure care and treatment was provided in a safe way through the proper and safe management of medicines;
- Ensure premises being used were fit for purpose and properly maintained;
- Ensure the service maintained an accurate, complete and contemporaneous record in respect of each patient. In particular, the completion of fluid intake charts and medical notes; and
- Ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to meet the needs of the patient.

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

- There had been a reduction in patient harm related incidents, particularly around pressure ulcers and falls.
- There had been improvements made in the clinical environment to support better care delivery.
- Although still a number of nursing and medical staffing vacancies, the trust had robust systems in place to manage staffing shortfall and had extended their recruitment reach with the appointment of a number of international nurses.
- The service had improved compliance against mandatory training and appraisal targets which had seen an increased uptake in Safeguarding (incorporating Mental Capacity Act 2005) training. Local support and supervision of junior staff had improved with the implementation of 'Professional Forums'. The features of this covered facilitated group sessions, reflective practice and a redeveloped preceptorship programme for newly qualified nurses.
- Overall, medicines management was good.
- There had been a marked improvement in record keeping standards following a continued programme of training. The division scrutinised audit figures and targeted areas of lower compliance with support from matrons and practice educators.
- The service had developed an action plan to address and progress areas for improvement highlighted in the 2015 inspection.

At this inspection we rated medical care (including older people's care) as'good'overall, with safe as'requires improvement', because:

- Staff understood their responsibilities to raise concerns and report incidents. The division had reported a reduction in patient harm related incidents. Senior staff managed nurse staffing shortfalls proactively and there were robust escalation processes in place to deal with nurse staffing concerns.
- Staff delivered evidence based care and the division were actively involved in local and national audit. There were some positive patient outcomes recorded in a number of national audits and there was good evidence of collaborative and effective multi-disciplinary team working.
- The division were passionate to deliver quality compassionate patient care and we observed this care being delivered. Patients were complimentary about the care they received and felt informed about treatment and management plans.
- The division reported excellent referral to treatment time figures across all specialisms. The division was responding to the internal and external demands placed upon it by developing a number of services and care pathways to reduce unnecessary hospital admissions. There was a positive drive to engage with partner organisations to maintain and further

Medical care (including older people's care)

services for the benefit of the population in the short, medium and long term. Staff made reasonable adjustments in response to individual patient needs and to accommodate vulnerable patient groups.

- Managers led the service well. The divisional strategy reinforced with the trust vision and aligned with the on-going work with partner organisations. Staff felt a real and palpable shift in divisional culture referring to a 'new energy', openness and a team approach in dealing with issues faced. Organisational governance structures had been encompassed within the division and there was evidence to show how this supported divisional governance processes.
- There were many excellent examples of improvement projects and innovative strategies which brought about changes in clinical practice, work efficiencies, improved patient care and delivered organisational benefits.

However:

- Fall related incidents remained a concern despite reducing numbers of patient related harms. The process of capturing the multi-factorial falls risk assessment was unclear and inconsistently applied. This was compounded by the recent transition of the core safety bundle from paper records to the electronic patient record.
- Some medicines related record keeping standards required improvement, in particular, around the recording of patient allergies and oxygen prescribing.
- There remained a significant number of nursing vacancies and there was a reliance on senior locum medical cover across many sub-specialisms at RLI. The division were actively recruiting to vacant posts however many remained unfilled.
- The division had some static patient outcome measures in stroke services at RLI. These findings were across a number of domains and the division had action plans in place to address areas for improvement.
- In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 0%. This placed the trust within the lowest 25% of all trusts for this measure. The 90-day post-operative mortality rate was not reported. The proportion of patients treated with curative intent in the Strategic Clinical Network was 38.9%, in line with the national aggregate.
- Seven day services were not fully embedded and the division fell below national averages on a number of key metrics in the NHS Services, Seven Days a Week Four Priority Clinical Standards. The division were involved with the trust task group looking at seven day working across the organisation.
- A combination of factors including extended length of stay, increasing bed occupancy levels and delays in obtaining suitable community care placements were causing access and flow difficulties at RLI. This had led to significant numbers of patient moves after 10pm and a number of medical outliers encroaching into other services. Divisional managers were working with partners looking at all variables affecting patient flow.
- To achieve the divisional strategic objectives, the service identified staff engagement as one of the key priorities. Clinical leaders recognised there was a risk of staff becoming fatigued and less resilient to deal with the pressures of working demands in the current climate. Staff considered the division managers could do more in terms of recognition and support for their wellbeing.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

We rated safe as 'requires improvement' because:

- The division continued to report a number of fall related incidents at RLI.
- There was some confusion surrounding the completion of the multifactorial falls risk assessment compounded by the transition from paper records to the electronic patient record. Therapists coordinated such assessments and these were discussed at daily board rounds and multi-disciplinary team meetings. Nursing staff however could not provide evidence in the electronic patient record to confirm the assessment had been completed in all cases.
- Equipment storage on some units led to areas of the ward becoming cluttered.
- We found some medicines related documentation required improvement in relation to the recording of allergies, venous thromboembolism risk assessment, oxygen prescribing and antibiotic prescribing procedures.
- We found some patients lacked individualised care plans and trigger levels used to support escalation of care for a deteriorating patient were not always followed.
- The division had a number of registered nurse vacancies across the wards at RLI. Escalation processes secured bank staff and ward managers forewent managerial shifts to support clinically. Despite active recruitment campaigns, a number of shifts remained unfilled and care support workers were used to back fill registered nurse gaps. This was reflected in shortfalls of planned and actual staffing, ratios, skill mix figures and fill rates.
- The division was reliant upon the goodwill of staff and locum use to cover the medical rota. Consultant medical staffing across a number of sub-specialisms was deficient and there was a reliance on senior locum appointments. Further senior medical staffing depletion would render the service vulnerable and at risk.

However:

- Staff confidently reported incidents and had an awareness of the Duty of Candour regulations. There were no never events in the division and a low number of serious incidents.
- The division recorded safety thermometer data and displayed results on wards, There had been a reduction in patient harm incidents related to falls and pressure ulcers. The prevalence of catheter acquired urinary tract infections had also reduced over time.
- Staff were conversant with infection prevention and control guidelines. Staff used personal protective equipment appropriately, isolation nursing procedures were followed and waste and sharps disposal was in accordance with trust policy. Ward cleanliness and hand hygiene audit findings were consistently good.
- There had been considerable environmental improvements across a number of ward areas and additional equipment purchased to support patient safety.
- Nursing and medical documentation was legible, up-to-date and there was evidence of consultant led review. Initial core safety bundle risk assessments were completed thoroughly and in a timely manner.
- Overall, medicines management, storage and safety was good.
- Staff responded to patient risk using a combination of clinical judgment, early warning trigger tools and treatment pathways. Audit compliance against key observation recording indicators was good.
- Nurse staffing requirements were calculated using a recognised acuity tool. The division also cross-referenced staffing ratios and qualified to unqualified skill mix. The division increased staffing levels in high dependency areas according to recognised multipliers. The division advertised nurse vacancies and were actively recruiting registered nurses from overseas. The division had clear escalation criteria for staffing concerns and where managers considered patient safety was compromised beds were closed.
- Medical staffing vacancies and rota gaps were covered by existing medical personnel in post with support from a number of locum appointments. Medical staffing out-of-hours and at weekends was appropriate for the unit at RLI and junior grades felt supported from senior colleagues and consultants.

Incidents

Medical care (including older people's care)

- The division reported incidents through the trust electronic reporting system.
- The division graded incidents according to risk rating and severity of harm in accordance with their policy on 'Reporting and Management of Incidents including Serious Incidents'.
- Such reported incidents were then categorised according to severity ranging from no harm, low, moderate, severe and fatal. Ward managers, matrons and patient safety team reviewed submitted incidents and grading of harm. All incidents graded moderate or above were reviewed at the weekly patient safety summit (WPSS).
- Between September 2015 to August 2016, the division overall reported 2,952 incidents, a third of all incidents recorded by the trust. Of incidents recorded across the division, 1,911 (65%) were no harm, 927 (32%) were recorded as low harm, 52 (2%) were rated moderate and less than 1% were classed as severe. The division reported no fatal incidents.
- Ward managers, matrons and divisional leads all Staff monitored incident trends and themes. The most common incident type within the moderate harm severity category related to slips, trips and falls accounting for 39% of all reported. Slips, trips and falls were also the highest contributor to the severe harm category accounting for 50% of all reported.
- We reviewed five incident investigation reports/root cause analysis (RCA) documents. We found the investigation reports to contain relevant history, detail surrounding the scope and level of investigation, timeline, findings and areas of good practice/concern. Actions were identified and progressed with evidence of lessons learnt.
- In accordance with the Serious Incident Framework 2015, medical care services at RLI reported four serious incidents (SIs) which met the reporting criteria, set by NHS England, between November 2015 and October 2016. Of these, the most common type of incident was slips/trips/falls meeting SI criteria accounting for 75% of those reported. There were no SIs reported between August 2016 and October 2016.
- Staff confidently reported incidents and provided examples of incidents they would report. These primarily focussed on patient safety matters such as falls, pressure ulcers, near misses and medication errors.
- Between November 2015 and October 2016, RLI reported no incidents which were classified as 'Never Events' for medical care. Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. . Although each Never Event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorized as a Never Event. (Strategic Executive Information System, STEIS).
- Staff we spoke with explained they received feedback on incident outcomes by e-mail, at 1:1 sessions, at ward meetings,and at safety huddles.
- Staff reported all PUs irrespective of grade or classification. The tissue viability nurses (TVNs" received all reported PU incidents. The TVNs completed a further assessment of the incident and graded according to severity. The TVNs aimed to respond to all PUs classified as 2 or above within 48 hours however it was not currently possible to meet this timeframe on all occasions due to the need to provide cross-bay cover, annual leave and workload generally. The TVNs worked with medical photography to obtain images so these could be reviewed remotely and when not on site.
- Staff we spoke to knew of the Duty of Candour (DoC) requirements and of the trust policy. 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 those persons.
- Junior staff understood that this involved being 'open and honest' with patients. Ward managers were aware of the Duty of Candour and some staff explained to us that they had been involved in investigating and responding to patients and families under this duty.
- Where staff considered DoC may apply to submitted incidents, this was discussed and confirmed by the WPSS team. The completion of the DoC requirements was monitored monthly by the Patient Safety Team.
- The division completed a quarterly audit of DoC completion which was presented to the serious incident review and investigation panel then onward to Quality Assurance Committee and the Board as part of the quarterly incident report.
- The division shared learning from incidents and when things went wrong at all levels. Management discussed outcomes at divisional meetings, matrons and ward

managers shared learning and cascaded key information to their staff at ward meetings, safety huddles, by email, and through bulletins and newsletters.

- The division heldweekly mortality review meetings. Staff considered data relating to all deaths in the preceding month,and audited a number of cases (between Apriland June 2016;64% of all medical deaths were audited by the group). The group discussed individual cases such as unexpected deaths, relevant factors and comorbidities, considered preventability and identified issues and actions to support learning. The group reviewed feedback from national enquiries (NCEPOD) to improve care and reinforce good practice. Learning from the mortality group was shared at ward governance meetings, for example, cautions and indications in the use of antiplatelet medication and early identification of the most appropriate care environment to avoid unnecessary hospitalisation.

Safety thermometer

- Safety thermometer is used to record the prevalence of patient harms at the frontline, and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.
- Data collection takes place one day each month – a suggested date for data collection is given but a ward can change this. The trust must submit data within 10 days of suggested data collection date.
- Data from the Patient Safety Thermometer showed that the division reported 36 pressure ulcers, 18 falls with harm and 17 catheter urinary tract infections (CUTIs) between September 2015 and September 2016. The prevalence rate of pressure ulcers (PUs) rose between August 2015 and March 2016, after which the rate started to fall. Both prevalence rates for falls and CUTIs saw a reduction over time.
- From August 2015 to August 2016, the proportion of patients who received harm free care averaged 92.6%, slightly worse than national figures for the same period (NHS Safety Thermometer).
- Senior nursing staff considered PUs and falls reduction to be a key priority.
- Between July and September 2016, the trust reported a total of 326 PUs. 72 (22%) of all recorded PUs during this period were hospital acquired. Compared to figures in the first quarter of 2016 (April – June), the trust has seen a 26.5% reduction in the number hospital acquired PUs. During this period there were no grade 3 or grade 4 PUs recorded.
- Staff at RLI reported 37 hospital acquired PUs (51%) across all medical wards. The highest numbers were recorded against ward 20, accounting for 22%.
- The division monitored falls prevalence and classified falls according to harm. The National Audit of Inpatient Falls (NAIF) 2015 showed that the number of falls per 1000 patient occupied bed days (OBDs) was higher than national average (9.96 against 6.63) and within the North West region, the trust reported the second highest prevalence. The trust reported falls with moderate or severe harm to be 0.17 per 1000 OBDs, lower than the national average of 0.19 and regionally rated 15 out of 20 trusts.
- The NAIF also collected data on whether patients had been assessed for all the risk factors and whether there had been appropriate interventions implemented to prevent falls. Compliance was reported using a 'red/amber/green' (RAG) rating. At RLI, NAIF auditors found no green indicators and identified areas for improvement across all seven indicators - the assessment of delirium, blood pressure, medication, vision, mobility aids, continence and call-bell factors.
- Between July to September 2016, the division reported 291 falls, a reduction on the previous quarter and a 13% reduction for the same period in 2015. 185 (63.6%) of reported falls came from RLI, the majority from ward 20 and ward 39. 80% of the falls resulted in no harm, 18% were reported as low harm and 2% was moderate. There were no major or severe classified falls.
- Matron's remotely monitored clinical indicators and risk assessment completion across their unit on the electronic patient record (EPR). This showed when individual risk assessments were last completed, which staff member completed them and when they were next due for assessment. Matrons attended units where risk assessments were incomplete, due or late to ensure immediate completion. Matrons also attended ward meetings and safety huddles to discuss risk assessment completion and compliance. Matrons were unable to confirm if a multi-factorial risk assessment had been fully completed by remote review and confirmed this would necessitate a review of the full record.

Medical care (including older people's care)

- We found safety thermometer information displayed clearly and consistently in an accessible and readable format on large whiteboards situated at the entrance of all wards.

Cleanliness, infection control and hygiene

- The division followed the trust healthcare associated infection (HCAI) prevention and control strategy underpinned by national guidelines and IPC policies to manage and monitor infection essential for patient and staff safety.
- All wards we visited were visibly clean and tidy.
- The division were involved in the trust wide QAAS (Quality Assurance Accreditation Scheme) to support in the measurement of quality and effectiveness of care. This included monitoring of the ward cleanliness and infection prevention and control procedures such as handwashing and compliance with cleaning schedules. Wards were rated according to compliance against national and best practice standards on a scale of good to inadequate. There were no wards at RLI rated inadequate. Where wards were rated 'requires improvement', action plans were implemented and revisited the following month to ensure full compliance.
- All clinical and non-clinical areas had specific cleaning rotas and all equipment checked was visibly clean. All clean utility areas and treatment rooms were visibly clean and tidy. We observed clinical waste and sharps been disposed of appropriately. Commodes had green stickers placed on them to indicate the time and date they had been cleaned. Staff told us the correct procedure for cleaning the commodes.
- Wards we visited displayed the number of and date of last case of Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C. difficile). There had been no reported cases of c.difficile across the division between July and October 2016.
- The division supported the trust's agenda to ensure effective prevention and control of healthcare associated infections (HCAI) including CUTI's. Staff referred to infection prevention and control team (IPC), procedure and policy when providing care for patients with indwelling catheters.
- The trust monitored hand hygiene compliance during monthly audits. Overall, division compliance between May to October 2016 averaged 97.5% against trust target of 96%. In September, all medical wards at RLI reported ward cleanliness and hand hygiene audit scores in excess of 95%.
- All staff completed an annual aseptic non-touch technique (ANTT) practical assessment and e-learning module. Managers reported compliance across the division at RLI was in excess of 95%.
- The wards displayed clear instructions and signage to encourage staff and visitors to wash their hands on entering the ward. The signage was repeated throughout the ward environments and there were numerous washbasins for handwashing. Wards provided wall mounted gel and soap for ease of use. Each patient had a personal bedside hand cleaning gel.
- We observed that personal protective equipment (PPE) such as disposable gloves and gowns were available to staff. Staff used PPE appropriately.
- We observed patients requiring isolation nursing cared for in side rooms. Staff displayed appropriate signage advising staff and visitors not to enter without appropriate protective clothing. We observed staff using appropriate protection when entering the room and disposing of the same appropriately when they left.
- We observed staff carrying out hand washing prior to and after patient contact. Staff adhered to the "Bare below the Elbow" protocol.
- IPC training was mandatory within the trust and comprised level 1 and level 2 core skills. 90% of staff in the medical division at RLI had completed this training so far this year. Staff accessed IPC staff for advice and guidance when required.
- The endoscopy suite had disinfection facilities and centralised decontamination services on site.
- The division contributed to the Patient Led Assessment of the Care Environment (PLACE) 2016 survey. In the cleanliness category, the trust scored worse than national average (95% compared to 98%).

Environment and equipment

- The hospital had been developed and expanded over many years from its original site in 1896. There had been considerable investment to improve internal facilities and external structure in a number of areas across the medical division.
- The division project to improve facilities for patients requiring stroke care will see a new acute stroke unit

built during the winter 2016. This had also allowed the development of the division CCU from its previous eight beds to an 11 bedded area adjacent to the new Lancaster Suite.

- The Lancaster Suite did not have a designated nursing base for private work related discussions and staff could not readily observe patients when not in a bay due to a lack of windows.
- The division opened a new frail elderly unit (AFU) for older person's care in March 2016 and physiotherapy services in medical unit one will move into a new therapies unit in medical unit two in 2017. This move allowed the division to develop a new diabetic centre on the old medical unit one site. The AFU comprised three five bedded bays and lacked individual cubicle areas for those patients who required isolation. There was no designated therapies area and bed space was limited.
- The CIU had purchased additional cardiac and respiratory investigatory equipment to coincide with hardware across other sites providing consistency across the service.
- Where ward doors were not closed or secured by way of remote monitoring, we were greeted and asked to provide identification.
- All patients had designated bed space which included a personal locker, table, call bell and access to gender specific toileting and bathing facilities.
- The division was involved in the trust-wide QAAS (Quality Assurance Accreditation Scheme) to support in the measurement of quality and effectiveness of care. This included '15 steps' (an assessment of the environment from the patient's perspective), monitoring of the ward environment and equipment such as oxygen, suction and resuscitation equipment. Wards were rated according to compliance against national and best practice standards on a scale of good to inadequate. In September 2016, there was one ward at RLI rated inadequate. On ward 23, auditors found some alcohol rub dispensers empty, a lack of labelling on ward equipment confirming it had been cleaned and a number of areas on the ward to be cluttered. Where wards were rated 'inadequate' or 'requires improvement', action plans were implemented and revisited the following month to ensure full compliance.
- During our visit to ward 20, we found the ward environment housed a lot of equipment. This led to some areas of the ward to appear cluttered with access restricted. Additionally, we noted each of the four bays (comprising four or six beds) shared a single oxygen and suction point. This was mirrored on ward 22. Both units did have portable oxygen and suction available if required.
- We checked the resuscitation trollies on all the wards we visited and these contained correct stock. Staff checked the electrical equipment daily (defibrillator and portable suction/oxygen) and after use. Staff completed fuller weekly content checks of all stock including emergency drug expiry dates. We saw each resuscitation trolley had a log attached to it for staff to complete. We found all checks completed accordingly. Trollies were fitted with a tamper proof tag.
- Staff told us the medical devices department coordinated the monitoring of equipment and calibration checks where necessary. We reviewed service and maintenance schedules provided by the medical engineering department which were all current and in line with trust target capture rate for all devices. All equipment we checked had safety-testing stickers in date which assured staff the equipment being used was safe and fit for purpose. Staff confirmed where equipment had not been routinely checked, they ceased to use it until they received medical engineering department approval.
- The division provided seven day endoscopy services at RLI. The unit was JAG accredited (Joint Advisory Group on GI Endoscopy providing formal recognition of competence to deliver services against recognised standards). In the last six months, the service decommissioned a number of endoscopes due to equipment wear and tear. Replacement endoscopic equipment was secured by the unit and other endoscopes are shared cross-bay with their units at Westmorland General Hospital ("WGH") and Furness General Hospital (FGH).
- Staff provided patients at risk of developing pressure sores with appropriate pressure relieving support surfaces such as mattresses and cushions in accordance with their assessed risk.
- For those patients who were admitted into hospital with pressure sores or developed skin damaged whilst in hospital, access to higher specification mattresses were available through TVN or equipment stores. The TVN team had developed a PU equipment pathway to assist staff in identifying the most appropriate pressure relieving equipment for their patient and how to access.

- The TVN team purchased additional pressure relieving equipment to support patient comfort and skin integrity such as the 'Repose Wedge' (air filled wedged used as a pillow, for foot support or to aid positioning).
- The division contributed to the Patient Led Assessment of the Care Environment (PLACE) 2016 survey. In the facilities category, the trust scored worse than national average (90% compared to 93%).

Medicines

- Medicines on the divisional wards at RLI, including intravenous fluids, were appropriately stored and access was restricted to authorised staff however we found a treatment room on ward 37 lacked an external door. All medicines were stored in locked cupboards. Staff did not consider this to be a risk to patients. Ward staff confirmed this had been reported to the estates department.
- Controlled drugs were managed appropriately and accurate records were maintained in accordance with trust policy, including regular balance checks.
- Patients told us they received their medicines at the right times, including pain relief, and doctors explained any changes to their medicines. We found the prescribing of oxygen was poor. We reviewed four patients who were receiving oxygen and found this had not been prescribed on their medicines chart.
- Medicines requiring refrigeration were stored securely. We found some omissions in daily temperature recording however readings remained within the upper and lower safe ranges. On AMU and ward 37 we found entries outside the prescribed upper and lower limits however there was nothing recorded to confirm what action had been taken to maintain medicine safety. Staff confirmed when temperature ranges were outside the limits, pharmacy would be alerted and medicines would be removed and stored in another medicines fridge.
- We checked medicines and equipment for emergency use and found they were readily available and stored appropriately. Staff carried out checks to ensure these were in place and fit for use in accordance with trust policy.
- There was a designated pharmacy team on medical unit 2, based on ward 22. This was primarily used to facilitate the prompt turnaround of medications for discharge.
- Staff we spoke with knew how to report incidents involving medicines. There was an open culture to incident reporting and staff received support from ward managers to learn from incidents.
- We reviewed 20 medication charts and overall documentation was variable. Medical and nursing staff completed the charts legibly with the names of the prescribed medication clearly written.
- We found three charts (15%) where the recording of allergies was not completed. There were four charts/ patient records (20%) where we could not evidence completion of a venous thromboembolism (VTE) assessment. There were two charts where antibiotics had not been prescribed in accordance with recognised guidelines; one with the indication omitted and the second with the route of administration missing. These were brought to the attention of staff and rectified immediately.
- We observed and were informed of the processes involved for the safe handling, management and disposal of cytotoxic medications on the oncology day unit.
- The division completed a monthly QAAS documentation audit against 12 key standard indicators which included a review of medication charts, legibility, patient demographics, allergy status and omissions. Between July and September 2016, auditors reported average compliance across to be 90%. Auditors highlighted the legibility of some written entries needed to be clearer.

Records

- The division were going through a transition from paper to electronic patient record (EPR). Wards were at various stages of implementation with nurse documentation and medical records remained in the written form.
- Where paper records were being used we found these to be stored safely in portable locked cabinets or in areas manned by staff.
- We reviewed 20 sets of nursing and medical records. Overall, the records were legible and up-to-date with evidence of regular consultant led review. Senior medical staff recorded clear management and treatment plans. Staff recorded MDT discussions detailing progress, input from therapies, discharge plans and dialogue with family. This was consistently good across all wards.
- We found nursing records overall to be up-to-date,with evidence of regular care reviewgenerally completed at

the end of every shift. We found the initial risk assessment care bundles(comprising falls, nutrition, pressure ulcers,and sepsis)had been completed in all cases. Where a falls risk assessment identified a risk and directed the need for a multi-factorial falls risk assessment, staff were unclearwhether this had to be completed on the EPR orshould be actioned and recorded in the medical records. We reviewed therapy entries in the EPR referring to falls risk,however, staff were unable to confirmwhether these entries equated to the formal multi-factorial falls risk assessment. Staff confirmedthat falls risk was discussed at safety huddles and during MDT meetings.

- Five sets of records (25% of those reviewed) were deficient to varying extents. Our review highlighted two particular themes:a lack of personalisation and individualisation of some nursing care plans;and a failure to escalate care in accordance with National Early Warning Score (NEWS) triggers.
- The division completed a monthly QAAS documentation audit against 12 key standard indicators such as legibility, demographics, care bundle and paper record (fluid charts, observation charts, food charts and risk assessments) completion. Between July to September 2016, auditors reported variability in compliance against criteria. Legibility overall was very good (96%), completion of care bundles were good (88%) however a number of entries failed to include NMC numbers showing poor compliance (40%). The main issue appeared to relate to the completion of the electronic patient record (EPR) which had recently been implemented in the division. There had been reported improvement, which ward managers and matrons considered to be due to staff getting more familiar with the transition to the electronic platform.
- All patients using oncology services had their records fully integrated into the EPR allowing network partners access in the event of contact out of hours.

Safeguarding

- The trust had a designated lead for safeguarding supported by a specialist team with responsibility for children.
- All staff we spoke with knew the trust safeguarding policy, how to access relevant information using the trust intranet and where to seek guidance for any out-of-hours concerns.
- Staff used 'flags' or icons on the EPR to highlight adults who were vulnerable or who had particular needs.
- The trust set a mandatory target of 95% for completion of mandatory safeguarding adults and children (level 1 and level 2) training. Across the division at RLI, level one training compliance ranged from 84% on CCU to 100% on ward 20, averaging 94%. Level two training varied on wards between 67% to 100%, averaging 89%. Level three training was above trust target of 95%.

Mandatory training

- Generic mandatory training modules covered eight core subjects namely conflict resolution, equality and diversity, fire, health, safety and welfare, IPC, information governance, moving and handling and resuscitation.
- The division adhered to the trust mandatory training target of 95%. In July 2016, four of the eight core modules met or exceeded the division target with the remaining four ranging from 82% to 92% completion overall.
- Mandatory training figures at RLI varied considerably from ward to ward. Figures provided by the trust showed an overall compliance range from 79% on ward 37 to 93% on ward 22 and ward 39. The ward manager had appointed all staff to attend future sessions to ensure compliance against trust target by year end.
- Ward managers also showed us mandatory training figures for their respective wards, which showed a slight variance from division figures. Generally, ward based capture of mandatory training was higher than reported.
- Ward managers kept an internal ward level list of key mandatory training dates.
- Staff that we spoke with understood they were up to date with mandatory training requirements in the current year. Staff accessed some mandatory training modules via the trust electronic learning system. This allowed staff to monitor training due dates when they logged onto the system.
- Ward managers confirmed where identified shortfalls in mandatory training, staff were booked to attend the relevant session.

Assessing and responding to patient risk

- Staff used various tools to assess and respond to patient risk and to ensure safety was monitored and maintained.

Medical care (including older people's care)

- All patients admitted into RLI had a standard risk assessment bundle completed which included falls, pressure ulcer, nutrition, sepsis and VTE. Staff informed to us all risk assessments were reviewed on at least a weekly basis or as patient circumstances changes such as changes in mobility or if infection develops.
- The division audited compliance of key risk assessment documentation under their monthly Quality Assurance Accreditation Scheme (QAAS). The standard required all entries within the care bundle to be completed within four hours of admission. The division reported compliance at 97%.
- Of 20 records reviewed, we found the initial risk assessment bundle completed in line with recognised quality standards in all cases. 100% of patient records reviewed had a full pressure ulcer risk assessment completed within six hours of admission and 80% of patient records reviewed had a venous thromboembolism (VTE) assessment completed on admission with re-assessment within 24 hours. We also observed in all patients who required VTE treatment, staff prescribed the relevant prophylaxis. The division engaged with the newly set up Patient Safety Unit team to support their priority objectives in the coming year around VTE and sepsis management.
- We found an initial falls risk assessment to be completed in 100% of patient records reviewed. Where the falls risk recommended the assessor complete a multifactorial falls risk assessment, there was some uncertainly amongst staff using the EPR where this was recorded. It was not immediately clear during our review and with direction from staff, when or if this assessment had taken place. Staff confirmed where patients were at risk of falling and a multifactorial falls risk assessment was required, this was generally coordinated by the therapy services, discussed during board rounds and at multi-disciplinary team (MDT) meetings.
- The division highlighted patient safety as a key concern within the trust and had increased resource to address particular areas of priority such as falls reduction. A senior divisional nurse was leading on falls reduction across the trust. All wards had purchased new equipment such as low beds, falls monitors and crash mats. Ward based staff had increased engagement with patients at risk with greater family involvement where appropriate. Staff also used cohort nursing techniques and MDT approaches with support from therapists and others to assess and respond to this risk.
- All patients had clinical observations (blood pressure, pulse, temperature, respirations) recorded at regular intervals however we found three observation charts (15%) where the frequency was not appropriate for their clinical need and in accordance with escalation criteria.
- Staff told us they previously used the Physiological Observation Track and Trigger System (POTTS) as an Early Warning Score (EWS) tool along with professional judgement as a trigger to escalate concerns. Staff confirmed they were moving away from POTTS onto the National Early Warning System ("NEWS" – where six observational parameters are scored, respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse rate and level of consciousness, to identify a variance from the norm).
- The trust monitored compliance in the use of POTTS as an early warning tool to aid in the identification of the deteriorating patient. Between April and July 2016, compliance across the medical division varied at RLI with two of the ten wards not reaching trust target of 90% (AMU recording 88% compliance and ward 23 recording 87% compliance).
- Of the 20 sets of records reviewed, we found observations to be accurately recorded in accordance with the desired frequency in 85% of cases. In three cases, staff failed to escalate care and increase observation frequency in accordance with trigger levels. We did not see any varied trigger thresholds for those patients with a higher than norm baseline or for those on oxygen therapy.
- In the event of a patient deteriorating and requiring senior medical input, staff confirmed they could always get a consultant promptly in and out-of-hours. If a patient required level 2 or level 3 critical care (for example on an intensive care unit with full ventilator support), RLI had an intensive care unit (ICU).
- The division followed the trust sepsis-screening tool (adapted from the Sepsis 6 tool) to screen and identify those vital high risk factors within an hour. The sepsis care pathway flowchart provided guidance on steps to be taken to treat severe sepsis, management plan documentation, critical care considerations and observation monitoring.
- At the time of our inspection, stroke patients were being thrombolysed in A&E,then transferred toto CCU for monitoring, prior to being transferred to the Lancaster Suite, and then on tothe stroke unit (ward 23).

- CCU housed a cardiac procedure room used when patients required additional cardiac interventions such as transoesophageal echocardiogram (TOE), temporary wires, peri-cardiac taps and echocardiography. The division at RLI also accessed the cardiac centre at WGH. CCU had the facility to monitor nine telemetry patients on adjacent medical wards with three designated for thrombolysed stroke patients on Lancaster suite.
- Staff on Lancaster Suite developed laminated information sheets for patients, family members and fellow professional colleagues to support falls management and harm reduction. These sheets were attached to patient tables to remind everyone involved in patient care, and to ensure after any care interaction, the call bell was returned to the patient and its use reinforced.
- The division provided a number of cardiac services at its Cardiac Centre based at Westmorland General Hospital in Kendal. This allowed in-patients requiring cardiac interventions such as cardioversions, pacemakers, angiograms, loop recorders, box changes, transoesophageal echocardiogram, dobutamine stress echocardiogram and adenosine challenges, to have these interventions completed safely during the current period of hospitalisation avoiding transfer, maintaining care continuity and reducing risk.
- In dealing with risk posed by a patient who was aggressive, staff had access to a security firm to support in providing 1:1 observation when unable to get any additional staff. Staff at RLI expressed some concern about the level of training the security staff received to deal with vulnerable patients and on occasions, had found the quality of the staff attending to be unhelpful.
- Staff from CIU attended CCU each morning (Monday to Friday) to complete echocardiograms to support prompt clinical decision making and treatment options.

Nursing staffing

- Division managers confirmed the service had used the 'Safer Nursing Care Tool' (SNCT) to measure patient dependency and determine the number of staff required to care for those patients. The funded staffing establishments for all the general medical wards were based on "red rules" which they confirmed to be a minimum of a 60:40 qualified: unqualified split and a minimum of 1:8 registered nurse: patient ratio. Managers confirmed in higher dependency areas, multipliers were used to vary nursing establishment figures aligned to acuity and dependency measurement, for example in CCU.
- Senior nursing staff also informed us they used their own internal professional judgment along with safe nursing indicators to reinforce SNCT findings and determine staffing numbers/skill mix as an on-going concern.
- The management team had identified nurse staffing as an issue within the medical division and this appeared on the services risk register. All wards visited confirmed they had vacancies.
- The trust provided us with data detailing qualified nurse and unqualified staffing vacancies across the medical division at RLI. Between April and July 2016, the number of whole time equivalent (WTE) registered nurse vacancies had increased slightly from 27.3 in April and 31.6 in July. Wards 37, cardiology and AFU showed the greatest number of vacancies. Actual unqualified nursing staff in post exceeded planned by 35 WTE. The divisional quarterly performance review dated July 2016 reported 85 WTE registered nurse vacancies across the whole division (inclusive of emergency medicine) with further shortfall due to sickness and maternity leave.
- Trust wide registered nurse vacancy rates were reported at 4.1% across the trust. The division registered nurse vacancy rate at RLI varied from ward to ward, however overall, was in excess of 5%. Turnover rates in the division were 9.2% and sickness rates were 2.1%.
- Managers acknowledged existing staff worked significant additional hours to support the unit which in the medium to long term would have a negative impact on health and wellbeing. To ensure safe staffing levels were maintained, managers reported they had previously reduced bed capacity at RLI with the closure of 27 across the wards.
- Ward 20 was a 24 bedded general medical ward providing services to older persons. At the time of our inspection, the unit was one registered nurse short against planned staffing figures. This gave a registered nurse to patient ratio of 1:8 during the day and 1:12 at night with skill mix at 45:55 during the day and 40:60 at night. We reviewed historic nurse staffing rotas back to July 2016 and found,on average,a deficit of 10 registered nurse shifts most weeks. The ward manager confirmed shifts were filled by their own staff and regular bank staff who knew the ward. The ward reported current adverts

to recruit into the four registered nurse vacancies. The unit also appointed a mental health nurse to provide specialist support to patients on the ward.Additionally, the division had gained approval from the Executive Directors Group, which was presented by the Chief Operating Officer at the Trust Board meeting 27 July 2016, to close 5 beds during the summer months. These were reopened in October 2016 following recruitment. September fill rates showed registered nurses at 101% during days and 100% at night with care support staff at 119% and 158% respectively.

- Ward 22 was a 24 bedded general medical ward. The ward was staffed above establishment at the time of our inspection with an additional registered nurse on duty in the morning and an additional care support worker on duty overnight. This provided registered nurse to patient ratios of 1:6 during the day and 1:12 overnight with skill mix at 65:35 and 40:60 respectively. Historic review of nurse rotas back to July 2016 showed a number of registered nurse and care support worker rota gaps averaging in excess of 40 shifts per week. We observed almost a third of registered nurse shifts remained unfilled with the ward working at less than establishment however where registered nurses were unavailable, the ward filled gaps with care support workers. This coincided with reported vacancy rates of four registered nurses and reinforced by September fill rates for the unit reported at 86% (day) and 99% (night) for registered nurses and 127% and 139% for care support workers.
- Ward 23 was a 24 bedded stroke rehabilitation unit and was staffed according to establishment on the day of our visit. This provided registered nurse to patient ratios of 1:6 during the day and 1:12 overnight. Skill mix was reported at 50:50 during the morning, 65:35 during the afternoon and 50:50 overnight. The ward also had a nurse practitioner and an associate practitioner. The ward reported two registered nurse vacancies and historic review of nurse rotas to July 2016 showed a number of unfilled shifts however with a reducing reliance on bank staff. September 2016 fill rates provided 95% registered nurse coverage on both day and nights with care support worker figures at 112% and 105% respectively.
- Ward 37 was a 27 bedded respiratory unit. Due to refurbishment, the ward had one cubicle closed. Review of historic nurse rotas back to July 2016 showed a significant number of registered nurse and care support worker gaps however almost all vacant shifts were filled by existing ward based staff and bank staff. The unit had four registered nurse vacancies however three positions were due to be filled by experienced staff in the coming month. The unit also hoped to attract some overseas nurses. Registered nurse fill rates in September averaged 88% during the day and 93% during the night with average care support worker figures being 168% and 109% respectively. On the day of the inspection, the ward was short against establishment of one registered nurse shift providing ratio of 1:6.5 on the early shift (skill mix 50:50), 1:6.5 in the afternoon (skill mix 55:45) and 1:8 overnight (skill mix 60:40).
- The Lancaster Suite (previously ward 39) had reduced in size from 50 beds to 34 beds. The unit accepted patients from multi-specialisms comprising oncology, haematology, gastroenterology, diabetes and endocrinology, stroke and cardiology. There unit had four registered nurse vacancies and one care support worker vacancy. A review of historical nursing rotas back to July showed on average between 10-20 registered nurse shifts down each week. Many of these shifts were covered by existing staff and bank nurses. Fill rates for the unit in September 2016 reported registered nurses at 99% during the day and 81% at night. Care support worker fill rates showed 137% and 90% respectively. At the time of our inspection, the unit was staffed in accordance with establishment which provided nurse to patient ratios of 1:7 during the day with a skill mix of 65:35 and 1:8.5 at night with skill mix of 55:45.
- AMU was a 39 bedded unit however three beds were closed due to staffing levels. Nurse staffing on the day of inspection showed a shortfall of one registered nurse but an additional care support worker. Staffing ratios provided 1:5 during the day and 1:6 at night with skill mix ratio of 55:45 and 60:40 respectively. The unit had improved staffing retention and had five registered nurse vacancies. Reference to historic nurse rotas back to July 2016 showed most shifts were deficient by at least one registered nurse. Existing staff covered the majority of shifts. Where registered nurses were unavailable, managers used care support workers to assist. Fill rates in September showed registered nurses at 91% for days and 96% for nights with care support worker figures at 108% and 164%.
- CCU had recently increased bed capacity from seven to 11 beds. The unit secured nine additional staff during the transition however not all staff had cardiac care

experience. The unit planned four registered nurses and two care support workers on all shifts providing staffing ratios to a maximum of 1:3 and skill mix of 65:35. The unit reported over five registered nurse vacancies and historic rotas from July 2016 showed almost all shifts were deficient of at least one registered nurse. The unit did not utilise registered nurses from the nurse bank due to the nature of this cohort of patients. Where short staffed, the ward manager relinquished her managerial time to work clinically and sought assistance from other wards. This reflected in September fill rates which showed registered nurses at 80% during the day and 67% at night with care support worker figures at 131% and 84% respectively.

- The AFU was a 15 bedded unit providing specialist older person's care. The unit was staffed in excess of establishment, with an additional care support worker, at the time of our inspection. This provided staffing ratios of 1:4 during the day and 1:7 at night with skill mix of 60:40 and 50:50 respectively. Historic nursing rotas back to July 2016 showed a shortage against establishment on average of 10-20 shifts a week. The unit covered gaps with bank nurses and by working additional hours. We viewed the roster analyser which showed approximately a third of all shifts were not filled. The figures coincided with vacancy rates of 10 registered nurses.
- The oncology day unit comprised two treatments rooms totalling 12 chairs. The unit was staffed from Monday to Friday between 7.30am and 5.30pm. The unit staff also covered the facility at Westmorland General Hospital ("WGH"). At the time of our inspection, the unit was one registered nurse down against establishment however staffing ratios of registered nurse to patient was still better than 1:3 and skill mix was better than trust target of 60:40.
- Overall, ward managers confirmed they had difficulty in filling registered nurse shifts which they put down to a lack of nurses generally. Managers relied on the goodwill of their own nurses to work additional hours and be flexible in their working patterns. Ward managers confirmed their supervisory and management shifts were often converted into clinical shifts to support staffing levels.
- Where shifts could not be covered by existing staff, nurse managers liaised with matrons to secure staff from the nurse bank and external agencies. Ward managers confirmed even accessing external resource did not ensure all registered nurse shifts were filled. Where registered nurse could not be obtained, ward managers requested care support workers to assist the unit. Additionally, the matrons and some specialist nurses worked on the wards during periods of increased activity.
- The division had appointed a number of international nurses and there was an on-going recruitment campaign to bring registered nurses to the trust from overseas. The division were upskilling a number of clinical support workers.
- Where the division considered staffing levels would compromise patient care, beds were closed.
- The trust provided us with data on the use of bank and agency nursing staff between July 2015 and March 2016. The use of agency nurses across the division wards at RLI was consistent with the exception of ward 23 showing a decreasing reliance. Bank and agency use range varied from 1% to over 20% (on ward 20) in some months.
- Patients, family members and carers described the nurses as being "very busy" and "run off their feet".
- Despite nurse staffing shortfalls, we obtained consistent evidence from all wards to confirm that there was a process in place for managing staffing levels and should there be a need to escalate due to a change in patient need. All staff confirmed patients were safe and not at risk.
- The nursing handover took place at shift change and was very thorough. The handover was timely, efficient and comprised a review of each individual patient followed by discussion of any overall safety issues or other matters of concern.

Medical staffing

- In July 2016, the medical staffing skill mix showed the proportion of consultant staff to be in line with England average and the proportion of junior (foundation year 1 and 2) doctors to be higher that England average. Consultant staff made up 38% of the medical staff group, registrar grades made up 23%, middle grades were 9% and junior grades equated to 30%.
- In July 2016, the trust reported a vacancy rate of 4.6% in Consultant Medical Staff. The trust reported that a major recruitment programme is underway to address the gaps in Consultant Medical Staff.
- The service had recently appointed a new clinical lead for stroke care at RLI. Two haematology consultants

(expected to be in post in January 2017), an associate specialist in respiratory medicine and interviews for positions in endocrinology and cardiology were planned.

- The division reported an improvement in junior medical staffing at RLI with the appointment of four locum medical grades employed by trust to cover teams when shortfall.
- The division secured funding to appoint three frailty consultants to support older person's services at RLI. The division had appointed one substantive post with one locum consultant to support the service. The AFU was further supported by two junior grade doctors. The unit was covered by general medical rota at weekends.
- The division provided detail on their on-call and out of hours medical cover. Broadly speaking, the general medical rota was covered by an on-call consultant on site for up to 12 hours and off site thereafter. Specialist registrars ("SpRs") supported the rota and middle grades on site covering twilight and full night shifts. Junior doctors provided further cover in line with middle grade colleagues.
- The gastroenterology service ran a 'consultant of the week' rota. This had freed up middle grade time to work on their endoscopy portfolio. The division had four gastroenterology consultant vacancies to work cross-bay however long term locums were covering at the time of our inspection. The service also reported senior vacancies in respiratory care and diabetes and endocrinology.
- Medical staffing on AMU was consultant led on weekdays until 10pm and at weekend until 5pm. There were three consultants and a specialist grade leading the service. The service was supported by registrar, middle grades and juniors on site in line with the general medicine on-call cover arrangements.
- The division provided two middle grades to attend in ambulatory care from Monday to Friday until 6pm. The AMU consultant provided support when required.
- The division had six consultant cardiologists to cover CCU and the service followed a consultant of the week rota. The cardiology medical staffing was further supported by two registrars, junior grades and advanced nurse practitioners (ANPs). Weekend cover was provided by the general medical rota with support from the cardiology consultant of the week.
- During April 2015 - June 2016, the division reported increasing locum costs across at senior medical grades. The division aimed to reduce these costs across the second half of 2016-17 with new substantive appointments. Acute medicine reported average monthly agency and locum use between July 2015 and March 2016 as 20% in diabetes and endocrinology, respiratory and gastroenterology. There was less use in older person's care and cardiology averaging 12% and 5% respectively. Junior grades were reported at 11%.
- Sickness rates for all medical grades across the division at RLI were below the trust average of 4.5% however turnover rate figures were reported as higher (the data was considerably skewed due to relatively low numbers being considered).
- Medical handovers at shift changes were comprehensive with detailed and relevant information shared. Medical handovers ran succinctly and timely prior to post-take ward rounds. Although invited to attend, senior nurses did so intermittently due to pressures and workload on their respective wards.
- The trust performed within expectations for all questions on the 2015 General Medical Council (GMC) National Training Survey.

Major incident awareness and training

- We saw that the trust had appropriate policies in place with regard to business continuity and major incident planning. These policies identified key persons within the service, the nature of the actions to be taken and key contact information to assist staff in dealing with a major incident.
- Staff we spoke knew how to access the major incident policies for guidance.
- Service managers and senior staff considered seasonal demands when planning medical beds within the trust.

Are medical care services effective?

Good

We rated effective as 'good' because:

- The service was actively involved in local and national audit activity and followed recognised guidance, which provided a strong evidence base for care and treatment. Staff reflected on audit outcomes, and there was evidence of action plan development and changes in practice.

Medical care (including older people's care)

- There were very good patient outcomes recorded in the heart failure and rheumatoid arthritis audit, and some good outcomes noted in diabetes and myocardial infarction audit findings, showing improvements from the previous audit window.
- The division had developed the role of 'hydration champion' to promote the importance of nutrition in hospital care. Patients confirmed that staff made sure they were comfortable and pain free.
- Nursing and medical staff confirmed that internal and ward-based learning opportunities were good. Many staff members were studying higher degree level qualifications relevant to their clinical area. The Tissue Viability Nurses had driven forward an educational programme to reignite awareness of pressure area care, to support harm reduction and improve preventative treatments.
- Staff had an awareness and understanding of the importance of considering consent, capacity, and safeguarding issues in delivering healthcare under the Mental Capacity Act (MCA).
- We found very good multi-disciplinary working (MDT) working across the division. There was a real strength of working relationships between nurses and therapists. The division developed a seven-day ambulatory care service.

However:

- Overall improvements in patient outcomes from the national stroke audit were static. The division had implemented action plans to improve in areas highlighted by audit findings.
- The quality of food to support patient's nutritional status was variable. A number of patients were unhappy with the temperature of hot meals. These comments were supported by findings from the CQC In-Patient Survey 2015 and the Patient Led Assessment of the Care Environment (PLACE) 2016 survey, where food was rated worse than national average.
- The division had not fully embedded seven day working. Benchmarking against the NHS Services, Seven Days a Week Four Priority Clinical Standards were variable however overall, fell below national averages on a number of key metrics. The division were involved with the trust task group looking at seven day working across the organisation.
- Induction processes and access to induction information for ad-hoc locum medical staff, unfamiliar with the hospital, was lacking.

Evidence-based care and treatment

- Staff referred to a number National Institute for Health and Care Excellence (NICE) Guidelines/Quality Standards, Royal College, Society and best practice guidelines in support of their provision of care and treatment. Local policies, which were accessible on the ward and on the trust intranet site reflected up-to-date clinical guidelines.
- We reviewed a number of clinical guidelines on the intranet and all were current, identified author/owner and had review dates.
- The division provided access for all grades of staff to a clinical guidelines package on the trust intranet. The resource referenced NICE clinical guidelines, treatment pathways, flowcharts, management plans and care standards. The package allowed junior medical staff to download the guidance onto their smart phone for ease of access and as an educational reference.
- The division was actively involved in local and national audit programmes collating evidence to monitor and improve care and treatment. The division compiled an Annual Clinical Audit Report of activity that specified a range of completed, planned and on-going evidence-based reviews.
- In accordance with NICE Quality Standards, the division was involved in data collection activity for numerous national audits such as chronic obstructive pulmonary disease (COPD), cardiac rhythm management (CRM), cardiac arrest, Parkinson's, pneumonia, heart failure, diabetes, acute coronary syndromes, falls and fragility fracture audit programme (including hip fractures) and gastrointestinal bleeding.
- The division had developed a number of evidence based condition specific care pathways to standardise and improve patient care and service flow. In ambulatory care for example, there were pathways for low risk pulmonary embolism and low risk upper gastrointestinal (GI) haemorrhage.
- The division had reflected upon National Audit Report findings and developed action plans to support evidence-based care and treatment. For example, in respiratory care staff were re-educated on the content of the trust antibiotic policy for the first-line management

of respiratory infections. In stroke services, action plans were in place to improve timeliness and reduce delays in accessing CT scanning. There were also a number of action plans for cardiology services.

- In December 2015, the division completed an audit of acute kidney injury (AKI) care looking at prevention, detection and management in accordance with NICE Clinical Guidance. The cross-bay study retrospectively sampled 38 case notes and reported areas of good practice and recommendations for improvement. The auditors highlighted good practice in identification of risk, monitoring of creatinine, AKI treatment plans and recording of urine output. The auditors identified the need for a more timely referral to nephrologist and to scanning when criteria met. In the sample considered, the auditors noted a high mortality rate and high readmission rate. The trust devised an AKI action plan to progress and implement an AKI care bundle, to update AKI training and to improve nephrology referrals.
- The division had adapted guidance for sepsis screening and management.
- All endoscopic procedures were carried out in accordance with recognised best practice and professional guidelines.
- The division had a designated audit lead and were active in the trust clinical audit and effectiveness steering group. We reviewed the clinical audit progress report for the period April 2015 to March 2016 which showed the division were on schedule or had completed all required audit requirements. There were no delays or causes for concern which required measures to be put in place to get back on track.

Pain relief

- We found all patients had access to prescribed analgesia. We found analgesia prescribed on a regular basis and on an as required basis.
- One patient described how he had been taking a pharmacopeia of medications at home to deal with his back pain. Medical staff at RLI investigated this further by way of scanning and the provision of an injection provided excellent results and a reduction in the need for on-going oral medications. The patient stated, "It's cured me!".
- Staff considered the use of analgesia alongside the patient's clinical condition and particular need.
- Staff informed us they monitored pain and assessed effectiveness of pain relief using a number of techniques such as direct questioning, by observation, anticipatory ahead of procedures and with reference to observations and pain assessment tools such as a severity scores from '1-10'.
- Patients confirmed staff recognised when they were distressed or uncomfortable and responded to their requests for pain relief in a timely manner.
- The trust had a number of pain management policies such as use of sedation, pain management on fractured neck of femur cases and in endoscopy.

Nutrition and hydration

- The division recognised the importance of good nutrition, hydration and enjoyable meal times as an essential part of patient care.
- The division monitored nutritional documentation compliance by auditing nutritional screening, risk assessments and care plans. In April 2016, compliance scores averaged 73%. Matrons used audit findings to re-inform staff on the importance of nutritional assessment for all patients.
- Of 20 records reviewed during inspection, we observed all patients had a malnutrition universal screening tool (MUST) risk assessment (equating to 100% compliance). Staff implemented care plans for those patients who required support and assistance with eating and drinking.
- Staff told us they accessed support from dietetics and speech and language therapy service (SALT) to support those patients who required additional input to maintain their nutritional status.
- We observed nutrition and hydration recorded on fluid and food charts which were kept by the patient bedside and summarised periodic intake during the course of the day. Overall, the completion and accuracy of these charts was good.
- The medical division engaged with trust monitoring of nutritional standards against various national stakeholder benchmarks such as the nutritional alliance, the diabetic association, Public Health England and Department of Environment, Food and Rural Affairs (DEFRA). The trust rated performance against these standards as 'green'.
- Patients had protected meal times. Staff allowed family members to attend during meal times where patients required help or support in eating or drinking.

- Staff used visual signage on the patient name board, alert symbols on the e-whiteboard and identifiers on jugs/glasses/trays to highlight patients who required assistance with eating and drinking.
- Staff on ward 20 provided bowls of fruit in sitting areas, used cups and saucers as opposed to mugs and coordinated weekend tea parties to promote engagement around food and nutrition.
- Staff on ward 22 developed visual pictorial menus to support and empower patients to make meal choices.
- The division had developed the hydration champion role through skills workshops to reinforce the importance of nutrition and hydration in patient care.
- We received variable comments from patients regarding food quality and menu choice. Of the 16 patients we spoke to, 11 confirmed the food choice to be good with specific praise given to the quality of soups and stews. Five patients however complained specifically about hot meals served warm or cold reducing their enjoyment of the meal. There were various menu options for individual dietary requirement such as halal and vegetarian options.
- We observed staff assisting patients with eating and drinking. This included the process of feeding, supporting with drinks, offering snacks during the course of the day, providing distraction therapy, opening packets and ensuring all personal items were in reach. Where encouragement was required this was given in a supportive way and at a relaxed pace. Staff updated care plans when a patient refused to eat.
- Staff provided snacks (sweet and savoury options) in between meals for those patients who preferred lighter options during the course of the day.
- The division contributed to the Patient Led Assessment of the Care Environment (PLACE) 2016 survey. In the food category, the trust scored worse than national average (84% compared to 88%).

Patient outcomes

- Royal Lancaster Infirmary took part in the quarterly Sentinel Stroke National Audit programme (SSNAP). On a scale of A-E, where A is best, the trust achieved grade D in latest audit (April to June 2016). There has been no change in the overall scores for the last three quarters. The domain occupational health saw a fall in grade from B to C whilst discharge processes rose from B to A. Team centred scanning also saw a rise from grade C to B.
- The stroke team worked with A&E colleagues to develop a 'code stroke alert' bleep system which identified when a patient would benefit from thrombolysis. The team were also hoped to work with the local ambulance service to progress direct computerised tomography (CT) scanning access.
- The divisional stroke team developed an action plan to review and progress improvements in stroke services following the recent SSNAP outcomes report. At RLI, the nurse specialists have provided training to A&E staff to improve early identification of stroke patients who would benefit from prompt access onto the stroke pathway. The service has extended the role of the advanced nurse practitioner to sign CT requests therefore progressing scanning investigations more efficiently. Staff worked closely with therapy colleagues to improve referral pathways and therapy activity with speech and language, physiotherapy and occupational therapy. The stroke team worked closely with network colleagues to share best practice and to improve patient outcomes across the region.
- Royal Lancaster Infirmary's results in the 2015 Heart Failure Audit were better than the England and Wales average for three of the four of the standards relating to in-hospital care and in six of the seven standards relating to discharge. Input from specialist and received echo both scored particularly well at 99.5%. Cardiology inpatient scored low at 12% versus the England and Wales average of 48.1%.
- Royal Lancaster Infirmary took part in the 2013/14 MINAP audit and scored better than the England average for two of the three metrics. Both metrics also showed improvement when compared to the 2012/13. The only metric not to score better than the England average was 'nSTEMI patients admitted to cardiac unit or ward' and saw a very small decrease when compared to 2012/13.
- Royal Lancaster Infirmary took part in the 2015 National Diabetes Inpatient Audit (NaDIA). They scored better than the England average in 13 metrics and worse than the England average in four metrics. The metrics relating to foot risk assessment scored particularly low.
- In the National COPD Audit Programme 2014, RLI scored a total of 33 points across the five domains (in line with the national median score of 33). The respiratory service scored well across all domains (non-invasive ventilation

services, managing respiratory failure/oxygen therapy, access to specialist care and integrated care) however recorded poor scoring against senior review on admission.

- The division participated in the 2015 Lung Cancer Audit and the proportion of patients see by a Cancer Nurse Specialist was 16.8%, which was worse than the audit minimum standard of 90%. The 2014 figure was 23.8%.The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 3.9%, this is significantly worse than the national level. The 2014 figure was 32.4%.The proportion of fit patients with advanced Non-Small Cell Lung Cancer (NSCLC) receiving chemotherapy was 62.0%; this is not significantly different from the national level. The 2014 figure was 89.5%. The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 90.9%; this is not significantly different from the national level. The 2014 figure was 100.0%. Case ascertainment was 136% which was higher than the national aspirational standard of 95%.
- In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 0%. This placed the trust within the lowest 25% of all trusts for this measure. The 90-day post-operative mortality rate was not reported. The proportion of patients treated with curative intent in the Strategic Clinical Network was 38.9%, in line with the national aggregate.
- The division were involved in collating data for the Cancer Patient Experience Survey 2015. The trust was in the top 20% of NHS trusts for seven of the 50 questions and in the middle 60% for 43 questions. The trust received no responses in the bottom 20% of NHS trusts.
- The division were involved in the trust-wide sepsis working group agenda to promote improvements in the identification and management of sepsis. The audit considered sepsis screening (emergency patients), antibiotic prescription within an hour and a 72 hour antibiotic review. The audit compared baseline figures recorded in 2015. In quarter two of 2016/17, the division reported increased compliance against all indicators ranging from 75% to 100%.
- The division took part in the National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis 2015. The audit reviewed the seven standards provided by NICE (CG79) under waiting times, time to short-term glucocorticoids and combination therapy, time to educational and self-management activities, treatment escalation, timeliness to advice on possible drug related side-effects and annual reviews. Waiting times for the service were longer than national average however the service were in line with or better than national levels for treatment times, follow-up and reviews.
- Healthwatch Lancashire completed an enter and view report on the Lancaster Suite in May 2016. The report broadly considered five areas namely patient information boards, signposting information, sleep-well campaign, staffing review and caring outcomes. Overall, patient information boards were completed, signposting information for concerns or complaints were displayed, there were positive comments on the ward sleep-well campaign, staffing shortfall was noted however well managed with support from other areas. The report also found caring was good, privacy and dignity for patients was maintained and call bells were answered in a timely manner. Staff acknowledged the improvements in the new layout compared to the 'old' ward 39 set-up. The divisional Assistant Chief Nurse and Executive Chief Nurse developed an action plan to reinforce good practice and progress areas for improvement. This was on-going at the time of our inspection.

Competent staff

- All staff employed by the trust and working in the division were required to meet their professional continual development obligations.
- The division provided a number of electronic on-line courses and specialist courses in house for staff to attend. The division also had strong links with network colleagues, higher education establishments, medical schools and universities.
- All newly qualified staff employed by the trust and working in the division were subject to a period of preceptorship and supervision, which varied according to the area worked, and subject to competency sign-off.

- Ward managers discussed formal learning and training needs with individual staff members at 1:1 sessions and during appraisal. Informally staff identified their own areas of interest and proposed study for consideration at a local level.
- Junior medical staff maintained close links with the Deanery as part of their clinical placements and post rotations. The junior medical staff stated they division were extremely supportive with their learning, training and developmental needs. They added the clinical exposure they received fully underpinned the classroom and clinical skills training.
- Senior nursing staff were recently supported by the division to access higher education, leadership and management courses.
- Staff received formal engagement sessions with their ward supervisor or academic lead. These took the format of 1:1 meetings, clinical supervision sessions, attachment to specialist practitioners, mentoring and observation, reflective practice and revalidation.
- Staff in CCU completed advanced life support training (ALS) to support their role on the unit and as part of their 'crash team' (members of staff attending other wards in the hospital to provide support in the event of a cardiac arrest).
- Senior nurses on the Lancaster Suite developed the 'skills on a plate' project on the unit to support junior nurses in developing key competencies to work across the unit. This was underpinned by more robust 12 month mentoring programme for newly qualified staff.
- A number of specialist areas had developed their own competencies aligned to national guidelines, training programmes and recognised best practice. On ward 37 for example, managers developed a competency framework covering blood gas interpretation, tracheostomy care, use of high flow oxygen and continuous positive airway pressure (CPAP). These competencies were monitored over a period of time with the designated preceptor and signed up when competency had been achieved. In oncology, staff had additional training and competencies to administer chemotherapy treatments.
- Clinical physiologists working in CIU developed specialist roles aligned to Masters (MSc) level training.
- Nursing staff told us that they had received information and support from the trust about Nursing and Midwifery Council (NMC) revalidation.
- Appraisal rates reported in the quarterly performance review dated July 2016 showed the division to be below trust end of year target of 95% across all staff grades. There was an improving and upward trend in appraisal completion across the period April to June 2016, with overall completion being in the region of 80%.
- Junior nursing and medical staff were supported by their senior colleagues who they described as approachable and willing to share. Many junior staff were involved in audit, improvement projects and invited to attend senior staff meetings.
- The directorate provided an on-line clinical guidelines resource accessed by all grades of staff which gave information/guidance/information/flowcharts/ treatment protocols on various clinical conditions such as sepsis management.
- Sepsis training was monitored locally and overseen by the divisional governance and assurance group (DGAG).
- The trust TVN's were visible in the division and provided comprehensive training packages to staff. TVNs advertised training dates on the intranet, on bulletin boards and via newsletters circulated to wards. The TVN's had set up a link nurse champion group and ran various courses such as categorisation and wound management. The TVN team also ran an annual event – STOP Pressure Ulcer Day every November. The TVNs also took the opportunity to provide bedside teaching to patients, families and junior staff members when attending wards to review patients.
- Where staff were having performance difficulties at work, ward managers discussed actions that could be put in place to support them at ward level or wider support that could be offered by divisional managers and human resources.
- Ward staff completed induction checklists with agency staff and ensured they were familiar with ward protocols before delivering any patient care however, there was no evidence of any induction or on-line resource for ad-hoc locum medical staff that had little or no knowledge of the hospital.

Multidisciplinary working

- We observed formal and structured multidisciplinary team meetings (MDT) throughout our visit. These meetings considered patient assessment, discharge planning and care delivery in hospital.

- Staff on the stroke unit held 'mini' daily MDT meetings with nurses and therapists to update patient condition and progress. The unit held MDT meetings twice weekly involving wider MDT colleagues, the patient and their family members.
- We observed a well-attended MDT safety huddle on AMU which involved various grades of medical staff, nursing staff, social workers, discharge coordinators and community based discharge team representatives from South Cumbria (STINT) and Lancashire (REACT).
- All attendees had a sound understanding of the needs of each patient, care priorities, clinical history and social considerations. Staff spoke about their patients with empathy, compassion and courtesy. Many referred to discussions they had with the patient and family members.
- Formal documented input from the MDT collective was recorded in nursing and medical records. We found all records reviewed had detail from MDT meetings regarding medical treatment plans, therapy support and discharge proposals however this was not always documented within the first 14 hours from admission. There was evidence of a medical treatment plan involving MDT support in all cases within 24 hours. We also found evidence of patient and family involvement in MDT care planning.
- There were clear internal referral pathways to therapy and psychiatric services. Many wards had developed strong links with community colleagues when implementing discharge plans and care packages. This was particularly apparent on the stroke unit with embedded working with community specialist nurses and primary care colleagues.

Seven-day services

- The trust monitored its current working scheme against NHS Services, Seven Days a Week Clinical Standards. The division was the greatest contributor to the March and September 2016 seven day service (7DS) survey with approximately two-thirds of all case notes reviewed.
- The division provided evidence to address the four priority clinical standards namely time to first consultant review, diagnostics, interventions and on-going review.
- On average, based on March 2016 data, 60% (slightly worse than national average and in line with regional average) of emergency admissions during weekdays were reviewed by a consultant within 14 hours. At weekend, the figure increased to 65% (slightly better than national and regional average). Based on September data, the figures were reported at 49% during weekdays and 40% during the weekend.
- Of the 20 sets of notes we reviewed, we found 95% of patients were reviewed by a consultant within the 14 hour standard.
- Figures in March 2016 showed over 60% of patients were made aware their diagnosis, management plan and prognosis within 48 hours from admission. This figure improved in September 2016 to over 70%.
- Of the 20 sets of notes we reviewed, we found all patients we informed of the plan of care and treatment goals within the 48 hour standard.
- The division confirmed there were formal arrangements in place to review patients admitted as an emergency where the trust offered no provision for that particular service, for example, neurology.
- With the exception of AMU and CCU, the division confirmed there was no formal provision in consultants'job planning to hold a consultant-led ward round on every ward, every day of the week. CCU provided a weekday clinical lead round followed by a speciality led ward round later in the day. Weekend ward rounds were covered by the acute physician of the day and/or the consultant of the week (CoW).
- The trust confirmed access to diagnostics (CT, echocardiography, histopathology, MRI, microbiology, upper GI endoscopy and ultrasound) is available during weekdays. There is a shared plan for MRI cover with a neighbouring trust at weekends and there is an ad-hoc arrangement in place for urgent upper GI endoscopies at weekend due to a lacking cross-bay GI bleed rota. The endoscopy unit have increased training to for a number of consultants and nurse endoscopists to progress this cover.
- The service has confirmed they are able to access interventions for critical care, primary percutaneous coronary intervention (PCI), thrombolysis, emergency surgical services and renal replacement therapy as the patient requires however cardiac pacing and interventional endoscopy is not usually available for emergency admissions as quickly as would be liked. The division are involved in a network arrangement to address the shortfall in weekend interventional services.
- The service does however have 24 hour access to consultant directed interventions seven days a week either on site or via formal network arrangements.

- The percentage of patients in high dependency areas such as AMU who were seen and reviewed by a consultant twice daily was between 40-45% broadly in line with national and regional averages in March 2016. The number of patients reviewed as part of a consultant delivered ward round at least 24 hours after transfer from an acute area to a general ward varied considerably during weekdays and at the weekend. Weekday figures from March 2016 reported less than 50% (worse than regional and national average) and at the weekend averaged 30% on Saturday (worse than regional and national average) and 80% (better than regional and national average) on Sunday.
- Of the 20 sets of records we reviewed we found all patients were reviewed by a consultant within 24 hours following transfer from the acute area.
- The division were involved in the trust-wide project steering group established to drive work to address gaps in the 7DS provision. The multi-organisational group devised action plans to address areas of shortfall and improve coverage.
- The division accessed the on-site psychiatry crisis team and support between 8am-9pm who were based in A&E seven days a week.
- Ambulatory care services at RLI were available every day to 8pm with the service providing flexible working hours at the weekend to support the division. The nurse led service provided care to patients from multi-specialisms who met specific referral criteria with a view to provide safe care avoiding unnecessary admission and improving flow elsewhere in the division. The ambulatory care service also hosted the hot clinics such as the transient ischaemic attack (TIA) service and the VTE service.
- There was seven day working in endoscopy services at RLI (up to 2pm at the weekend) and the unit had developed a 24 hour on-call gastrointestinal bleed rota.
- The oncology day unit provided patient access to a 24 hour helpline. Out-of-hours the helpline service was manned by triage nurses across the North West Network.

Access to information

- Staff we spoke with raised no concerns about being able to access patient information in a timely manner.
- Medical staff informed us they received investigation results in a timely manner.
- Staff informed us discharge-planning considerations commenced on admission with input from the discharge coordinators and complex case managers.
- Staff informed GPs of discharge in writing by way of a discharge summary, which tended to follow the patient on the day of discharge. The division were moving to full electronic patient records and this would provide more efficient communications with stakeholders.
- If GPs had any queries or concerns regarding on-going patient care needs on discharge they called the service where they spoke to a relevant member of staff. Staff informed us a member of the medical team would always avail themselves to take the call or respond at the earliest opportunity to answer any queries.
- Staff accessed records electronically and refered to policies, clinical guidelines and current trust information via the intranet.
- In the CQC In-Patient Survey 2015, patients rated various criteria around information sharing. Patients found information shared about continuity of care (6.5 out of 10), medications (7.8 out of 10), danger signals (5.5 out of 10) and details provided to family and friends (6.3 out of 10) to be in line with national average for similar trusts.

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

- We observed staff asking patients for their consent prior to care being delivered and procedures carried out.
- We saw that the trust had an appropriate policy informing staff about the consent process. This included reference to obtaining consent where patients may have capacity issues and included guidance on the Mental Capacity Act.
- All the staff we spoke with were aware of the safeguarding policies and procedures and had received training. Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was delivered as part of the mandatory training programme.
- We observed safeguarding and MCA guidance on all wards. Staff referred to the DoLS flowchart to detail the steps to follow to progress an application. Staff also referred to the trust intranet pages designated for safeguarding issues.
- Staff were not entirely clear on the processes to be followed after a Safeguarding application had been submitted however stated to us that the Safeguarding team followed this up.

Medical care (including older people's care)

- Staff provided us with examples of DoLS, explaining steps taken to identify and support patients who may not have the capacity to consent. We saw evidence of mental capacity assessments completed in medical records.
- Staff accessed the Safeguard Team if concerned about a patient and they confirmed responses were prompt.

Are medical care services caring?

Good

We rated caring as 'good' because:

- Staff stated their priority was to deliver quality patient care.
- We observed staff delivering care with sensitivity and interacting with patients respectfully.
- Overall, feedback and comments received from patients and their family members was positive about the care received.
- Staff considered physical, emotional, and social elements of wellbeing equally and without exception. Patients and family members were included when discussing care decisions and treatment plans. Staff considered patient and family involvement in care.
- There was a variable response rate in the NHS Friends and Family Test (FFT) and good recommendation rates for the service. The service reported good outcomes from the National Cancer Experience Survey 2015 and the Patient Led Assessment of the Care Environment (PLACE) 2016 survey.
- All patients had individual care plans which were reviewed and evaluated as an on-going concern and as a minimum, at the end of each shift.

However:

- Some patients and family members described staff interaction as hurried;
- Family members confirmed some meetings were convened at short notice and not truly established for any significant patient and family involvement.

Compassionate care

- Staff confirmed their priority was to ensure patients received the quality care they needed.
- Staff showed an awareness of the 6 C's (care, compassion, courage, communication, commitment and competence - an indicator of values underpinning compassionate care in practice) and we noted wards had posters displaying the core values.
- During our inspection, we observed care being delivered by nursing, medical, therapy, non-clinical staff and volunteers interacting with patients in a genuinely caring manner. This included addressing patients by name, introducing themselves by name, actively listening, speaking politely and respectfully, recognising each patient as an individual, and coming to the patient's level when they were in beds and chairs. We found all patients had nurse call bells within reach and these were answered in a timely manner.
- Patients described the care they received as consistent at all times of the day and night. They commented care delivery to be "perfect" and staff always "willing and polite" however that they did have to wait on occasions when staff were especially busy. Patients were also complimentary about the care they received from domestic and housekeeping staff.
- On ward 20, we observed some skilled nursing interactions between staff and a distressed patient who was wandering the ward upsetting others. They reassured the patient and provided suitable distraction which allowed him to settle comfortably.
- We observed all grades of staff spending time listening to and talking with patients. We observed patients responding favourably to those interactions however, some patients referred to communication barriers and language difficulties with international nurses.
- Staff confirmed when they assess patient needs they always take into account personal, cultural, social and religious needs. Staff considered this as important as the physical assessment.
- Prior to our inspection, we attended a number of listening events with patients and family members. Overall, the feedback received on the care across the division at RLI was good.
- Of the 16 patients and relatives we spoke to, the consensus supported the findings from our listening events, care was good.
- The division captured feedback from patients on how likely they would be to recommend the service and their experience of the care delivered. The feedback was scored and benchmarked against national standards.

- The RLI response rate to the NHS Family and Friend Test (FFT) between October 2015 to September 2016 was lower than national average (22% compared to 25%) however response rate on some individual wards was excellent with ward 20 reporting an average response rate of 99%. The monthly recommendation scores by ward ranged from 40% to 100% however overall were good. 'Likely to recommend' scores improved from 91.9% to 94.9% with 'unlikely to recommend' scores reducing from 3.7% to 2.1%. The 5 star score marker from April to June 2016 showed an improvement from 4.67 to 4.76 (out of five).
- In the National Cancer Experience Survey 2015, patients rated their overall experience of the service on a scale of 1-10. The trust reported a score of 8.8 out of 10 in line with national average. 81% of patients stated they were involved in decision making, 89% were given the name of their specialist nurse, 93% confirmed they were treated with dignity and respect and 92% stated they received contact information.
- The division contributed to the Patient Led Assessment of the Care Environment ("PLACE") 2016 survey. In the privacy, dignity and wellbeing category, the trust scored better than national average (86% compared to 84%) and dementia care at 75% in line with national average.
- Patients explained to us staff maintained their privacy and dignity and always informed them of any care delivery or procedure in advance.
- The majority of the wards we visited had set visiting times to ensure meal times were protected. Staff authorised visiting outside these hours to assist in individual circumstances.
- Staff enjoyed telling us of positive feedback received from patients and family members and most wards we visited displayed 'thank you' cards.

Understanding and involvement of patients and those close to them

- Staff actively encouraged and involved patients and their family (where appropriate and relevant) in all aspects of care planning, treatment options and discharge plans.
- Many wards advertised ward manager appointment slots where family members could book an uninterrupted convenient time to discuss matters.
- Nursing and medical staff kept patients and their family members updated about investigations, treatment plans and care progression. Patients and family members were invited to MDT meetings however some family members found it difficult to attend meetings arranged at short notice or where they were given insufficient advanced warning. Additionally, some patients and family members felt MDT meetings were not always the ideal setting for them to voice their opinion.
- Patients and family members felt informed, involved and up-to-date with nursing and medical care plans. Staff answered questions and concerns about care and treatment in a timely manner however did not always have time to engage in lengthy dialogue.
- Staff used the 'Hello my name is' signage to inform patients and family the name of the nurse responsible for the care during a given shift.
- Staff assessed patients and used clinical judgment to identify those who may require additional support in understanding care and treatment plans. Staff gave examples of interpreters, specialist practitioners and support by way of family presence.
- Staff displayed and signposted patients and family members to support groups and specialist services who could provide additional information and on-going input after discharge such as Age UK and The Bay Dementia Hub.
- One family member described how staff supported her to get involved in her grandmother's care. She described the change in her grandmother as "remarkable".

Emotional support

- Staff acknowledged admission into hospital could be very distressing for some patients. Staff considered the emotional and social impact this could have on their wellbeing. Staff empathised with patients who were frightened and concerned about their health and being hospitalised. We observed genuine warm and caring interactions.
- We observed emotional support being provided by nurses and indirect care being provided by non-clinical personnel such as domestic and housekeeping staff. We overheard a ward housekeeper ask a patient why he appeared "sad today" and she told him to take a seat while she got tea and biscuits and they could talk about what was upsetting him.
- A number of patients commented on the physical and emotional support provided by the physiotherapists

during often difficult and distressing rehabilitation programmes. Therapy staff provided reassurance and encouragement during sessions which empowered patients to do their best.
- Staff recognised the best person to provide emotional support at a particular time could come from a variety of sources and they did not discourage non-clinical staff for supporting patients within given boundaries.
- Staff informed us they accessed psychiatric services, psychologists and counsellors to provide additional emotional support to patients when appropriate. Patients also received emotional support from chaplaincy and bereavement services, support groups, charity and volunteer staff.
- Staff offered patients and relatives private areas if they wanted time away from their bed area to discuss personal matters.
- On the oncology day unit, staff provided dedicated and private quiet areas and education rooms to support patients and their family members when required.

Are medical care services responsive?

Good

We rated responsive as 'good' because:

- The division planned, developed and adapted services, in conjunction with partners and stakeholder input, to meet the needs of the local people across its significant geographical reach.
- The division had excellent results against 18-week standards across all specialisms.
- To assist with pressure on in-patient services and bed occupancy, the service made use of ambulatory care services and rapid access clinics where safe care was provided without the need for hospitalisation. Additionally, AMU triage allowed fast-track admission routes into stroke services and AFU pathways providing earlier specialised clinical decision making and treatment options.
- To promote access and flow for older persons, the division had opened an AFU to provide early assessment and specialist care pathways to this group of patients.
- Divisional managers closely monitored access and flow through the division and were involved in a number of initiatives to identify problems within patient pathways leading to blockages in care progression, increasing unnecessary length of stay and discharge planning. The division had appointed a number of complex case managers and discharge coordinators to support the patient transition into the community.
- The division actively looked at strategies to improve patient experience for those vulnerable patient groups. The division provided reasonable adjustments for this cohort such as those living with dementia, those with additional needs due to learning disabilities and those with hearing problems or visual impairment.
- There was evidence of positive outcomes following the divisional response to some patient concerns.

However:

- The division recorded significantly longer length of stay durations for elective medical patients at RLI.
- Bed occupancy rates had seen a number of medical outliers encroach into other clinical wards. Medical outlier figures were consistent at RLI and this coincided with a significant number of patient moves after 10pm.
- There were a significant number of patients medically fit where discharge was delayed.

Service planning and delivery to meet the needs of local people

- The division was engaged with the Better Care Together (BCT) strategy, bringing together a total 11 local organisations including neighbouring trusts, clinical commissioning groups (CCGs), GP Federations, local authorities, and the ambulance service, to plan and deliver the BCT strategy.
- BCT was designed to provide integrated care closer to the community through changes to clinical pathways aimed at reducing unnecessary interventions and where clinically appropriate, introducing initiative such as patient initiated follow-ups (PIFU). This worked alongside innovative, locality based, out of hospital proposals to enhance locally provided health services and facilitate management of long term conditions closer to home and reduce the number of, predominately elderly, patients in acute hospital beds.
- Since BCT was developed thinking has evolved and work is ongoing to create an Accountable Care System to take responsibility for the whole health and care needs of our population. Clinical and operational partners are working with key partners across all the

BCT work-streams to ensure that there is safe and sustainable planning across entire pathways of care with whole system solutions to the challenges faced. BCT is the trust and divisional strategy.
- Divisional management staff attended meetings with local Clinical Commissioning Groups (CCG's) in order to feed into the local health network and identify service improvements to meet the needs of local people.
- In planning and delivering services, the wider BCT strategy was heavily influential and there were a number of priorities being considered to ensure the needs of the local and regional population were being met.
- The division had appointed a number of specialist nurses and developed a number of specialist clinics.
- AFU opened and developed operational flow chart detailing referral and admission criteria. The process was developed to support flow through AMU and to provide early access to older person's care pathways under the care of elderly care consultants.
- Patients at RLI had access to an ambulatory care service seven days a week which provided care for those with certain clinical presentations meeting specific referral criteria such as deep vein thrombosis, asthma, abdominal pain, pulmonary embolism and urological problems.
- The division had appointed a specialist stroke nurse at RLI. The role had been developed to improve stroke services cross bay, and in particular, to outreach into other clinical areas on site to capture patients requiring specialist stroke care. The specialist nurse worked with their counterpart at FGH to improve and develop the stroke patient pathway. Activity was focussed on improving patient outcomes against nationally recognised standards which involved closer working with radiology, improving training across the division and developing more robust therapy involvement in stroke care pathways. A number of staff in the stroke service rotated through stroke rehabilitation into community care therefore providing continuity for a number of patients requiring on-going therapy support.
- The division offered internal referral and external access into acute medicine clinics, also known as 'hot clinics' at RLI and these were managed by the ambulatory care team. This allowed patients to attend promptly, see consultants for same day reviews and avoid unnecessary admission. For patients who resided nearer Kendal, and required access to day care services, therapies and rehabilitative care, a number of these services were provided at the Dunmail Treatment Centre, Westmorland General Hospital who saw in excess of 600 patients and provided almost 400 treatments during September 2016. On these units, there was a strong emphasis on support and education, patient engagement and multi-disciplinary team input.
- The division had installed clinical investigation units (CIUs) on all sites. At RLI, patients had access to echocardiography, pacing follow up, ambulatory electrocardiography, stress testing within the rapid access clinics and respiratory investigations. This had improved access to investigatory tests, prompter results and earlier treatment options for the treating physician and patient.
- The medical oncology and chemotherapy service provided a 24 hour helpline for patients and their family should they need advice or support OOH. This was supported by the North West Network.

Access and flow

- The medicine division at RLI accounted for two-thirds of the total admissions into the medicine service across the trust. The majority of these admissions (56%) were classified in the emergency category. The division provided care and treatment for patients in cardiology, gastroenterology, general medicine, oncology, dermatology, respiratory, older person's medicine and stroke services across its 213 in-patient beds.
- Between October 2015 and September 2016 the trust's referral to treatment time (RTT) for admitted pathways for medical services hadbeen better than the England overall performance. The latest figures,for September 2016,showed 100% of this group of patients was treated within 18 weeks,versus the England average of 90%. The trust hadbeen consistently better than the England average in the 12 month period.
- There were no medical specialties below the England average for admitted RTT (percentage within 18 weeks).
- The latest figures for July 2016, showed 100% of all medicine patients were treated within 18 weeks.
- Between March 2015 and February 2016, patients at Royal Lancaster Infirmary had a lower than expected risk of readmission for non-elective admissions and a lower than expected risk for elective admissions. Elective Clinical Haematology was the only medical specialty to have a higher relative risk of readmission.

Medical care (including older people's care)

- Between April 2015 and March 2016, the average length of stay for medical elective patients at the Royal Lancaster Infirmary was 13.6 days, which is worse than England average of 3.9 days. For medical non-elective patients, the average length of stay was 5.6 days, which is better than England average of 6.6 days.
- Divisional managers confirmed bed occupancy had a significant impact on flow through the service. The threshold occupancy levels for efficient transition within the service was 75% on AMU and 85% on the wards. Divisional managers confirmed bed occupancy had been running in excess of 100% in recent months which led to increasing numbers of medical outliers (medical patients being cared for on non-medical wards) and encroachment into surgical beds. This coincided with trust percentage occupancy, which rose between April to June 2016 to 99.1%. The divisional bed position had been further compounded by bed closures due to inadequate staffing levels.
- The trust provided data detailing numbers of medical outliers at RLI from July to September 2016. On average, the division had consistently seen approximately152 outliers each month with ward 33 receiving the most. Medical outliers were cared for on 'buddy wards' to keep a particular specialism or cohort together in one location. This assisted non-medical-ward based staff to work with one particular medical team,and assisted medical staff when reviewing outlying patients by keeping them together.
- We spoke with nursing staff on ward 33 (general surgery) and they confirmed medical staff attended the ward every day to check on patients. Our review of medical records confirmed this.
- The directorate captured live bed occupancy rates, admissions by ward/consultant/site, outliers, bed vacancies and patient length of stay on an electronic platform which was accessed by matrons and senior managers. This assisted in anticipating access and flow issues which senior staff responded to accordingly.
- All wards held daily board rounds and staff worked with pharmacy colleagues to obtain patient medications to take home in a timely manner. Ward 22 housed a designated pharmacy satellite which was used to facilitate the prompt turnaround of discharge medications.
- The trust held local and cross-bay bed meeting teleconferences during the day to address access and flow issues. Division senior nursing staff, business managers and discharge coordinators attended to record bed occupancy and availability, discharges and pending admissions. Here staff identified actual and potential bottlenecks to patient flow for that day and prioritised actions to remove obstacles for patient admissions and discharges.
- The division had appointed five specialised complex case managers (CCMs). The CCMs supported patients and their families with more complex care packages such as Continuing Healthcare ("CHC") processes and the transition of care into suitable community care facilities.
- The division had also employed a number of discharge coordinators to support in the transition from hospital care into the community. Not all wards had a discharge coordinator in post however all staff commented on the positive impact this role has had on ward pressures, progressing care packages and supporting the patient and their family toward discharge.
- Staff triaged all patients referred for medical assessment through AMU to assess the appropriateness of the referral and to ensure the most suitable care pathway such as ambulatory care, stroke services, AFU or access to a rapid access clinic ("Hot clinic"). The unit coordinator challenged inappropriate referrals with the referrer to ensure all patients receive the right care from the right team at the earliest opportunity.
- Staff on AFU hoped to develop the frailty pathway further to reduce pressure in AMU, support access and flow in the division and to provide early assessment for this cohort of patients. Staff in AFU commenced early discharge planning processes and had developed relationships with community colleagues to facilitate continuing care outside the hospital setting.
- Staff on the stroke unit confirmed patients residing in the Cumbria region did not benefit of an early supported discharge service whereas patients residing in Lancashire did. Staff informed us this sometimes led to delayed discharges for this cohort.
- The reported reasons for delayed transfer of care (DTOC) between July 2015 and June 2016 were patients awaiting nursing home placement or availability (38.3%) and awaiting residential home placement or availability (23.1%).
- Divisional managers worked with multiple partners to look at improvements in DTOC. The priority of the group was to reduce unnecessary admissions in the first instance as it was found this patient cohort accounted

for approximately 30% of in-patient bed occupancy. The project was six months old at the time of the inspection and work was on-going. Divisional managers had also taken part in DTOC rapid improvement events with community care colleagues and 'Hospital Home Care Team' projects. Outputs from these pieces of work had seen the division support social workers integrate into the discharge team and care support workers appointed to the Hospital Home Care Team.

- At the time of our inspection, staff reported there were 72 patients at RLI (113 cross-bay) where discharge was delayed.
- Staff in AMU confirmed the triage process had allowed them to redirect patients to the most appropriate care pathway, for example, direct to AFU, stroke services, rapid access clinics and ambulatory care services. AMU staff improved flow through their unit by utilising designated pharmacy support to provide prompt discharge medications.
- The division had developed a seven day ambulatory care model at RLI. The service provided treatment to patients from a variety of specialisms and had standard operating procedures detailing referral criteria. These included treatment pathways for certain clinical presentations such as deep vein thrombosis, asthma, abdominal pain and urology problems. These pathways provided criteria to help staff identify patients whom could be safely cared for in the community without hospitalisation.
- The division had also developed a number of acute medicine clinics or rapid access clinics (hot clinics), for example to deal with suspected transient ischaemic attacks (TIAs) and VTE. The hot clinic initiative hosted by the ambulatory care service at RLI avoided admission for many patients, ensured same day consultant review and was well regarded by local stakeholders. The unit also acted as a discharge lounge for patients heading home from AMU.
- Between June 2015 and June 2016, RLI medical wards reported an average of 75% of patients did not have to move ward during their admission, 20% on one occasion, 5% on two occasions or more.
- From January – June 2016, there were a number of patients moving wards at RLI after 10pm. The total numbers were high and in June 2016 totalled 352 with 112 (32%) being recorded against the division. Ward managers confirmed moves at night were not helpful to staff and could lead to distress to patients. Staff confirmed where such moves were necessary this was generally due to changing patient need or late admissions from general practitioners or A&E.
- There had been no mixed sex breached in the division in the previous 12 months.

Meeting people's individual needs

- The divisional managers confirmed when planning services, the needs of all patients, irrespective of age, disability, gender, race, religion or belief were taken into account.
- Staff confirmed where patients required additional support, for example, those with complex needs or who were vulnerable; the division took all reasonable steps to ensure the care they required was uncompromised.
- The division had appointed specialist nurses for vulnerable patient groups such as those living with dementia and those patients with learning difficulties. The trust had a dementia strategy which was embedded across the division.
- Staff ensured patients living with dementia were appropriately screened, treated for any underlying cause that may be contributory to a delirium and were signposted for further assessment if needed.
- Where patients living with dementia were admitted onto a ward, staff used the butterfly scheme to identify those patients as having particular needs. The butterfly scheme is a visual identifier to alert staff of particular care needs an individual living with dementia may have. This was used in conjunction with a bed-side and e-whiteboard symbol and a bed-side care summary identifying detailed personal preferences, likes/dislikes, anxiety triggers and interventions, which are helpful in supporting during difficult periods.
- Staff recognised meal times could cause concern for many patients and their family members. The division had adapted visual menus suitable for those patients who preferred hot finger food options and snacks to improve calorific intake and the pleasure of eating. The division had also adopted 'John's campaign', a formal recognition of the importance of families and carers to be involved in the care and decision making. The division offered open visiting and provided nominated persons with a lanyard and badge to acknowledge them as being in the scheme.
- We visited wards which had undergone some refurbishment to become 'dementia friendly' with

appropriate signage to aid communication and perception, with triggers for reminiscence such as music, photographs and decorations to encourage positive interactions and to reduce environmental conflict.

- All patients coded with a diagnosis of dementia from an inpatient admission were referred to the Care of the Elderly (COTE) team where appropriate. A carer survey questionnaire was sent to the patient, their family or carers to ask if they have been adequately supported during the episode of care. Staff presented the feedback along with dementia audit findings to the ward managers, in the quality committee report "I want great care" and published findings on ward information boards.
- The AFU developed a frailty referral pathway to provide a comprehensive geriatric assessment (CGA) to ensure patients were receiving the appropriate level of care delivered by the most appropriate team on the correct care pathway.
- The division accessed the newly appointed learning disability (LD) nurse specialist for support where necessary. The LD nurse coordinated care for those patients with more complex needs. All LD alerts went directly to her and all reasonable measures were considered to assist the patient through their care pathway whilst hospitalised and to support a smooth transition back into the community.
- Staff provided a 'passport' to patients with LD, which was owned by the patient and detailed personal preferences, likes/dislikes, anxiety triggers and interventions, which are helpful in supporting during difficult periods. The LD nurse specialist identified, in conjunction with carers and ward staff, what reasonable adjustments were required to support the patient whilst in hospital. This could be pre-visits to suites for procedures to support desensitisation, an offering of a side-room for privacy and to reduce anxiety, flexible visiting, carers staying with the patient overnight and other individual preferences unique to that individual.
- We observed bed-side physical therapies and activities being provided on the wards at RLI. Ward 22 provided a computer for patient use which was used in various activities and diversional therapies such as music, coordination tasks, games and reminiscence programmes.
- Staff had built good working relationships the community LD teams and where required, they would be invited to attend MDT meetings in order to encompass a wider holistic assessment and for involvement in any future on-going care package.
- The division were in the process of making the transition onto the EPR. Consequently, the division were working to ensure alert identifiers were included in the record to assist staff and patients.
- Patients who have visual impairment or hearing difficulties have their particular needs fully assessed. Where appropriate staff liaised with medical, nursing and specialist colleagues in Ophthalmology and ENT. To assist the MDT, staff used bedside and e-whiteboard identifiers to highlight particular patient needs associated with their visual or hearing deficit.
- The division were developing 'deaf champions' who will undergo additional deafness awareness training to support patients. The division propose to develop the role for those patients with visual deficits.
- All wards displayed information for patients and carers on a variety of topics such as trust information, quality standards, disease/condition specific information, ward/staff contact details, a who's who of staff on the ward and general useful signposting on where to get further information such as PALS, complaints and support groups.
- Staff explained that translation services were available by telephone or by attendance in person. Staff also accessed British Sign Language (BSL) services.
- The trust had chaplains who provided access to major faiths within their communities. Staff accommodated faith preferences in accordance with patient wishes.
- Staff we spoke with explained that they could easily access bariatric equipment via equipment storage when this was required. This included access to special beds, wheelchairs and chairs
- On AMU, staff used colour coding on bay doors to help patients locate their bed area, for example, the green room. Some units had champions for vulnerable patient groups such as dementia and hydration.
- Staff at RLI used an external security firm to provide support with 1:1 observation for vulnerable or aggressive patients when they were unable to secure additional nursing staff. Staff recognised this was not an ideal scenario and had found the quality of the security staff used was variable.

- The endoscopy suite at RLI allowed family members or carers to be present during consultation and in attendance for the procedure to reduce distress and anxiety for their loved one.

Learning from complaints and concerns

- The division reported 120 complaints between October 2015 and October 2016, of which 82 (68.3%) were attributed to the medical division at RLI.
- Of the 82 recorded complaints, 56 (68.3%) were logged against AMU. The division took an average of 23.02 days to investigate and close complaints, which was in line with the trust complaints policy, which states complaints should be signed off within 35 working days from receipt, unless another timescale has been agreed with the complainant.
- The main categories of complaint related to clinical treatment and staff attitude.
- The wards we visited displayed leaflets and posters outlining the complaints procedure. We saw that the trust had a complaint policy and staff were aware of it.
- Staff discussed feedback from complaints and lessons learnt at ward meetings and at safety huddles.
- Ward staff took actions to address patient feedback. On ward 37 for example, managers also secured funds to refurbish and redecorate cubicle areas. Staff reconfigured the ward layout to provide greater window access to patients. This necessitated a move and rebuild of a stock room.

Are medical care services well-led?

Good

We rated well-led as 'good' because:

- The division had a clearly defined strategy and vision which was aligned to organisational aims and wider healthcare economy goals. The division recognised the delivery of the strategy could not be achieved in isolation therefore engaged with internal and external partners to drive objectives.
- Divisional leads had a real grasp and understanding of the pressures and risks the service faced. The service prioritised resource to address key considerations around quality and safety matters.
- The division embraced recent changes within the governance directorate, and in a short space of time, appeared to have embedded the governance and assurance framework throughout the service from ward level into senior management structures. Governance arrangements enabled the effective identification and monitoring of risks. Managers reviewed key divisional risks, action plans and progress in a timely manner. There was evidence that controls were in place to mitigate such risks.
- There were defined leadership structures in place supporting the division which had recently changed following the merger of emergency medicine and acute medicine. Staff knew their individual roles and accountability however all considered themselves to be part of a wider cross-bay team with collective responsibilities.
- Staff confirmed the strength and culture within the divisional team had greatly improved over the last 12 months which a "new energy" and refocus on patient care. Staff considered their clinical leaders to be peers and acknowledged a greater openness within the division.
- The division considered staff and public engagement to be fundamental to its future success. The organisation were involved in a number of known initiatives to gather feedback from persons using and working in the service.
- Staff of all levels were actively encouraged to get involved in projects to develop services, promote efficiencies, inform learning and improve patient care. Senior staff member support for such projects was apparent and there was evidence of some excellent project outcomes from the Learning into Action programme.

However:

- The divisional strategy stressed the importance of engaging with public and staff opinion to progress organisational priorities in the coming years. Whilst there was evidence of public and staff engagement we did not see any new activity to suggest a shift in emphasis to reinforce this priority objective.
- The new governance framework had only been in place for a short time within the division and the effectiveness of the process needed to be fully reviewed;
- Divisional managers accepted there were current limitations within their leadership expertise. To reinforce their skills, knowledge and development in this area they had undertaken relevant courses and training to enhance their ability to manage and lead the service.

- Whilst staff accepted the difficulties for the division in recruiting to vacant posts, they felt as though there was a pressure and almost an expectation to work additional hours as a norm and this was not fully recognised by divisional leads. Senior clinical leads recognised the vulnerability of sustaining this in the medium to long term.

Vision and strategy for this service

- The vision and strategic goals for the division mirrored the aims and objectives of the trust, "to constantly provide the highest possible standards of compassionate care and the very best patient and staff experience by involving patients, staff and partners."
- Divisional managers expressed their overreaching vision was to deliver a quality and safe service.
- The divisional strategy had short, medium and long term projections. Managers were actively focussed on areas for improvement highlighted during previous inspection activity. The division also prioritised work to address current risks around workforce and patient safety. In the short to medium term, the division were keen to improve patient flow through a number of options by working with partner organisations. In the medium to longer term, the division were working with the collaborative to develop and further the 'Better Care Together' agenda aligned to the NHS Five Year Forward View.
- The division ambitions, service priorities and principles of working in the coming year were incorporated in the trust priorities for 2016/17 of strategy, engagement, quality and safety, partnership and performance.
- The management team recognised the importance of 'the team' and encompassed opinion cross-bay. Managers considered quality clinical governance, an open and honest culture, and listening to patients, stakeholders and staff as key to the success and development of the service. This was underlined with the considerable work undertaken by the trust in terms of governance review from ward to board during 2015/16.
- The management team told us they were actively involved in the shaping of the trust agenda. The management team actively sought staff opinion on the strategy of the service and for future plans.
- Staff knew and understood the vision of the trust and the division.
- Ward 22 had developed their own vision statement for the unit in line with divisional objectives and trust priorities. This had been developed by all staff and was displayed on the ward noticeboards.

Governance, risk management and quality measurement

- The division had clear governance channels into the wider organisational management structure. The medical division governance was clinician driven with multi-specialism input.
- The governance and assurance framework permeated all levels within the division and was well embedded throughout despite the recent creation of the governance directorate.
- The two-way 'Board to ward' framework (known locally as 'WESEE') was well structured and there were clear lines of responsibility and accountability from individual units, through DGAG, into the divisional management board to divisional performance meetings before moving into the workforce, finance and quality committees at Board.
- Ward staff described the new governance framework as simple and effective. Staff confirmed 'WESEE' worked well on wards and had brought a consistency and uniformity across the division in the last 12 months.
- We reviewed minutes of ward governance meetings under the 'WESEE' framework covering the set agenda items of workforce, efficiency, safety, effectiveness and experience. There was a clear and fluid process for sharing information (such as Board issues, divisional headlines and ward matters) through this process up and down the organisational structure. The format allowed ward meetings to be consistent, structured, timely and efficient.
- In conjunction with the division strategy, we were provided with sight of a very detailed and comprehensive risk register which recorded concerns, rated according to risk/priority, along with control measures and action plan progress.
- The management team stated their three main concerns were surrounding nursing and medical staffing, patient flow issues and patient safety. These were recorded on the risk register and we were told of progress made by the division to mitigate risk.

- There was a consistency and alignment in what the division was concerned about and what appeared within the register. Senior management were open and honest about this and their plans to address perceived shortfalls in areas of concern.
- The division monitored risk register key performance indicators. Managers completed 90% of risk reviews on time, 79% of risks had on-going or open actions and 98% of open actions had progress recorded.
- The division were actively working to address areas previously highlighted for improvement and progress was monitored in the CQC action plan. The division also had a 'journey ahead' plan which brought together the organisation objectives, divisional strategy, key priorities and the governance framework. The key themes highlighted recruitment, reducing patient harms, delivering RTTs and engage and motivate staff to be fundamental.
- The division were involved in the implementation and embedding of National Safety Standards for Invasive Procedures (NatSSIPs), revised in September 2015. In particular, staff were involved in local NatSSIP projects (LocSSIPs) aligned to national alerts and work streams such as cardiological and endoscopic procedures. Projects were on-going at the time of the inspection however we were able to review some of the safety changes implemented in the trust cardiac centre. Staff had revisited the cardiac centre safety standards and had developed an enhanced safety briefing, checklist, handover and debrief standard document for use in the service. Staff planned to audit the use of the new documentation as part of the division governance framework.
- The division were involved in the trust wide QAAS (Quality Assurance Accreditation Scheme) to support in the measurement of quality and effectiveness of care. QAAS aligned with division aims and national objectives. Division staff had developed QAAS tools to benchmark against standards, guidelines, staff driven objectives and patient satisfaction. The tools included themes around safety, leadership and the care environment. The designated matron implemented the process with wards rated according to compliance (red – inadequate, yellow – requires improvement and green – good). Lessons learnt and themes were highlighted to ward managers, discussed at quality committee, division governance groups and published in trust bulletins and newsletters.
- There was internal clinical audit activity and monitoring of performance and quality within the division. Senior staff recorded local and national measures and outcomes, which fed into divisional activity, drove the vision, strategy and quality improvement projects.
- The service used clinical audit, monitored quality and performance dashboard measures and took outcomes to identify areas of good practice, improvements projects and future initiatives. The DGAG lead on sepsis management across the division. Staff shared lessons learnt from all audit activity and performance measures using the governance framework with also included wider input from the Patient Safety Unit and Learning Into Action (LiA) team.

Leadership of service

- The medicine division had a clear management structure defining lines of responsibility and accountability. The division was led by a clinical director, a divisional general manager and a chief nurse.
- The division and clinical directors had an open-door policy and invited regular contact with their unit heads.
- The division had recently brought together emergency medicine and acute medical services under one management structure cross-bay. A deputy chief nurse, deputy divisional general manager, six matrons, five service managers and a designated divisional governance lead further supported the divisional management structure.
- Managers recognised the importance of having the right skills, knowledge and experience to carry out their duties. A number of the management team completed higher education leadership course at a local university to support their appointment.
- Divisional managers spoke with pride about the work and care their staff delivered on a daily basis despite the pressures faced.
- All staff we spoke with told us their clinical managers were visible and approachable. Ward staff interacted with matrons and managers as peers. Staff commented how their matron and assistant chief nurse visited clinical areas regularly.
- Nursing and medical staff agreed the reconfiguration of the old ward 39 into the Lancaster Suite has seen a significant improvement in nurse leadership and medical management.
- Divisional leadership recognised their cross-bay responsibilities and encouraged staff to engage with

colleagues on other trust sites to build team networks. Some roles provided staff with the opportunity to work cross-bay and liaise with the wider divisional team. The division held regular videoconferencing meetings to get together to discuss issues, share learning and cascade updates within their area.
- Staff were aware of the issues faced by the directorate and considered their managers were doing everything in their power to improve the situation for them and their patients.

Culture within the service

- Staff at all levels spoke enthusiastically about their work, about the quality of care they delivered and the pride they felt working for the trust. Staff described a "new energy" within the culture of the organisation. They commented the organisation had become "more caring" and there had been a re-emphasis on patient care.
- Staff felt divisional managers were part of the team. They described how the organisational and divisional objectives aligned with their own aims and intentions to have the patient central to their purpose.
- At staff listening events and focus groups prior to the inspection we heard staff describe a real 'team' culture however staff felt under pressure and believed there to be an element of expectation for them to work additional hours to fill vacant shifts. In the NHS Staff Survey however the trust performed better than other organisations against the question 'staff working extra hours' (68% against England average of 72%).
- All staff we spoke with told us their immediate line managers were professional, supportive and helpful.
- Junior nursing and medical staff described their senior peers to be supportive, approachable and willing to spend time with them when necessary.
- Junior doctors described the teamwork across all staff disciplines as "excellent".
- Staff agreed there was a culture of openness and honesty throughout the division underpinned by the trust 'Speak out Safely' campaign. Staff stated they were comfortable in raising concerns with their line manager and knew of the trust 'Freedom to Speak Up Guardian' and the whistleblowing policy.
- In May 2016, the division managers published outcomes from their values and culture based project to gain further understanding of staff opinion on working for the organisation. There was some agreement within staff that the culture within the division was caring, care was of a good standard and there was togetherness in working for patients. The project also identified some cultural entropy (an amount of time and energy consumed doing unproductive and unnecessary work associated with a degree of organisational dysfunction). This tended to focus around staff working long hours, a feeling of being taken for granted and an element of bureaucratic control. The division managers acknowledged the way in which they led required improvement. The trust supported a number of the division managers to attend internal and external management and leadership courses to address this.
- Overall, morale was good on the wards we visited. Staff commented on the strength of ward comradery and their resilience to cope with difficulties. Matron's recognised staff on wards were getting stressed and tired with the constant pressures faced. Staff felt as though senior management could do more for staff wellbeing but acknowledged some of the issues faced across the division were outside managers' control.

Public engagement

- One of the organisational and divisional objectives was to canvas opinion on the services from the public.
- Patients and their families provided views and feedback on their experiences of using the service in the Family and Friends Test, through the 'taking two minutes of your time' capture and via 'Tell us what you think' comment cards or website.
- Some wards provided designated appointment times for family members, at a time convenient to them, to discuss the care and treatment plans for their loved one.
- Wards displayed information for patients and their families on ways in which they could provide commentary about their experiences in a more confidential setting such as accessing the Patient Advice and Liaison Service (PALS).
- The division invited members of the public to become a member of the trust, allowing them to link into trust consultations, service development proposals and vote for representation on the Council of Governors.
- The division supported the governance directorate mystery shopper project whereby a member of the public would attend the division anonymously and provide feedback to the governance team about their experiences.

- The division had good links with numerous volunteer organisations, charities and national support groups such as Macmillan and Age UK.
- The stroke team planned to engage with patient and public representatives by way of a stroke steering group to further develop services cross-bay.
- Some wards used social media (Twitter and Facebook feeds) for patients and their family members to discuss ward related topics.

Staff engagement

- One of the organisational and divisional objectives was to canvas opinion on the services from their staff.
- The division provided staff with information via WESEE, newsletters, intranet updates and e-mail on trust developments, clinical issues, patient themes and staff recognition.
- The division were involved in a number of trust initiatives to engage with staff such as the staff survey, invitations to listening events, involving staff with harm free care group projects and LiA proposals. This provided staff with the opportunity to input into areas of interest, influence change and learn and develop.
- The division recognised staff achievements in a start of the month scheme and at annual events such as the health hero award.
- The division encouraged staff to get involved in the '#flourishatwork' campaign to promote staff health and wellbeing. The flourish campaign focussed on physical health, mental health and the importance of exercise and nutrition.
- The division implemented team building away days for different staff banding groups. This allowed cohort groups of staff working cross-bay to come together to discuss topics of interest, attend learning events and build team networks.
- Staff had developed good links with external professional colleagues, support organisations, charities and volunteer groups.
- Ward 22 undertook a review of their progress in the past 12 months and developed a 'tree of growth'. This process encouraged staff to reflect upon areas where the ward had performed well and consider areas for development and improvement. The same was depicted as a virtual tree which was displayed on ward information boards for staff, patients and families to comment upon and engage with through suggestions and comments.
- Divisional managers invited staff to a 'get to know the Board' speed dating event which staff found useful, interesting and fun.
- In the NHS Staff Survey 2016, the trust performed worse than other organisations in the question 'staff experiencing harassment, bullying or abuse from other staff in the last 12 months' (29% compared to England average of 26%). Staff in the division at RLI reported no incidents of this nature to us during the course of our inspection.

Innovation, improvement and sustainability

- The division was proud to talk about the progress and improvements they had made over the last 12 months, in particular, responding to areas of concern previously highlighted and a number of successful improvement projects.
- There were a number of cost improvement projects (CIPs) and quality improvement projects (QIPs) in the division which were focussed on key areas of risk such as improving nursing and medical recruitment, reducing agency and locum spend, optimising patient flow, reducing length of stay and procurement schemes.
- The division were very active in the trust LiA improvement programme. These programmes, open to all staff, focussed on projects, proposals, suggestions and research to bring about change and improvements in working practice and patient outcomes.
- Divisional staff in older person's care developed dedicated care of the elderly frail pathways underpinned by the opening of the AFU in March 2016. This incorporated a rapid assessment programme, comprehensive older person's assessments and development of 85+ and 65+ care pathways. The division reported improved relationships with Integrated Care Communities (ICCs", stronger links with care homes and improved access to discharge options.
- The division hosted the Hospital Alcohol Liaison Service (HALS) at RLI. The service provided specialist care for patients with alcohol related illness and withdrawal management. The team forged links with colleagues in mental health services and facilitated community integration for this cohort of patients. The HALS service had developed into a seven-day service providing expert advice, support and training to staff in hospital and community settings. The team were named as a finalist in the Health Service Journal (HSJ) Awards 2016 and the Nursing Times Awards 2016.

Medical care (including older people's care)

- Staff in oncology wanted to develop and share guidelines with all staff involved in peripherally inserted central catheters line care (PICC) for chemotherapy administration. The project brought consistent practices across the division, the patient experience improved, lines of communication cross-bay were strengthened, there were fewer blocked lines reducing the numbers of removals and reinsertions and cost savings.
- Division staff were involved in on-going harm free care specific projects looking reducing falls and pressure ulcers.
- As part of the LiA programme, the division were involved in a number of 'Big Ticket' schemes (larger clinically led projects). Following on from the AKI LiA, the division extended the reach of project to aim to reduce AKI mortality. The division employed two AKI practice nurses who provided specialist support to the trust and a number of presentations were made to the collaboration. The dual approach to inform trust staff and engage with the collaboration led to a reduction in patient mortality from 25% to 18.6%. The divisional consultant leading on this project picked up an award from the network for the team's work.
- Staff made a number of changes to improve care for patients living with dementia. The project followed feedback from patients and families, staff concerns and increasing use of security staff. The project brought a reduction in complaints, reduced spend on security staff, reduced staff sickness and reduced harm to patients.
- Respiratory staff across the division sought to redesign the care pathway to improve patient access to diagnosis and treatment. This project saw division staff working with community colleagues to improve access to investigations, develop a one-stop clinic and a specific sleep apnoea pathway progressed within the CIU. Respiratory RTTs have been reduced and patient flow improved.
- Division staff were involved in the 'Think SEPSIS: Save Lives' project to reduce patient harm. This project was heavily focussed on education and training to improve early recognition and treatment of sepsis. Staff improved screening compliance, increased intravenous antibiotic administration within one hour and standardised training in line with national guidance.
- In stroke servicesthe team wanted to maximise performance, deliver better patient outcomes and improve patient care. The team developed a rapid access service for brain scans, introduced stroke champions in A&E, extended the scope of the advanced nurse practitioner to request CT scans, developed specialist e-learning training packages,and developed an expert patient programme.
- Wards 23 and 37 achieved the gold standard framework recognition for end of life care.

Surgery

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

Information about the service

University Hospitals of Morecambe Bay NHS Foundation trust provides a comprehensive range of acute and support services to a population of 350,000 based around Morecambe Bay. Surgical services were managed divisionally across all three locations rather than by single location.

Royal Lancaster Infirmary provides a range of surgical services including urology, ophthalmology, trauma and orthopaedics and general surgery (such as colorectal surgery). There were four surgical wards, a day case ward, and an acute surgical unit (ASU). There were four general theatres that carry out emergency and elective surgery procedures, two gynaecology and obstetrics theatres and two day case theatres. There were 182 inpatient and 17 day case beds located within 11 wards.

Hospital episode statistics data for 2015 / 2016 showed that 16,590 patients were admitted for surgery at the hospital. As part of the inspection, we visited the main theatres, the pre-operative assessment unit, the day case unit, the ASU, ward 36 (trauma and orthopaedic unit), ward 33 (ENT, maxilla-facial and general surgical ward), ward 34 (colorectal and urology) and ward 35 (elective orthopaedics).

We spoke with 17 patients. We observed care and treatment and looked at 18 care records. We also spoke with 21 staff at different grades including nurses, doctors, consultants, ward managers, general managers, theatre managers, and clinical leads.

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

Surgery

Summary of findings

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

- Ensure there were systems in place to identify themes from incidents and near miss events.
- Ensure all theatres were monitoring compliance with the 5 steps to safer surgery.
- Ensure all staff understood the process for raising safeguarding referrals (in the absence of the safeguarding lead).
- Reduce and improve readmission rates.
- Ensure they were clear risk assessments in place for situations where practice deviates from the guidance.
- Must continue to engage staff and encourage team working to develop and improve the culture within the theatre department.

During the 2016 inspection we found that these actions had been taken. There were systems in place to identify themes from incidents and near miss events. We saw improved audits for the 5 steps to safer surgery and had discussions with staff about the process and procedure for raising safeguarding referrals. There were risk assessments and escalations plans in place for situations where practice deviated from guidance. Readmission rates were worse that than the England average in 2015. In 2016 we found that Between March 2015 and February 2016, patients at Royal Lancaster Infirmary had a similar expected risk of readmission for non-elective admissions and a higher expected risk for elective admissions compared to the England average. We found that although the culture of the surgical division was much improved, work was ongoing with further improvement required.

We rated surgical services as 'good' because:

- Staff knew the process for reporting and investigating incidents using the trusts reporting system. They received feedback from reported incidents and felt supported by managers when considering lessons learned. All wards used the national early warning scoring (NEWS) system for recording patient observations and systems for recognition and management of deteriorating patients. Infection prevention and control was managed effectively.
- Wards and theatre skill mix was variable during shifts, but measures were in place to ensure the safety of patients. Generally, nursing staff to patient ratio was one to eight. We reviewed the nurse staffing levels on all wards and theatres and found that numbers and skill mix appropriate at the time of inspection.
- The hospital had an escalation policy and procedure to deal with busy times and staff attended bed meetings in order to monitor bed availability on a daily basis. Staff treated patients in line with national guidance and used Enhanced Recovery (fast track) pathways.
- Local policies were written in line with national guidelines. Staff told us appraisals were undertaken annually and records for Royal Lancaster Infirmary showed that 82% of staff across surgical wards, and theatres had received an appraisal against the trust target of 95%. Appraisals were on going to the year end.
- Allied health professionals (AHP's) worked closely with ward staff to ensure a multi-disciplinary team approach to patient care and rehabilitation.
- Evidence based care and treatment national audits identified mixed outcomes for all audits. The National Bowel Cancer Audit Report (2015) showed better than the England average for four measures.
- The National Emergency Laparotomy Audit (NELA) report (2015) showed Royal Lancaster Infirmary achieved a rating over 70% for five measures and had a good rating for nine out of 10 elements of the audit.
- The Patient Outcomes Reporting Measures (PROMS) for groin hernia metrics and knee replacement metrics were about the same as the England average whilst hip replacement metrics had mixed performance. We saw that orthogeriatricians had contributed to the development of the care pathway of elderly patients.
- Staff received Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training as part of staff induction. All the staff we spoke with received training in and knew about safeguarding policies and procedures

Surgery

- The trust's referral to treatment time (RTT) for admitted pathways for Surgery has been worse than the England overall performance between October 2015 and August 2016. However, the latest figures for September 2016 showed an improvement in the trust's performance, with 75% of this group of patients treated within 18 weeks versus the England average of 75%.
- We saw staff treating patients with compassion, dignity, and respect throughout our inspection.
- Ward managers and matrons were available on the wards so that relatives and patients could speak with them
- Complaints were dealt with informally at ward level in the first instance and where necessary escalated to ward managers and matrons in line with trust policy. Complaints were discussed at monthly staff meetings where training needs and lessons learning were discussed. The directorate risk register was updated at governance meetings with action plans monitored across the division.

However:

- Theatre staffing comprised of 72:28 ratio of qualified nurses to support staff. The lowest monthly level of agency usage was 12.8% in April 2015 and the highest monthly agency usage of 20.9% August 2016. The average level of agency use in theatres was 16.5% across the 12 month period from April 2015 to March 2016. Although the agency figures were high, staff we spoke to felt that practice remained safe.
- An audit sample of 116 surgical patients completed in April 2016 showed 110 patients had venous thromboembolism (VTE) and bleeding risk recorded within 24 hour of admission (95%), 34 patients had VTE risk and bleeding risk reassessed 24 hour after admission (29%) . As a result of poor audit results, the trust established as VTE Lead, VTE Policy now rewritten to comply with NICE guidance, a steering group established, standalone bridging guidelines developed, VTE training package now available on the training management system and there was a new VTE algorithm in the clerking documentation.

Are surgery services safe?

Good

We rated safe as 'good' because:

- Staff were familiar with the process for reporting and investigating incidents using the trust's electronic reporting system and feedback was given from a senior level. Patients at risk of falls, pressure ulcers and urinary tract infections had robust electronic care management plans. The prevalence rate for pressure ulcers and falls with harm both show a reduction over time, whilst catheter acquired urinary tract infections (CAUTI) have shown an increase in prevalence.
- Records showed risk assessments were completed at each stage of the patient journey from admission to discharge, with an National Early Warning Score (NEWS) system used for the management of deteriorating patients. We observed theatre staff practice the 'Five Steps to Safer Surgery' and complete the World Health Organisation (WHO) checklist appropriately.
- Controlled drugs were managed appropriately and accurate records were maintained in accordance with trust policy, including regular balance checks.
- All the staff we spoke with were aware of the safeguarding policies and procedures and had received training. Mental capacity assessments were undertaken and Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was delivered as part of the mandatory training programme.
- Planned staffing levels for wards worked on a one to eight registered nurse to patient ratio. In times of greater patient need, ward staff ratios increased through the use of overtime and bank usage or ward beds were closed. We reviewed the nurse staffing levels on all wards visited and within theatres and found that levels were variable due to both nursing and medical staff shortage. However, the trust were actively recruiting to these posts. In July 2016, a vacancy rate of 4.1 % in qualified nurses and 4.6% in consultant medical staff was reported.
- The hospital had an escalation policy and procedure to deal with busy times and bed management meetings were held to allow senior staff to monitor bed availability on a daily basis.

However:

- The controlled drugs cupboard on ward 36 did not meet with legislative requirements. This was reported during inspection and were advised that action would be taken to ensure the cupboard met the legal specification.
- Theatre staffing comprised of 72:28 ratio of qualified nurses to support staff. The lowest monthly level of agency usage was 12.8% in April 2015 and the highest monthly agency usage of 20.9% August 2016. The average level of agency use in theatres was 16.5% across the 12 month period from April 2015 to March 2016. Although the agency figures were high, staff we spoke to felt that practice remained safe.
- An audit sample of 116 surgical patients completed in April 2016 showed 110 patients had venous thromboembolism (VTE) and bleeding risk recorded within 24 hour of admission (95%), 34 patients had VTE risk and bleeding risk reassessed 24 hour after admission (29%) . As a result of poor audit results, the trust established as VTE Lead, VTE Policy now rewritten to comply with NICE guidance, a steering group established, standalone bridging guidelines developed, VTE training package now available on the training management system and there was a new VTE algorithm in the clerking documentation.

Incidents

- Definition of Never event has changed. Although each Never Event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorized as a Never Event The trust were aware they must ensure systems were in place to identify themes from incidents and near miss events following the 2015 inspection.
- Between September 2015 and August 2016 Royal Lancaster Infirmary reported one incident, which was classified as a never event for surgery. This was reported under maxillofacial surgical when a patient was operated on to remove a foreign body discovered to be a dental burr tip from a previous surgical procedure.
- In accordance with the Serious Incident Framework 2015, the trust reported 11 serious incidents (SIs) in Urgent and Emergency Care which met the reporting criteria set by NHS England between November 2015 and October 2016. Of these, the most common type of incident reported was surgical/invasive procedure incident meeting SI criteria. Of the 11 SIs five were reported for Royal Lancaster Infirmary.
- Staff told us how they reported incidents through the electronic system and most said learning was shared through meetings, ward communication, team briefings, handovers and notice boards.
- Matrons had an overview of every incident, complaint and concern and operated a system of response and feedback to patients and staff.
- The trust introduced a weekly patient safety summit to review any harm (or near miss) incidents with senior doctors, nurses and AHPs within a week of that harm occurring. The detail relating to the incident was discussed along with any actions taken and confirmation of individual learning. An example provided was a case of testicular torsion that was missed. This went to the patient safety summit and shared with CCG's. Training was provided by urology clinical lead, at the time. Duty of candour was shared with the patient. The senior team leading the patient safety summit considers and promotes wider learning that can be applied across the organisation, and monitors adherence to the duty of candour. This evidence was obtained the Divisional Governance & Assurance Group.
- Duty of candour is a process of open and honest practice when something goes wrong. We saw that legal requirements were explicitly stated within trust policies, intranet guidance, and training.
- We saw evidence of Duty of Candour and staff were able to articulate action they would take. We were told by nursing staff that when something went wrong with patient care they would be open and honest with patients by explaining what went wrong, why and how the issue would be resolved. Staff were also aware of the formal written Duty of Candour process.
- The trust held regular mortality and morbidity case review meetings within all specialities, and these were well attended by the multi-disciplinary team (MDT). Staff presented and discussed case descriptions, outcomes and key lessons learned. The lessons learned were used to inform service development through audit safety huddles, ward meetings and on a one to one basis as necessary.

Safety thermometer

- A safety thermometer was used to record the prevalence of patient harms at the ward level, and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the ward level was intended to focus attention on reducing patient harms.
- Data collection took place one day each month with a suggested date for data collection given, but the ward could change this. Data must be submitted within 10 days of suggested data collection date.
- Data from the Patient Safety Thermometer showed that the trust reported a prevalence rate for Surgery of 22 pressure ulcers, 13 falls with harm and 12 catheter urinary tract infections between September 2015 and September 2016. The prevalence rate of pressure ulcers and falls has fallen over time.
- An audit sample of 116 surgical patients completed in April 2016 showed 110 patients had venous thromboembolism (VTE) and bleeding risk recorded within 24 hour of admission (95%), 34 patients had VTE risk and bleeding risk reassessed 24 hour after admission (29%) . As a result of poor audit results, the trust established as VTE Lead, VTE Policy now rewritten to comply with NICE guidance, a steering group established, standalone bridging guidelines developed, VTE training package now available on the training management system and there was a new VTE algorithm in the clerking documentation.

Cleanliness, infection control and hygiene

- The trust had policies in place, amongst others, to cover aseptic techniques, patient transfers, hand hygiene, outbreaks, norovirus and methicillin resistant staphylococcus aureus (MRSA). These were available on the trust intranet.
- The trust reported no incidences of MRSA between September 2015 and May 2016. Eight cases of clostridium difficile were reported in the same period.
- Surgical site infection (SSI) at RLI rates were 2.8% for total hip replacements, which is above the national 90th percentile, and 4.3% for total knee replacements. However, when considering the elective pathways for elective hips and knee patients, it was noted that higher ASA patients (related to the average age and overall health of the patient) were seen at the RLI, resulting in a significantly lower percentage of patients with complex needs at FGH than at RLI.
- Sepsis screening for emergency admission patients was 75% with a target of 70%.
- Hand hygiene targets were not met for three out of 14 departments in April 2016 (ward 35 was 85% and ward 36 was 83%) and on three occasions between February 2016 and July 2016 (ward 36 was 61% and 72%, and day surgery 75%). The target for hand hygiene was 96%.
- We saw that the standard of environmental cleanliness was good across all wards inspected. Infection control and hand hygiene signage was consistent and we observed clear signage for isolation of patients in single rooms.
- Each ward had daily, weekly and monthly cleaning schedules for domestic staff, housekeepers and nursing staff. Cleaning and environmental audits were completed on a monthly basis and these showed results variations of 80% and 100% between June 2015 and June 2016.
- Incidence of infection and cleaning audits were displayed clearly to visitors at the entrance to all wards and surgical areas. These showed 87.7% compliance with clean commodes, hand hygiene, cannula and catheter audits.
- We observed staff washing their hands and all patients we spoke with told us that this was done. Hand gel was available throughout the hospitals and at the point of care. Staff used personal protective equipment (PPE) compliant with policy.
- We observed clean equipment throughout surgical areas and staff completed cleaning records and domestic cleaning schedules. Wards had appropriately equipped treatment rooms, used for aseptic technique and dressing changes.
- Clinical and domestic waste disposal and signage was good and we saw staff disposing of clinical waste appropriately. Linen storage, segregation of soiled linen in sluice rooms and the disposal of sharps followed trust policy.

Environment and equipment

- All wards and surgical areas were uncluttered and in a good state of repair. Wards had a spacious design, large floor plan and storeroom capacity was available on all wards.
- We inspected resuscitation trolleys, suction equipment on wards, and found all appropriately tested, clean, stocked and checked as determined by policy.

- All managers were responsible for ensuring risk assessments were completed to reduce the risk of slips, trips and falls. Risk assessments included types of hazard and likelihood of occurrence, quality and condition of flooring, maintenance and cleaning procedures.
- The trust took part in the Patient Led Assessment of the Care Environment (PLACE, 2015). The results showed the surgical division scored 95.4% on the cleanliness and 87.9% for the condition of the environment.

Medicines

- Medicines, including intravenous fluids, were appropriately stored and access was restricted to authorised staff. Controlled drugs were managed appropriately and accurate records were maintained in accordance with trust policy, including regular balance checks.
- We found that medicines reconciliation was not always completed in a timely way. For example, one patient had not received their medicines to treat Parkinson's disease for six days after they were admitted. A second person who had been in hospital for three days had not had their medicines reconciled by a member of the pharmacy team.
- Medicines requiring refrigeration were stored securely, however maximum and minimum temperatures had not been recorded in accordance with national guidance. In addition, temperatures had not been checked on seven occasions in September 2016.
- We checked medicines and equipment for emergency use and found they were readily available and stored appropriately. However, checks to ensure they were fit for use had not been performed in accordance with the trust policy on four days in September 2016.

Records

- We looked at 18 sets of medical records across Royal Lancaster Infirmary surgical wards. We saw they were appropriately completed, legible and organised consistently. All documentation checked was signed and dated, clearly stating named nurse and clinician.
- Royal Lancaster Infirmary used an electronic recording system so that care plan and risk bundles were accessible in real time.
- Daily entries of care and treatment plans were clearly documented and care plans and charts we reviewed had a completed patient assessment, observation charts and evaluations, food and fluid balance sheets, consent forms with mental capacity assessments where necessary, diabetes and wound care charts as applicable.
- All records reviewed included a pain score and allergies were documented in the notes. We observed patients wearing red wristbands to raise staff awareness of allergies.
- We reviewed handover sheets used by ward staff and the escalation documentation which was effective in communication and decision making for those patients at risk of deterioration.
- We saw good examples of complete preoperative checklists and consent documentation in patient's notes.

Safeguarding

- The trust had a clear safeguarding strategy and safeguarding board meetings. Minutes and action plans were clear and these meetings were well attended by senior staff from across the trust. Learning from serious case reviews was monitored and showed good attendance and compliance of staff at safeguarding training.
- Following the 2015 inspection the trust were asked to ensure all staff understood the process for raising safeguarding referrals. We found that staff on the surgical wards understood their responsibilities and discussed safeguarding policies and procedures confidently and competently. Staff felt safeguarding processes were embedded throughout the trust.
- Information was available at ward level with guides, advice and details of contact leads to support staff in safeguarding decision making.
- A safeguarding thematic review took place in 2015. The action plan from this thematic review was discussed monthly at the safeguarding operational performance group and quarterly at the Clinical Commissioning Groups (CCG's) and local safeguarding committee board.
- Training completion rates for safeguarding adults level two was 88% and 91% safeguarding children level two.

Mandatory training

- The trust set a mandatory target of 95% for completion of mandatory training.
- The trust has adopted the ten key subjects as defined in NHS Core Skills Training Framework, as its reference

point for mandatory training. Equality and diversity, health safety and welfare, infection prevention and control and information governance met or exceeded the target.

- Records showed 100% of staff at Royal Lancaster Infirmary attended the trust induction, 95% completed equality and diversity training and 98% of staff had completed health and safety training, with 92% having completed governance information training. Additionally, 83% of staff had attended adult basic life support, 94% infection, prevention and control training level one and two.
- Display boards in each ward manager's office had a mandatory training plan information and staff training data. An action plan was in place to achieve trust targets.
- Staff told us they accessed mandatory training in a number of ways, such as online modules and eLearning and by trainer delivered sessions. Staff said they were supported with professional development through education and revalidation.
- Most staff we spoke with confirmed they were up to date with mandatory training. However, some felt they were behind with training due to staff shortages.
- Senior managers told us that training rates were increasing due to easier access to eLearning.
- Staff said they had a robust induction mentorship and preceptorship programme.

Assessing and responding to patient risk

- The trust had recently introduced the National Early Warning Score (NEWS) risk assessment system for recognition and treatment of the deteriorating patient. Prior to this, the trust used their own version of an early warning system for 15 years. The strategy and processes for recognition and treatment of the deteriorating patient in surgery had been updated in August 2016 to align with national guidance and change from a previous early warning score and 'track and trigger' system.
- NEWS audits in 2015 showed that a target of 91% was not met on two wards out of six between August 2015 and Nov 2015 on Ward 34 with consecutive scores of 71%, 78%, 66%, and 67%. Ward 33 did not meet the 91% target in September 2015 with a score of 87%, and again in December with 88% and March 2016 with a score of 84%. Two of the four wards met the NEWS targets.
- We saw full completion of NEWS risk assessments and sepsis screening tools in the records we checked. Staff we spoke with told us that they were aware of escalation procedures.
- Comprehensive risk assessments were in place in surgical records and included the completion of cognitive assessment tools, falls risks, pressure ulcer risks, and bed rails assessments.
- Care planning based on patients assessed risk was good. We saw evidence of risk assessment for nutrition with the Malnutrition Universal Screening Tool (MUST) and this helped staff identify patient nutritional needs. Pain scores for patients were available.
- Staff knew how to highlight and escalate key risks that could affect patient safety, such as staffing and patient assessment and screening.
- A trust audit (April / May /June 2016) measured compliance with the 'Five Steps to Safer Surgery' procedure. This showed 98% compliance for the undertaking of the team brief before surgery. The audit also showed 100% sign-in by the surgeon prior to anaesthesia, 99.6% 'time out' opportunities taken by all members of the theatre team to stop and listen to patient safety information. Debrief was recorded at 90% attendance rate. The audit recommended further work on encouraging the team debriefs and the dissemination of learning.
- We observed the checklist being used appropriately in theatre, saw completed preoperative checklists, and consent documentation in patient's notes.

Nursing staffing

- The National Institute for Health and Care Excellence (NICE) states that assessing the nursing needs of individual patients is paramount when making decisions about safe nursing staff requirements for adult inpatient wards in acute hospitals.
- As at July 2016, the surgical division reported a vacancy rate of 4.1 % in registered nurses. The trust reported that national and international campaigns were in place to address the recruitment gap.
- Sickness rates at Royal Lancaster Infirmary were 4% between April 2015 and March 2016.
- As at July 2016, the trust reported a turnover rate of 8% for all staff groups in the surgical division. The trust reported that turnover is reducing in key areas and hot spots are being acted on at a divisional level.

Surgery

- As at July 2016, the trust reported the surgical division attendance rate of 95.5% for all staff groups; this is 0.2% below their target of 95.7%. The trust reported that workforce teams are identifying hot spot areas, provide intervention and support, plan programmes of support, and conduct audits including return to work. Long term absence cases are reviewed on a monthly basis by the divisional workforce teams, supported by occupational health & wellbeing to consider reasonable adjustments to facilitate a return to work.
- The trust had introduced a 'red rules' and 'safer staffing system' to identify when lower than optimal staff numbers may affect patient care and to provide support and initiate mitigation of risk to patient safety. Escalation processes were in place through a process of contacting the matron, service manager and chief matron.
- Nursing skill mix was established as a 60:40 ration of qualified nurses to health care assistants. The nurses to patient ratio was calculated at a 1 qualified nurse to 8 patients in surgical wards. The nurse to patient ratio in the Acute surgical Unit (ASU) was 1:5 on day shift and 1:8 at night. They had an online system of monitoring acuity on a daily basis. This ran alongside a dashboard of staffing to make it easy to work out staffing shortfalls and accurate real time ward acuity levels.
- We were told that staffing in ASU was always above national guidelines. No bank or agency staff were used in ASU and all shifts were covered by current staff.
- Monitoring of patient acuity, dependency and actual against planned staffing levels took place on a shift-by-shift basis on all wards. Site management cover was provided out of hours 24 hours per day, seven days per week by a team of senior nurses.
- Trust information (September 2016) showed actual staffing levels were less than planned staffing levels on some shifts, but safe in relation to surgical activity and the assessed patient acuity.
- Staffing levels for qualified nursing staff was 158.4 whole time equivalent (WTE) across all wards between April 2016 and July 2016 inclusive. The planned qualified staffing levels were 175 WTE. Figures provided showed non-qualified staff levels were 113 WTE. The planned unqualified levels were 87.4 WTE. Showing that unqualified staff was increased to support the shortage of qualified staff but causing an alteration to the skill mix on the wards.
- Theatre staffing comprised of 72:28 ratio of qualified nurses to support staff. The lowest monthly level of agency usage was 12.8% in April 2015 and the highest monthly agency usage of 20.9% August 2016. The average level of agency use in theatres was 16.5% across the 12 month period from April 2015 to March 2016. Although the agency figures were high, staff we spoke to felt that practice remained safe.
- Numbers of staff on duty was displayed clearly at ward entrances.
- The trust had established a staff 'bank', which provided cover for short notice requests to reduce agency staff usage.
- Although, most staff acknowledged the trust had tried to increase the effectiveness of recruitment and retention, they told us individuals had been working under extreme pressures for some time to cover shifts. During individual and group interviews staff told us they had been working in difficult circumstances during the last eighteen months to cover staff and skill shortages
- We reviewed staff rotas for the month before inspection and saw 11 shifts were not staffed to establishment at Royal Lancaster Infirmary. There were processes in place to move staff from other wards and departments when possible to ensure safe staffing levels.

Surgical staffing

- As at July 2016, the trust reported a vacancy rate of 4.6% in consultant medical staff. The trust reported that a major recruitment programme was underway to address the gaps in consultant medical staffing.
- The proportion of consultants and junior (foundation year 1 and 2) doctors reported to be working at the trust were higher than the England average. Junior doctors said they required additional doctors at foundation level one and two due to demands on the service. They were aware of on-going recruitment drives and stated that managers were realistic and problem planning. The doctors we spoke with felt that practice was same regardless of the shortages.
- Consultants followed an 18 week rota. However, this will change in January 2017 to a 10 week rota to increase consultant visibility, continuity and to extend theatre lists.
- There was consultant, specialist and associate specialist (SAS), and specialist trainee (ST3) doctors onsite and out

of hours on- call providing cover from 8am to 6pm Monday to Friday for general surgery, trauma and orthopaedics, urology, ENT, ophthalmology, breast and maxillofacial.
- ENT and urology (each service) had an on-call Monday to Thursday with one consultant & one SAS. Friday to Sunday, 24 hour cover was provided from one site, by either a consultant or SAS. Maxillofacial and ophthalmology (each service) received 24 hours per day consultant on-call cover across the trust.
- Daily handovers were carried out with members of the multidisciplinary team and referrals were made to the dietitian, diabetes nurse, or speech and language team when needed.

Major incident awareness and training

- Surgical staff participated in training to test the business continuity plans and escalation processes.
- The trust major incident response plan was in place and available to staff on the trust intranet.
- There were business continuity plans for surgery and senior staff explained these during a group interview. These included the risks specific to the clinical areas and the actions and resources required to support recovery.
- A trust assurance process was in place to ensure compliance with NHS England core standards for emergency preparedness, resilience, and response.
- The trust's major incident plan provided guidance on actions to be undertaken by departments and staff, who may be called upon to provide an emergency response, additional service, or special assistance to meet the demands of a major incident or emergency.

Are surgery services effective?

Good

We rated effective as 'good' because:

- Patients were treated in accordance with national guidance and enhanced recovery (fast track) pathways were used. Local policies were written in line with national guidelines. A range of standardised, documented pathways and agreed care plans were in place across surgery.
- Evidence based care and treatment national audits identified mixed outcomes for all audits. In the 2015 Bowel Cancer Audit (trust wide results), 75% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was better than the national aggregate. The 2014 figure was 52%. The Risk-adjusted 90-day post-operative mortality rate was 3.8% which was within the expected range. The Risk-adjusted 2-year post-operative mortality rate was 24.7% which falls within the expected range. The Risk-adjusted 90-day unplanned readmission rate was 16.8% which falls within the expected range. The Risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 56% which falls within the expected range.
- The National Emergency Laparotomy Audit (NELA) report (2015) showed Royal Lancaster Infirmary achieved a rating over 70% for five measures and had a good rating for nine out of 10 elements of the audit. The element which was worse than required related to orthogeriatricians input for patients over 70 years old.
- The Patient Outcomes Reporting Measures (PROMS) for groin hernia metrics and knee replacement metrics were about the same as the England average whilst hip replacement metrics had mixed performance.
- Pharmacists regularly reviewed drug records for pain medication. Various pain relief methods were used for major surgery to assist with pain relief post-operatively, which improved patient comfort.
- Thematic reviews were undertaken as part of everyday practice and included patient falls, number of injuries and low harm incidents, ophthalmology capacity issues, urology incidents, waiting list office incidents, safeguarding referrals, and pressure ulcers.
- The enhanced recovery pathway was used for patients requiring hip and knee replacement, with multidisciplinary input from the pre-assessment team, nurses, physiotherapists, occupational therapists, consultants, orthogeriatricians and anaesthetists.

Evidence-based care and treatment

- Patient treatment was in accordance with national guidance from the National Institute of Health and Care Excellence (NICE), the Association of Anaesthetists, and The Royal College of Surgeons.
- We saw that patients had their needs assessed and their care planned and delivered in line with evidence-based guidance, standards and best practice.

- The trust did not participate in the 2015 National Vascular Registry (NVR) audit, as teh trust did not provide vascular services.
- The trust's results from the Patient Reported Outcomes Measures (PROMS) from April 2015 to March 2016 for Groin Hernia metrics and Knee Replacement metrics were about the same as the England average whilst Hip Replacement metrics had mixed performance with EQ VAS being better than the England average, EQ 5D index and the Oxford score were slightly worse.
- According to the National Joint Registry Report covering period January 2016 to October 2016 data, the trust had performed 129 hip and 132 knee replacements.
- Thematic Reviews were undertaken as part of everyday practice and included patient falls, number of injuries and low harm incidents, ophthalmology capacity issues, urology incidents, waiting list office incidents, safeguarding referrals, and pressure ulcers.

Pain relief

- Patients were regularly asked about their pain levels, particularly immediately after surgery, and this was recorded on a pain scoring tool that was used to assess patients' pain levels. All patients reported their pain management needs had been met.
- There was a pain assessment scale within the NEWS chart used throughout the hospital. NEWS audits were in place and supported through feedback from the Friends and Family Test and directly from patients.
- Each ward had identified a pain link nurse and pre-planned pain relief was administered for patients on recovery pathways. All patients we spoke with reported their pain management needs had been met.
- An audit of pain management in the recovery room recommended the provision of more information to patients regarding patient controlled analgesia (PCA) to optimise pain relief. Staff asked patients regularly if they had any pain, so they could administer analgesia promptly or request an anaesthetic review.
- A dedicated pain team was accessible to educate on new equipment and medications. The pain team visited patients with PCAs the day after surgery. The pain team were available Monday to Friday 8am to 5pm. Anaesthetists provided support with pain relief out of hours.
- Patients admitted with a fractured neck of femur had their pain assessed immediately upon presentation at hospital and within 30 minutes of administering initial analgesia, hourly until settled on the ward and regularly as part of routine nursing observations throughout admission.

Nutrition and hydration

- Priority was given to appropriate nutritional and hydration support for surgical patients on each ward. Staff identified patients at risk of malnutrition by working with patients and their families to complete a MUST score.
- Snack rounds were carried out on all surgical wards to supplement scheduled meals and ensure that appropriate patients had high calorie options throughout the day.
- Ward audits included checking whether patients received a nutritional risk assessment on admission and whether this risk assessment was reviewed within the required timescales. Information we saw during inspection was good.
- We observed appropriately completed fluid balance charts and dietary intake charts.
- The nutritional risk assessment identified the levels at which dietitian referral was recommended. The dietetics service received electronic inpatient referrals and provided input to all wards as required.
- Arrangements were in place for when enteral feeding was required out of hours as part of a protocol to ensure that patients did not have to wait for a dietitian to be on duty.
- We saw a range of food choice, meals and snacks. Patients who required nutritional support were identified.
- Surgical pre-operative assessments performed by nursing staff, offered tailored nutrition and hydration guidance to patients and provided all elective patients with fasting instructions to follow on the day of their surgery.
- Information and lessons learnt information was shared at the clinical leaders, clinical managers and nutrition link nurses forums, nutrition steering group, and with catering managers.
- Records showed patients were advised as to what time they would need to fast from. Fasting times varied depending on whether the surgery was in the morning or afternoon.

- We reviewed 18 records and saw nurses completed food charts for patients who were vulnerable or require nutritional supplements and support was provided by the dietetic department.
- Meal charts were completed comprehensively and reviewed.

Patient outcomes

- Between March 2015 and February 2016, patients at Royal Lancaster Infirmary had a similar expected risk of readmission for non-elective admissions and a higher expected risk for elective admissions. Trauma and Orthopaedics has the largest relative risk of readmission for both non-elective and elective admissions.
- In the 2015 Hip Fracture Database Annual Report for Royal Lancaster Infirmary the proportion of patients having surgery on the day of or day after admission was 67.4%, which does not meet the national standard of 85%. The 2015 figure was 60.5%. The perioperative medical assessment rate was 87.7%, which does not meet the national standard of 100%. The length of hospital stay was 28.1 days, which falls in the worst 25% of trusts. The 2015 figure was 25.4 days. There were 310 cases in the audit and case ascertainment was 83.1% in 2015 which was lower than the national aggregate of 90.7%.
- In the 2015 Bowel Cancer Audit (trust wide results), 75% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was better than the national aggregate. The 2014 figure was 52%. The Risk-adjusted 90-day post-operative mortality rate was 3.8% which was within the expected range. The 2014 figure was 3.4%. The Risk-adjusted 2-year post-operative mortality rate was 24.7% which falls within the expected range. The 2014 figure was 26.7%. The Risk-adjusted 90-day unplanned readmission rate was 16.8% which falls within the expected range. The 2014 figure was 14.3%. The Risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 56% which falls within the expected range. The 2014 figure was 59%.
- Results from the Patient Reported Outcomes Measures (PROMS) from April 2015 to March 2016 for Groin Hernia metrics and Knee Replacement metrics were about the same as the England average whilst Hip Replacement metrics had mixed performance with EQ VAS being better than the England average, EQ 5D index and the Oxford score were slightly worse.
- The National Emergency Laparotomy Audit (NELA) report (2015) showed Royal Lancaster Infirmary achieved a rating over 70% for five measures and had a good rating for nine out of 10 elements of the audit. The element which was worse than required related to orthogeriatricians input for patients over 70 years old. This showed a positive outcome.
- Royal Lancaster Infirmary theatre usage in June 2016 was highest in the Centenary Theatre 4 at 87.8% and lowest in the Women's Unit Theatre 2 (Obstetrics) at 59.7%. The operating time is calculated as time between anaesthetic being induced and operating ending.

Competent staff

- At July 2016 the trust reported that, in surgery, 90% of appraisals for leaders with staff responsibility, 100% of appraisals for senior leaders with no staff responsibility, and 93% of appraisals for medical staff had been completed. Eighty-two percent all other staff had received an appraisal compared to a trust target of 95% for other. The trust has implemented a new e-appraisal system for leadership appraisals and that some appraisals in the 'other' category have had to be deferred due to acute service pressures. We saw evidence to confirm appraisal rate data. Staff told us the appraisal target would be met within the allocated timescales.
- Staff we spoke with felt able to discuss their training needs with their line manager. Many discussed opportunities to further their career and stated they were encouraged to undertake modules appropriate to their training needs.
- Support was provided for nursing revalidation by identifying expectations and continued education required.

Multidisciplinary working

- Protocols had been developed for the effective handover of patients to Royal Lancaster Infirmary when needed. These involved the identification of bed availability, NEWS assessment and both verbal, electronic and written transfer of information.

- Therapists worked closely with the nursing teams on the ward where appropriate. Ward staff told us they had good access to physiotherapists and occupational therapists.
- There was pharmacy input on the wards during weekdays and dedicated pharmacy provision for each ward was planned.
- A Pharmacy Transformation Project within surgical services, was underway to enable focusing the pharmacy workforce towards clinical activities; working more closely with patients and working alongside doctors and nursing staff in clinical roles to optimise medicines and secure better outcomes for patients. It included review of all non-clinical pharmacy services to identify those that might be stopped or delivered differently in future. The trust has developed a partnership with a provider of pharmaceutical services; external pharmacy to provide on-site retail outlets and undertake dispensing for outpatients. Good progress has been achieved with seven day opening hours.
- Staff explained to us the wards worked with local authority services as part of discharge planning and weekend discharges requiring support were identified at pre-assessment so that appropriate equipment and support could be arranged.
- Protocols had been developed for the effective handover of patients to Royal Lancaster Infirmary when needed. These involved the identification of bed availability, NEWS assessment and both verbal, electronic and written transfer of information.
- We observed staff, including those in different teams and services, becomes involved in assessing, planning and delivering people's care and treatment.
- There were established multi-disciplinary team (MDT) meetings for care pathways and these included nurse specialists, surgeons, anaesthetists, and radiologists.
- Ward staff worked closely with the patient, their family, allied health professionals and the local authority when planning discharge of complex patients to ensure the relevant care was in place and that discharge timings were appropriate.

Seven-day services

- The elective orthopaedic theatre and surgical team had plans to deliver a seven day service from January 2017. Weekend morning capacity was currently utilised in theatres.
- Out of hours ward and on-call cover for general surgery and trauma & orthopaedic service had a non-resident overnight consultant, SAS or ST3.
- We were told that medical support was provided by foundation year 1 doctors and a senior review on Saturday and Sunday . Weekend ward cover was provided as part of general on-call with junior doctors providing 24 hours per day ward cover. Theatres had 24 hour shift cover plus a non-resident on call.
- All surgical wards were looking at undertaking Keogh ward rounds to improve seven day working. Keogh ward rounds are consultant-delivered ward rounds providing a structured and consistent opportunity for the multidisciplinary team to review patients' progress, share information and communicate with the patient.
- There were dedicated physiotherapist and occupational therapists for each ward available Monday to Friday. There was limited access to physiotherapists and occupational therapist at the weekend and patients were prioritised by level of need and orthopaedic plan of care and treatment. Prior to visiting patients the physiotherapist and occupational therapist receive a handover from the weekday dedicated team.
- There was no speech and language support service at the weekends.
- There was a pharmacist onsite Monday to Sunday, 9am to 5pm. A pharmacy technician attends the ward daily to undertake medication reconciliation.

Access to information

- Risk assessments, care plans, and test results were completed at appropriate times during the patient's care and treatment. Records were available to staff enabling effective care and treatment.
- We saw surgical wards utilise a new electronic records system to record patient care plans and risk bundles. This allowed for immediate access by any other clinician or professional providing care for that patient. The system was not fully embedded but actively used on all surgical wards.
- There were appropriate and effective systems in place to ensure patient information was co-ordinated between systems and accessible to staff.
- Staff had access to policies, procedures and guidelines on the trust intranet system. All staff felt confident in accessing the information they required.

Surgery

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We looked at clinical records and observed that patients had consented to surgery in line with the trust policy and Department of Health guidelines.
- Mental capacity assessments were undertaken by the nurse or Consultant responsible for the patient's care and Deprivation of Liberty Safeguards (DoLS) were referred to the trust's safeguarding team.
- Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was delivered as part of staff induction. The completion rated for MCA and DoLS training was 88% and was completed as part of the Safeguarding adults level 2 training.
- MCA and DoLS assessments were included in risk assessments.
- We found policy and procedures in place, ensured that capacity assessments and consent was obtained by middle grade level medical staff or above. Elective patients were informed about consent as part of their pre-assessment process and were given information regarding risks and potential complications. However, most patients consented on the day of procedure.
- An action plan created to improve consent practice includes the creation of patient information leaflets, procuring color printers for clinical areas-consent to be taken in the clinics with documentation of contact details, developing electronic consent forms, and the standardising of the consent process with clear documentation.
- There was access to an independent mental capacity advocate (IMCA) when best interest decision meetings were required.
- Mental health liaison support was available at Royal Lancaster Infirmary.

Are surgery services caring?

Good

We rated caring as 'good' because:

- The Friends and Family Test (FFT) response rate for Surgery at the trust was 31% which was better than the England average of 29% between October 2015 and September 2016. Royal Lancaster Infirmary (RLI) had a response rate of 29%, which was the same as the England average of 29%. The monthly percentage recommended fluctuated between 82% and 100%.
- The National Cancer Experience Survey 2015 (published 2016) published a score of 8.8 out of 10 average rating. 81% of patients stated they were involved in decision making, 89% given the name of their specialist nurse, 93% treated with dignity and respect and 92% stated they received contact information.
- We observed the treatment of patients to be compassionate, dignified, and respectful throughout our inspection. Ward managers and matrons were available on the wards so that relatives and patients could speak with them as necessary.
- Patients and relatives said they felt involved in their care and they had the opportunity to speak with the Consultant looking after them. Patients told us staff kept them well informed and explained procedures and treatment. Patients felt they were well educated, supported, and prepared for their surgical procedures.
- Patient and family feedback was very complementary. Patients we spoke to said, "Service beyond amazing", "polite nurses", "can't fault anything", communication good" and "treated perfectly".
- Multi-faith spirituality groups were accessible.

Compassionate care

- The Friends and Family Test response rate for Surgery at the trust was 31% which was better than the England average of 29% between October 2015 and September 2016. Royal Lancaster Infirmary (RLI) had a response rate of 29%, which was the same as the England average of 29%. The monthly percentage recommended fluctuated between 82% and 100%.
- The National Cancer Experience Survey 2015 (published 2016) published a score of 8.8 out of 10 average rating. 81% of patients stated they were involved in decision making, 89% given the name of their specialist nurse, 93% treated with dignity and respect and 92% stated they received contact information.
- The trust took part in the Patient Led Assessment of the Care Environment (PLACE, 2015). The results showed the surgical division scored 85.3% for providing privacy and dignity for patients and 86% for dementia care.
- 'You said, we did' was used to identify patient views. Some comments related to improved food with involvement of chef and meals plated up on ward.

- Patients we spoke to said, “Service beyond amazing”, “polite nurses”, “can’t fault anything”, communication good” and “treated perfectly”.
- Each patient felt their privacy and dignity had been respected and they were happy with the quality of care they had received.
- During inspection, we observed patients being spoken to in an appropriate manner, information being shared in a method that they understood and saw staff take the time to reassure and comfort patients.

Understanding and involvement of patients and those close to them

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

Emotional support

- Patients reported that staff spent time with them and staff recognised the importance of time to care and support patients emotional needs. Care plans highlighted the assessment of patients emotional, spiritual and mental health needs.
- We were given information about support groups for patients. These included stoma care support groups, pain management groups and open access to clinical nurse specialist helplines for surgical patients.
- An extensive multi-faith chaplaincy service was available within the hospital. We observed chaplains during their support to patients and relatives. Patients and relatives said this was an extremely positive experience and individualised support.
- Clinical psychology support services commissioned by the trust supported patients as necessary. For example support was routinely provided for burns patients, amputees and those requiring stomas.
- Staff were aware of the impact that a person’s care, treatment or condition may have on their wellbeing, both emotionally and socially.

Are surgery services responsive?

Good

We rated responsive as 'good' because:

- The trust was actively working with commissioners to provide an appropriate level of service based on demand, complexity and commissioning requirements. This included changes in discharge procedures such as the implementation of the ‘Hospital Home Care Team’ and the discharge support team to enable more efficient and timely discharge with on-going rehabilitation.
- The divisional management team had taken action to address the low referral to treatment targets (RTTs). This included a local amnesty with CCGs allowing the treatment of patients in order, treating the longest waiters on the RTT pathway, changes to the RTT standard, and through provision of additional capacity (sub-contracting to the independent sector, additional activity sessions and operating department efficiencies).
- The trust’s referral to treatment time (RTT) for admitted pathways for Surgery has been worse than the England overall performance between October 2015 and August 2016. However, the latest figures for September 2016 showed an improvement in the trust’s performance, with 75% of this group of patients treated within 18 weeks, versus the England average of 75%.
- For the period Q1 2015/16 to present the trust cancelled 561 operations on the day of surgery. Of the 561 cancellations, all were rescheduled andtreated within

28 days> This was better than the England average. The trust's cancelled operations as a percentage of its elective admissions were worse than the England average.

- The hospital had an escalation policy and procedure to deal with busy times and matrons and ward managers held capacity bed meetings to monitor bed availability.
- The service was responsive to the needs of patients living with dementia and learning disabilities. The surgical division had dementia champions. There was access to an independent mental capacity advocate (IMCA) for when best interest decision meetings were required.
- Further initiatives such as completion of the Intensive Support Team (IST) model, identification of theatre productivity improvement through The Productive Operating Theatre model (TPOT) and identification of outpatient efficiency improvement were developed.
- Complaints had reduced from the previous year, were handled in line with the trust policy, and discussed at all monthly staff meetings. This highlighted that training needs and learning was identified as appropriate.

Service planning and delivery to meet the needs of local people

- The trust was actively working with CCG's to provide an appropriate level of service based on demand, complexity and commissioning requirements. This included changes in discharge procedures such as the implementation of the Hospital Home Care Team and the discharge support team, to enable more efficient and timely discharge with on-going rehabilitation.
- The trust advised that delivery plans with three main objectives were in place to implement the NHS Five Year Forward View; to restore & maintain financial balance; and to deliver core access and quality standards for patients.
- The surgical and critical care business plan for 2016/17 incorporates the Better Care Together restructuring of its healthcare for the local population with a significant shift in emphasis on to community care.
- Better Care Together aimed to give greater support to patients in the community, reducing the need for hospital admissions and creating a significant reduction in hospital beds. It saw a key part of the success of this change being in the community partnerships that it could develop. Community Partnerships in place included the Hospital Home Care Team and the Discharge Support Team, which were integrated care teams working together to improve and quicken appropriate discharges in the community post-surgery.

Access and flow

- Between April 2015 and March 2016 the average length of stay for surgical elective patients at the Royal Lancaster Infirmary was 3.7 days, compared to 3.3 days for the England average. For surgical non-elective patients, the average length of stay was 5.9 days, compared to 5.1 for the England average. The current length of stay for trauma, orthopaedic and general surgery patients was above the national average due to complexity of cases and shortage of local authority services.
- The trust's referral to treatment time (RTT) for admitted pathways for Surgery has been worse than the England overall performance between October 2015 and August 2016. However, the latest figures for September 2016 showed an improvement in the trust's performance, with 75% of this group of patients treated within 18 weeks, versus the England average of 75%.
- The divisional management team had taken action to address the low RTTs. This included a local amnesty with CCG's allowing the treatment of patients in order, treating the longest waiters on the RTT pathway, changes to the RTT standard, and through provision of additional capacity (sub-contracting to the independent sector, additional activity sessions and operating department efficiencies).
- Only trauma and orthapedics, and opthalmology specialties were above the England average for admitted RTT (percentage within 18 weeks).
- The National Cancer 2 Week Wait target confirmed performance was 95.1%, 98.2%, 96.3%, 96.6% and 95.3% between April 2016 and August 2016 across the trust surgical division. The trajectory for 2016/2017 was 93.1% in 8 of the 12 months, and has been exceeded.
- For the period Q1 of 2015/16 to the date of inspection, the trust cancelled 561 operatiosn on the day of surgery. Of the 561 cancellations, all were rescheduled and treated within 28 days. This was better than the England average. The trust's cancelled operations as a percentage of its elective admissions were worse than the England average.

Surgery

- The National Cancer 18 week referral to treatment pathway performance against the sustainability and transformational fund (STF) trajectory showed that the trust achieved the trajectory of 88.6% in April at 89.47% and the trajectory for May at 89.71%.
- Further initiatives such as completion of the Intensive Support Team (IST) model, identification of theatre productivity improvement through The Productive Operating Theatre model (TPOT) and identification of outpatient efficiency improvement were developed.
- For the period Q1 2015/16 to the present date, the trust/site cancelled 561 operations on the day of surgery. Of the 561 cancellation, all were rescheduled and treated within 28 days. This was better than the England average. The trust's cancelled operations as a percentage of its elective admissions were worse than the England average.
- Total on day cancellations for non-Clinical reasons for June 2016 were 55, which equates to 1.34% with a year to date position of 0.93% against a new, internal, stretch target of 0.7%.
- The key cancellation themes for June were: 19 cancellations encountered for lack of sufficient operating time, 13 associated with trauma impacting on electives, four due to bed shortage, 18 cancellations encountered for admin/others, six cancellations associated with equipment availability and four cancellations associated with medical staff sickness or absence.
- The cancellation themes associated with the admin others category were associated with booking errors or availability of medical staffing.
- There were no 28 day breaches encountered for the year to June 2016.
- Individual theatre usage was consistent from April 2016 to June 2016 inclusive. Five theatres had remained consistently above 83% usage.
- Pre-operative assessment of elective patients was organised to take place as early as possible in the elective pathway once patients were added to the waiting list.
- The elective orthopaedic service operated electively up to six days of the week. Elective admissions were planned based on Consultant availability and complexity of the procedures. We found the trust had plans in place to increase the service with a daily extra theatre list and by extending hours at the weekend.
- The elective ward had daily Consultant led ward rounds, Monday to Friday. Work was on going to review the options available to the department to enhance the care provided to patients and to increase flexibility with theatre lists.
- The trust followed a transfer policy regarding the movement of patients between hospital sites for rehabilitation. This policy was in place to minimise the risk to patients post-surgery and to prevent transfer of patient with complex medical needs. Patients with an ASA 3 (American Society of Anaesthesiologists- severe systemicdisease) or above do not transfer and remain at Royal Lancaster Infirmary. Several members of staff informed us that the protocol for transfer was embedded, safe and robust with strict guidelines to adhere to.
- Discharge planning began at the pre-assessment stage. The trust set a planned date of discharge as soon as possible after admission. surgical wards worked with the discharge co-ordinators to reduce delays in handing over care to social services or nursing home providers for those patients with complex needs.
- At an operational level, flow was maximised by employing discharge co-ordinators. The role of the co-ordinator enabled improved communication between patient, ward staff, clinicians, Adult Social Care and all AHP's involved in their care. We were told that having dedicated co-ordinators increased efficiency on the ward when planning and arranging appropriate discharges.
- Royal Lancaster Infirmary theatre usage in June 2016 was highest in the Centenary Theatre 4 at 87.8% and lowest in the Women's Unit Theatre 2 (Obstetrics) at 59.7%. The latter was due to the theatre being an emergency obstetric theatre, with protected access. The operating time is calculated as time between anaesthetic being induced and operating ending.

Meeting people's individual needs

- Surgical teams' personalised patient care in line with patient preferences, individual and cultural needs.
- Ward information boards identified who was in charge of wards for any given shift and who to contact if there were any problems.
- Leaflets were available for patients regarding their surgical procedure, pain relief and anaesthetic. Alternative languages and formats were available on request.

- Ward managers were clear about zero tolerance for discrimination.
- There was good access to the wards. There were lifts available in each area and ample space for wheelchairs or walking aids.
- The Bay Dementia Hub was a service to help people worried about their memory, or residents diagnosed with dementia and their family and friends. This new initiative sought to build on the existing work of dementia-specialist. The surgical division applied the 'This is me' personal patient passport / health record to support patients with learning needs and dementia. Symbols on electronic white boards identified special requirements such as dementia, falls risk and dietary needs. Forget-me-not personal information booklets.
- The care of the elderly team screened everyone for confusion, delirium and undiagnosed dementia as part of the National Commissioning for quality and Innovation(CQUIN), which also identified diagnosis of dementia using specific admission documentation. If confusion or forgetfulness was evident but there was no confirmed diagnosis of dementia a cognitive assessment was carried out by nurses on the surgical ward and appropriate referral is made for diagnosis.
- There was a Matron for Professional Standards in Dementia in post that formed part of the Safeguarding Team. She managed the Care of the Elderly teams to ensure the appropriate care was put in place on assessment, and carer/family involvement was included. The surgical division had dementia champions. There was access to an independent mental capacity advocate (IMCA) for when best interest decision meetings were required.
- Royal Lancaster Hospital offered a dementia menu for those who needed it. Support needs were identified through the Butterfly Scheme. This encouraged families and carers to be involved in choosing from the menu and helping at mealtimes.
- There were no mixed sex accommodation breaches over a 12 month period on wards 33, 34, 35, or 36.
- Specific equipment had been designed for the use of bariatric patients to ensure safety for both staff and patients. Requests were made when further equipment was required.
- The trust utilised the NHS Shared business contract and regularly accesses services from two translation providers. The translation and interpretation service is available 24 hours per day and is booked by the ward or department calling the hospital switchboard. The switchboard holds the corporate booking PIN and passcodes. For planned activity the translation service can been booked in advance, pre booking has the option of requesting a preferred translator to ensure continuity.

Learning from complaints and concerns

- Between 27 October 2015 and 27 October 2016, there were 126 complaints about surgery and critical care, of which 86(68.3%) related to Royal Lancaster Infirmary. The trust took an average of 26.43 days to investigate and close complaints. This is in line with its complaints policy, which states that complaints should be dealt with within 35 days, unless another timescale has been agreed with the complainant. There was an average of 10 complaints per month, and trend analysis showed that the number of monthly complaints remained consistent. RLI's theatres received the highest number of complaints overall (19, which is 16% of the surgery and critical care total).
- Ward meetings discussed complaints received as a standing agenda item. A full report is provided monthly, quarterly and annually.
- All wards and departments had posters situated at the entrance clearly explaining what to do if anyone is unhappy with the care, services or facilities we provide. Contact details for the Patient Advice Liaison Service and Complaints is clearly listed. Wherever possible the patient Advice Liaison Service (PALS) would look to resolve at a local level.
- Patients or relatives making an informal complaint were able to speak to individual members of staff or the ward manager. Themes of complaints were discussed with staff who were encouraged to share learning to prevent recurrence.
- Ward staff were able to describe complaint escalation procedures, the role of PALS and the mechanisms for making a formal complaint.

Are surgery services well-led?

Good

We rated well-led as 'good' because:

Surgery

- Senior managers had a clear vision and five year plan for the surgical service division. Staff were able to repeat and discuss its meaning. Joint clinical governance and directorate meetings were held each month.
- The directorate risk register was updated following these meetings and we saw that action plans were monitored across the division. Staff said managers were available, visible, and approachable. They also said leadership of the service and staff morale was good with staff supported at ward level.
- Staff spoke positively about the service they provided for patients and emphasised quality and patient experience. Staff on the wards and in theatres worked well together with respect between specialities and across disciplines. We saw examples of good team working on the wards between staff of different disciplines and grades.
- Improvements compared with results from the 2014 survey were seen in other areas, such as staff who felt they received support from their immediate line manager, staff feeling the trust made effective use of patient and service user feedback, improved percentage of staff reporting most recent experience of harassment, bullying or abuse.
- Clinical audit and effectiveness steering groups took place on a monthly basis to provide a holistic understanding of performance, which integrates the views of people with safety, quality, activity and financial information.

However:

- Staff told us they had been working in difficult circumstances during the last eighteen months to cover staff and skill shortages. Staff said this had led to some staff working under extreme pressures for an extended period to cover shifts.
- The trust supported the Nursing Times 'Speak Out Safely' campaign encouraging staff members who had a genuine patient safety concern to raise this within the organisation at the earliest opportunity. Staff we spoke to told us they felt confident about speaking out. However, some staff continued to have concerns about speaking out and felt that there were on-going difficulties around speaking out due to a previous blame culture and alleged bullying.

Vision and strategy for this service

- The trust launched the Better Care Together clinical strategy in February 2014. We met with senior trust and divisional managers who were clear about the vision and strategy for surgery and identified actions for addressing issues within the division.
- The trusts Better Care Together is one of 50 'vanguards' helping to deliver The Five Year Forward View, the vision for the future of the NHS. Vanguards are leading on developing new care models that will act as blueprints for the future of the health and care system across the country.
- The trust vision and strategy was displayed in wards and staff demonstrated the values of the trust during the inspection and were clear about their role in contributing to achieving the trust wide and directorate goals.
- The programme management office also reported into the sustainability programme board and offered support to the divisional teams with hands-on assistance to help identify and deliver efficiency.

Governance, risk management and quality measurement

- Staff told us that the governance framework had greatly improved. They said process was effective and efficient in supporting the delivery of the strategy and good quality care.
- We were told that wards received a monthly 'we see' report, which included lessons learned feedback. Matrons disseminated information with ward staff at ward meetings and safety huddles.
- A clear responsibility and accountability framework had been established and was referred to as 'board to ward'. Staff at different levels were clear about their roles and understood their level of accountability and responsibility. It was highlighted that staff felt that openness and transparency had also improved and that staff at all levels were eager to learn and improve their practice.
- The surgical division had a detailed risk register, which was detailed and thorough in identifying, recording and managing risks, issues and mitigating actions. There was alignment between the recorded risks and what staff told us is 'on their worry list'. The main concerns were linked to staff shortages at nursing and junior doctor levels. The register was updated regularly.

- Statistics showed that the number of risk reviews completed on time was at 94.1%. The risk register showed that there were 86.3% risks with open actions and 88.9% open actions showing progression.
- All senior staff in the service were responsible for the monitoring of performance and quality information. Measures included finance, complaints, mortality, and morbidity, cancelled operations, the quality dashboard metrics, capacity and demand information and waiting time performance. The matrons conducted weekly audits of the ward areas with ward managers to measure quality.
- Clinical audit and effectiveness steering groups took place on a monthly basis to provide a holistic understanding of performance, which integrated the views of people with safety, quality, activity and financial information.

Leadership of service

- The clinical director, divisional general manager and assistant chief nurse led the surgical division. The surgical division comprised of four matrons, six service managers and five clinical leads.
- Most staff we spoke with told us that they felt leaders had the skills, knowledge, experience and integrity that they needed, both when they were appointed and on an on-going basis. This included the capacity, capability, and experience to lead effectively.
- Staff said that leaders understood the challenges of achieving and maintaining good quality care and had identified the actions needed to maintain and improve services.
- Senior team members were said to be visible and approachable. It was acknowledged that matrons, service managers and deputy chief nurse were very "hands on" in supporting the staff on the wards.
- The matrons met regularly with all of the divisional matrons and the deputy director of nursing. Information from these meetings was shared with ward managers, clinical leads and ward staff as necessary.
- The trust offer a range of management and leadership development programmes through on-going work with local universities.
- A new quality ambassador scheme has been developed to help improve quality of care at Royal Lancaster Infirmary hospitals. The scheme gave staff the opportunity to explore and promote good practice by understanding the way care was delivered in different settings, and sharing good practice with colleagues across the two organisations.
- The medical staffing committee met every three months within working hours to encourage a higher attendance rate. Meetings were said to be productive and accountable, with dissemination of progress and opportunity to interchange ideas. Clinical commitments were re-scheduled to help attendance and management were said to attend every meeting. It was felt that the management team had 'done a good job' changing culture, communicating, making improvements, and managing engagement with medical staff.

Culture within the service

- During interviews with staff, they told us the division had strong leadership and most of the senior managers were visible and 'hands on'. This reflected the vision and values of the division and the trust. We interviewed number of staff on an individual basis and held group discussions throughout surgical wards, theatres and units.
- Staff spoke positively about the service they provided for patients and high quality compassionate care was a priority.
- Most staff described good teamwork within the division and we saw staff work well together; there was respect between specialities and across disciplines. We saw examples of good team working on the wards between staff of different disciplines and grades.
- However, some staff told us they had been working in difficult circumstances during the last eighteen months to cover staff and skill shortages. Although, staff were enthusiastic about their work, the service they provided and generally the organisation they worked for, staff morale was variable but had increased greatly on wards and in theatres.
- The trust supported the Nursing Times 'Speak Out Safely' campaign encouraging staff members who had a genuine patient safety concern to raise this within the organisation at the earliest opportunity. Staff we spoke to told us they felt confident about speaking out. However, some staff continued to have concerns about speaking out and felt that there were on-going difficulties around speaking out due to a previous blame culture and alleged bullying.

- There were concerns of a bullying culture in theatres July 2015 and surgical ward 36 in 2016. These concerns have been investigated and actions implemented to prevent bullying and harassment in the work place. Investigations were timely, detailed and appropriate. Staff told us there was now higher morale and a better working environment following resolution of individual behaviours and a change of staffing.
- The trust developed and implemented a Behavioural Standards Framework to improve patient experience and satisfaction, staff well-being and experience, partnership working, performance, culture and to progress continuous improvement. The Behaviour Standards Framework was mandatory and incorporated into induction and appraisal.

Public engagement

- People using the service were encouraged to give their opinion on the quality of service they received. Leaflets about the friends and family test, and Patient Advice Liaison Service (PALS). 'Tell us what you think?' questionnaires were available on all ward and reception area. Internet feedback was gathered along with complaint trends and outcomes.
- Ward managers were visible on the ward, which provided patients the opportunity to express their views and opinions.
- Discussions with patients and families regarding decision making was recorded in patient notes.
- The Friends and Family Test (FFT) survey was used to elicit patient feedback on how likely patients are likely to recommend the hospital to family and friends, respect and dignity, involvement in care and treatment, cleanliness, kindness and compassion received. Test performance (percentage response rate) was 31%, which was better than the England average of 29%. The monthly percentage recommended fluctuated between 82% and 100%.
- These results were supported through discussions with patients during our inspection. Patients were very complimentary about the care and treatment received at both hospitals and were very supportive of the services provided at the hospital.

Staff engagement

- Staff survey results published February 2016 showed more staff felt motivated at work and would recommend University Hospitals of Morecambe Bay NHS Foundation trust (UHMBT) as a place to work or receive treatment. The score for staff feeling motivated at work rose to 3.95 out of 5, compared with 3.81 in 2014, and the score for staffrecommending the organisation as a place to work or receive treatment rose to3.72 out of5, compared to 3.47 in 2014.
- Improvements compared with results from the 2014 survey were seen in other areas, such as staff who felt they received support from their immediate line manager, staff feeling the trust made effective use of patient and service user feedback, improved percentage of staff reporting most recent experience of harassment, bullying or abuse.
- Results also showed staff felt the trust had improved in satisfaction with pay, managers taking an interest in health and wellbeing, incident reporting, acting on concerns and prioritising the care of patients.
- We saw senior managers communicate to staff through the trust intranet, e-bulletins, team briefs and safety huddles. Each ward held monthly staff meetings, which discussed key issues for continuous service development.
- All staff were invited to speak with the matron and were able to voice their opinions, receive feedback and discuss any concerns.
- Staff we spoke to said they felt appreciated and listened to when they raised concerns.
- Staff said they were well supported when dealing with personal or family illness and advised that the trust as employers showed compassion, kindness and support.
- However, staff also responded that most problems were related to "putting themselves under pressure due to staffing shortages, which prevent them doing their job properly".

Innovation, improvement and sustainability

- The Bay Dementia Hub was a service created to help people worried about their memory, or diagnosed with dementia. This new initiative sought to build on the existing work of dementia-specialist.
- Surgical wards worked with the discharge co-ordinators to reduce delays in handing over care to social services or nursing home providers for those patients with complex needs.
- At an operational level, flow was maximised by employing discharge co-ordinators. The role of the co-ordinator enabled improved communication between patient, ward staff, clinicians, Adult Social Care

and all Allied Health Professionals. We were told that having dedicated co-ordinators increased efficiency on the ward when planning and arranging appropriate discharges.

- The surgical wards had implemented safety huddles to improve communication and safety.
- The electronic patient record enabled staff to document patient information in real time and the information was accessible by all appropriate nursing, medical, and surgical staff immediately. This system was in use across the trust.
- The surgical division used a new quality ambassador scheme to help improve quality of care.
- The dementia care volunteer ward programme was launched to support dementia patients, prevent isolation, encourage engagement, and to provide support and stimulation.
- Each ward had electronic smart boards, which displayed minimal patient information with coding known to nursing and medical personnel, which enabled them to received 'live' patient information at a glance. The use of symbols meant patient information was anonymous, such as a butterfly for dementia, care and a maple leaf for end of life care.
- Further initiatives such as completion of the Intensive Support Team (IST) model, identification of theatre productivity improvement through The Productive Operating Theatre model (TPOT) and identification of outpatient efficiency improvement were developed.

Critical care

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

Information about the service

The University Hospital of Morecambe Bay (UHMB) provides critical care services in the Royal Lancaster Infirmary (RLI) and the Furness General Hospital (FGH). The surgical and critical care directorate manages the service. The unit is part of, and works closely with, the Lancashire and South Cumbria Critical Care Network (LSCCCN).

The trust has a total of 14 adult critical care beds and the Intensive Care National Audit and Research Centre (ICNARC) data indicates that there are around 850 admissions a year, with 500 at the RLI site. Across two sites there are nine 'intensive care' (ITU) beds, for complex level 3 patients, who require advanced respiratory support or at least support for two organ systems; and five 'high dependency' (HDU) beds, for level 2 patients who require very close observation, pre-operative optimisation, extended post-operative care or single organ support and this includes care for those 'stepping down' from level 3 care.

The focus of this report is the critical care unit at RLI. ITU (ward 38) can flexibly admit six level 3 and two level 2 patients, two bed spaces of the eight in total are single rooms. The service provides intensive and high dependency care for patients who have had complex surgery. It also provides care for emergency admissions.

During inspection our team spoke with 17 members of staff. We spoke with three patients and one relative. We observed care, reviewed policy and documentation and checked equipment. We were able to review a range of performance data during the inspection.

Summary of findings

Following our last inspection in July 2015, we found that overall the critical care service provided at the Royal Lancaster Infirmary required improvement. During this inspection we rated this service as 'good' overall with 'good' ratings in safe, effective, responsive, and well-led. We rated caring as 'outstanding' because:

- Patients were at the centre of decisions about care and treatment. The weight of positive comments gave evidence of a caring and compassionate team. Staff were positive and motivated and without exception delivered care that was kind and promoted peoples dignity, and focused on the individual needs of people.
- The team in critical care services was well-led. A genuine culture of listening, learning, and improvement was evident amongst all staff we spoke with. Staff we spoke with across the team were passionate about their roles and proud of the trust. The investment in leadership programmes was good and it was clear the learning was shared, staff had a shared purpose and made an impact in practice. Governance arrangements were embedded in the directorate.
- During our inspection we found that nurse staffing was good with sufficient staffing levels for provision of critical care. Recruitment was underway to provide a supernumerary coordinator and practice educator in line with Guidelines for the Provision of Intensive Care Services (GPICS) (2015). Supernumerary

induction for new nursing staff was good with an organised approach to nurse appraisal and nursing achievement of competence in critical care skills. This was an improvement to findings in 2015 where we found that although nurse staffing levels had improved from the 2014 inspection findings, there was no supernumerary coordinator or funded practice educators in post.

- Medical staff we spoke with discussed the historical shortfalls in anaesthetic staffing levels for out of hours cover and this was being addressed by increasing numbers of Consultant staff. We had noted in 2015 that the intensive care services, obstetrics, anaesthetics and emergency surgical services across the trust did not have enough anaesthetic staff to meet the required national recommendations and standards. However, this was well understood by the executive team and clinical staff. We can report that an additional five consultants at RLI and three consultants at FGH have been funded to ensure safe staffing levels and mitigate risks. A recruitment strategy was in place.
- Pharmacy cover was good at RLI and met the standards outlined in GPICS (2015) with a critical care pharmacist and senior technician support. We had reported in 2015 that medicines were not stored securely in the unit; however this had improved with provision of new storage cabinets and performance of a regular safe storage of medicines audit.
- The emergency resuscitation equipment and patient transfer bags were checked daily with a good system in place as per trust policy. There was good provision of equipment in critical care with robust systems for medical device training. The risks associated to loss of service if equipment was broken and needed replacement were on the risk register.
- The unit was visibly clean; standards of infection prevention and control were in line with trust policy. Staff we spoke with told us that isolation of patients was risk assessed and documented. Liaison with the infection control team supported assurance that patients with infections received best practice and the small proportion of patients that may need specialist ventilated isolation facilities would be transferred if required. Patients with infections were isolated as per policy, however the two isolation rooms were not designed in line with Health Building Note (HBN 04-02) and did not have ensuite shower rooms or ventilated lobby areas.
- There was on-going progress towards a harm free culture. Incident reporting was good with low incidence of harm and infection. There was a proactive approach to the assessment and management of patient-centred risks and staff took responsibility for driving improvement to reduce risk of patient harm or acute deterioration. The programme for care of patients with tracheostomy across wards was comprehensive.
- In 2015 we reported there was no Critical Care Outreach Team (CCOR) across both units at UHMB. The trust did not have a dedicated CCOR team and this continued to be on the risk register, however during our inspection we noted good provision of principles in line with GPICS (2015), NICE CG50 and against the seven core elements of Comprehensive Critical Care Outreach,(C3O 2011) 'PREPARE'; 1. Patients track and trigger, 2.Rapid response, 3.Education and Training, 4.Patient safety and governance, 5. Audit and evaluation (monitoring patient outcome), 6.Rehabilitation after critical illness and 7. Enhancing service delivery. Staff we spoke with told us that there was an 'educational model' of outreach embedded across the trust. We observed three occasions of a rapid response to acute emergencies by the team.
- We found that ICNARC data showed that patient outcomes were comparable or better than expected when compared with other units nationally, this included unit mortality.
- Follow up clinics were in place at the RLI for critical care patients, as recommended by NICE CG83 and GPICS (2015), who had experienced a stay in critical care of longer than 4 days. Emotional support was given as part of the follow up appointment, post critical care admission and additional psychological support was assessed on an individual basis. The use of patient diaries had been embedded in practice since our last inspection.
- Patients received timely access to critical care treatment and consultant led care was delivered 24/7. A low number of critical care elective admissions

Critical care

were cancelled and there was a low number of readmissions to the unit. Patients were not transferred out of the unit for non-clinical reasons. Staff worked hard to not discharge patients to wards during the night with low number of out of hours discharges, comparable with other similar units.

- Over half of all discharges to ward areas were delayed beyond 4 hours due to the pressures on hospital beds, with 50% - 75% reported in ICNARC 2015/16. however this did not prevent the patient from receiving the care and treatment they needed and staff paid attention to patient dignity when single sex accommodation breaches occurred. ICNARC data did indicate that the unit position was comparable nationally with other units against the 8 hour reported target in the CMP.
- Staff we spoke with in critical care and theatres did not express concern about risk to patients when 'outlier' admissions took place and staff had not reported any incidents of harm as a consequence. This was an improved arrangement since our last inspection, with a 50% reduction in annual admissions, (from 46 to 24). Critical care training had been increased for staff in theatres. Nurse skill mix in the critical care unit was not compromised to cover the theatre recovery activity, as had been previously reported.

However:

- In 2015 we reported that the unit had limited space and during this inspection we noted again that the unit was over twenty years old and would not meet current national standards for new buildings and environment. There was however a clear estates strategy which outlined the plans for unit upgrade and expansion. Issues around estates and environment were on the directorate risk register and had been identified as a 'not met' against National D16 commissioning service specifications for critical care services, during an assessment by the LSCCCN.
- There was poor access to hand wash sinks in the unit, which did not comply with health building note HBN 00-09, (infection control in the built environment; hand hygiene facilities, clinical wash-hand basin provision). We did observe good compliance with hand hygiene, with regular 100% audit results.
- Patients discharged from critical care should receive a ward follow up visit by critical care nurses within 36 hours of discharge, it was reported that this had not be provided consistently by staff in the unit and was affected by activity and staffing resources. Staff we spoke with were planning improvement as part of the appointment of a supernumerary coordinator.
- We observed that physiotherapy cover in the unit did not provide enough opportunity to be involved in unit activity, deliver care to eight patients that was in line with GPICS (2015) and reduced opportunity to develop standards of patient rehabilitation in critical care. The unit should ensure that physiotherapy services can be provided to GPICS (2015) standards.

Critical care

Are critical care services safe?

Good

We found improvement in safety during this inspection and rated safe as 'good' because:

- Reporting and learning from incidents was embedded across the critical care team. There was an open and transparent reporting culture and low incidence of patient harm in the unit.
- At the time of inspection there were good numbers of skilled nursing staff. Staffing levels and acuity of patients was monitored.
- Recruitment was underway to provide a supernumerary coordinator and practice educator in line with GPICS, (2015). This was an improvement to inspection findings in 2015.
- Medical staffing rotas offered continuity for patient care and we observed good handovers and consultant led ward rounds. Consultant to patient ratios were in line with GPICS (2015). Consultants were all experienced in critical care and there was a consultant clinical lead. Funding had been agreed to increase safer levels of consultant anaesthetic staffing across both hospital sites. Mortality and morbidity review took place as part of the surgical and anaesthetic directorate governance meeting agenda.
- The unit was visibly clean, we observed staff adhering to infection prevention and control policy without exception. There were good processes in place for decontamination of equipment and provision of domestic services.
- We observed good mitigation of the risk associated to the lack of storage in the unit, an estates strategy outlined plans for unit upgrades and staff we spoke with told us that interim measures were also planned to support maintaining cleanliness standards.Issues around estates and environment were on the directorate risk register.
- Pharmacy cover was good at RLI and met the standards outlined in GPICS (2015) with a critical care pharmacist and senior technician support. We had reported in 2015 that medicines were not stored securely in the unit, however this had improved with provision of new storage cabinets and performance of a regular safe storage of medicines audit.
- Mandatory training provision was organised and staff attendance was good overall with a plan to achieve the trust target of 95% attendance in all areas across 2016/17. This included safeguarding training to protect vulnerable adults and children and staff had good understanding of safeguarding.
- There was a proactive approach to the assessment and management of risks to patients and staff took responsibility for driving improvement to reduce risk of patient harm or acute deterioration. We saw good practice around; the implementation of the National Early Warning Score (NEWS) and escalation systems, care of patients with tracheostomy in wards, with oversight from critical care staff and significant reduction in avoidable in-hospital cardiac arrests, with low readmissions to critical care.

However:

- The arrangements for provision of clinical fridges and the location of three fridges in the unit , both drug and non-medication needed review and relocation. We found one fridge to be unlocked and incorrect storage of patient insulin, and fridge temperatures were not consistently recorded. Pharmacy staff we spoke with during inspection agreed that action was required to support staff to follow policy for drug storage and the correct recording of temperatures as per national standards for pharmacy.
- We observed poor provision and access to handwash sinks in the main bay, which did not comply with health building note HBN 00-09, (infection control in the built environment; hand hygiene facilities, clinical wash-hand basin provision) We noted two sinks on opposite sides of the main six bedded bay area behind bed spaces. We observed staff using alcohol hand gels and good compliance withhand hygiene by all nursing staff.Uniform and ‘bare below the elbows’ policy was observed to be good and staff use of personal protective equipment (PPE), whilst caring for patients was also good. There was a robust action plan in place to ensure consistent high compliance in hand hygiene performance. to mitigate the risks created by the poor handwash sink access.
- We reviewed three care records and three large ITU care charts. The team were using both systems whilst learning to use the electronic patient record (EPR) system in practice. Entries in the records were complete and in line GPICS (2015) and professional General

Medical Council (GMC) and Nursing and Midwifery Council (NMC) standards. We noted that NMC/GMC numbers did not accompany signatures, and this was also identified in matrons audits. The three patients received a daily review and treatment plans.

Incidents

- There was a consistent understanding by staff we spoke with of the incident reporting system and trust policy. Learning from incidents was shared across the team in meetings and daily communications. There was good understanding of duty of candour amongst nursing staff we spoke with, however zero incidents that had triggered the duty in 2015/16. The duty of candour is a legal duty on healthcare providers that sets out specific requirements on the principle of being open with patients when things go wrong.
- We reviewed the National Reporting and Learning System (NRLS) incidents between September 2015 to August 2016. There were 407 incidents attributed to critical care across both hospital sites. All incidents were reported in low, no harm or moderate harm categories. There were five moderate harm incidents with no themes or trends. Of the remaining reported incidents half were reported as delays in discharges or admissions. There was a good level of detail in the reporting and it was clear that staff were able to report safety concerns and near misses accurately.
- Incidents were discussed in multi-professional meetings to share learning as needed and actions were documented. There was an open and transparent safety culture and approach demonstrated.
- Mortality and morbidity review took place as part of the surgical and anaesthetic directorate governance meeting agenda. Staff we spoke with told us that meetings took place regularly (weekly) for review of all deaths and alternate monthly themes were discussed in the directorate audit meeting. Where there are lessons to be learnt details are discussed in monthly medical meetings. Grading of cases adhered to National Confidential Enquiry into Patient Outcome and Death (NCEPOD) guidance. The meeting was open to the MDT. We reviewed minutes of meetings for RLI, and themes were discussed with and open and transparent reporting approach to learning.
- Staff we spoke with told us that a theme of incidents involving transducer systems in the unit had led to improvements in care, standardising approaches with labelling transducer bags at a local level had also been shared across the LSCCCN.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harm-free care. This focuses on four avoidable harms: pressure ulcers, falls, catheter associated urinary tract infections (CAUTI) and blood clots or venous thromboembolism (VTE).
- Avoidable patient harm incidents were reported as zero in 2015/16 (falls, CAUTI, VTE) or low (pressure ulcers) in RLI critical care across all four reportable areas.
- The unit displayed information at the entrance to the unit on a 'how are we doing board'. The display included two of the measures of harm, including pressure ulcers and falls for the previous month, both had been recorded as zero.
- We observed good practice in critical care for completion of VTE risk assessments on admission and prescription of prophylaxis. There were zero reported incidents for 2015/16 in critical care. The surgical and anaesthetic directorate were working to improve variable compliance with the standard, in order to reduce preventable incidence. We noted consistent audit, teaching and monitoring of progress. The issue had been reported in the directorate risk register with improvement being made against an action plan.
- There had been a commitment to reducing pressure ulcer incidence in ITU by senior staff. Staff reported three grade 2 pressure ulcers in critical care in 2015/16.
- The team had regular updates on trust and unit safety thermometer incidents and a monthly 'learning to improve bulletins' highlighted areas to target for improvement.

Cleanliness, infection control and hygiene

- According to the data published by the intensive care national audit and research centre (ICNARC) and the trust the unit performed better than similar units for unit acquired infections in the blood, unit acquired methicillin-resistant staphylococcus aureus (MRSA) and clostridium difficile infection rates.
- The clinical environment was visibly clean in main patient areas but cluttered with equipment in drug

storage, drug preparation areas and the counter tops in the sluice. Domestic and nursing staff we spoke with told us that limitations of storing equipment and the design and age of the space created challenges in maintaining cleanliness. The domestic for the unit completed cleaning schedules and there was a process of sign off by supervisors.

- There was a green label system in place to indicate that equipment was clean. We checked 34 pieces of equipment and found all to be clean with appropriate labelling and safety checks, however we checked blood gas monitoring and point of care equipment and found small blood splashes on both items. Nursing staff were informed at the time and this was addressed during inspection.
- Staff had access to trust infection prevention and control policies. Training provision for infection prevention and control was good with 100% of staff having attended hand hygiene and infection prevention and control mandatory training.
- We observed good compliance with hand hygiene by all nursing staff, although poor access to sinks in the unit, which did not comply with health building note HBN 00-09, (infection control in the built environment; hand hygiene facilities, clinical wash-hand basin provision) We noted two sinks on opposite sides of the main six bedded bay area behind bed spaces. We observed staff using alcohol hand gels. Uniform and 'bare below the elbows' policy was observed to be good and staff use of personal protective equipment (PPE), whilst caring for patients was also good.
- The unit matron performed a range of audits as part of the trust Quality Assurance Accreditation Scheme (QUAAS). Standards of infection prevention and control practice were monitored more frequently in recognition of the environmental and hand hygiene challenges. Hand hygiene, environmental cleanliness, disposal of sharps and aseptic technique audit data showed consistently good standards in critical care, with 100% compliance in most areas. When standards fell below expected quality targets we saw evidence of action plans that had been implemented with good effect. The issues around environmental cleaning and storage challenges in the unit were recognised as an ongoing problem, and were on the risk register.
- The unit was visibly clean, standards of infection prevention and control were in line with trust policy. The two isolation rooms were not designed in line with Health Building Note (HBN 04-01, HBN 00-09) and did not have ensuite shower rooms and ventilated lobby areas and this had been identified during a previous inspection. However staff we spoke with told us that isolation of patients was risk assessed and documented. Liaison with the infection control team supported that patients with infections received best practice and would be transferred out of unit if required, this was relevant for a small proportion of patients who would require specialist ventilated isolation facilities. We observed patients with infections were isolated as per policy.
- The consultant microbiologist attended the unit daily and reviewed patients as part of the consultant led ward round.
- A new process had been implemented to reduce line insertion associated infection incidence. Staff were required to complete a form for insertion of all devices to identify key elements of the care given at the time. This provided an audit trail if incidents occurred.
- Care bundles for infection prevention and control of Central Venous Catheter (CVC) and Ventilator Associated Pneumonia (VAP) were completed by staff with improved compliance. There was zero incidence of both infections reported in 2015/16. The VAP bundle had been the focus of a trust ambassador LiA project with ongoing audit and action to improve and sustain compliance and understanding amongst staff.

Environment and equipment

- The unit had eight bed spaces including two single rooms. A central nurses station allowed staff good visibility to all patients in the unit.
- The unit was accessed securely from a spacious corridor with good display of information for patients and staff. There was access to a visitors room, staff and patient kitchen, offices, equipment storage and large staff room from the corridor without the need to pass through the clinical unit.
- The unit was over twenty years old and would not meet current national standards for environment. There was however a clear estates strategy which outlined the plans for unit upgrades. Issues around estates and environment were on the directorate risk register and had been identified as a 'not met' against National D16

commissioning service specifications for critical care services, during an assessment by the LSCCCN. Staff we spoke were involved in planning refurbishments and were positive about the planned upgrades.

- Patient bed spaces were noted to be around half the recommended 25.5 m2 (Department of Health, Health Building Note - HBN 04-02, 2013) for a new build intensive care unit. The bed space size we observed, did not give sufficient clear floor space to allow room for visitors, staff and equipment brought to the bedside. We observed difficulties manoeuvring portable x-ray equipment around the bed space and observed staff having to move beds to allow access for patient chairs.
- The emergency resuscitation equipment and patient transfer bags were checked daily with a good system in place as per trust policy. The equipment was central and easy to access.
- There was good provision of equipment required for level 3 and level 2 critical care. We observed a thorough record and robust system of medical device training for all staff. Staff we spoke with told us that the links with the medical engineering team were good. The risks associated to loss of service if equipment is broken and replacing capital equipment were on the risk register.
- Staff and visitor access to hand washing facilities were challenging and did not comply with Health Building Note (HBN 00-04 and 00-09). In the main unit only two sinks serviced six beds, and the location of both sinks were behind the bed spaces. Both single rooms had dedicated handwashing sinks. The sink in the drug storage area was out of service after a recent refurbishment and staff did not have direct handwashing access in that area at the time of inspection. The handwashing sink on the main corridor was signposted from the ceiling but obscured by a large filing cabinet, which did not support staff or visitors handwashing prior to accessing the main unit.
- Storage was inadequate in the main unit, and we observed the department to be cluttered with stock and equipment on the floor space, around the central station and on countertops used for drug preparation, and in the sluice area. Equipment including transfer trolleys, additional stock of infusion devices, full and used oxygen bottles, additional fridges, hoists, and pressure care mattresses which were awaiting collection.
- We observed three fridges in the unit. Pharmacy staff we spoke with told us that the drug fridge temperatures were monitored and recorded as per policy, and we found this to be correct for the main drug storage fridge, however;
  - There was an additional under counter fridge for storage of a small number of medical device items, for example nasogastric tubes. This was not locked and at the time of inspection and we observed a patient insulin pen to be stored in this fridge and not in the drug fridge as per trust policy. We informed the pharmacy staff and this was removed. Temperature recording for this fridge was not in line with national pharmacy guidance.
  - There was also a third fridge in this area, which was on a portable trolley, not plugged in and labelled to indicate its sole use for research samples.

Medicines

- During our last inspection we found medicines were not locked away safely. The unit had new locked cabinets for medicines storage as part of a recent refurbishment.
- The Guidelines for the Provision of Intensive Care Services (GPICS, 2015) state that there should be at least 0.1 whole time equivalent (WTE) Band 8a specialist clinical pharmacist for each level 3 bed and for every two level 2 beds. Pharmacy provision at the RLI site exceeded the guidelines for the size of the unit with additional support of a recently appointed senior technician.
- Recent improvements in ordering, stock control and reconciliation of patients own medications by the senior technician had been acknowledged as positive by staff we spoke with. Intravenous fluids were also managed by the pharmacy team and a monthly check of expiry dates was performed. There was a good system of labelling opened liquid medication to ensure staff were aware of expiration dates after opening.
- We saw good practice and checking systems for use and storage of controlled drugs by nursing and pharmacy staff. There were no related incidents in 2015/16.
- The pharmacist accompanied the morning consultant led ward round which included daily review of prescribing Monday to Friday. There was no available dedicated pharmacist at weekends and additional support could be requested from the main pharmacy department when required.

- Changes in supply of infusion drugs in critical care had been implemented. Results of an approach to using pre filled syringes of drugs had been shared by the 8a pharmacist across the LSCCCN. This was in line with the approach advocated by the National Patient Safety Agency (NPSA) top 20 risks, 'Safety in Doses' report.
- Monthly pharmacy audits were performed. A safe storage and security audit, controlled drug management and antibiotic usage audit in critical care were performed by the main pharmacy department. There was good performance against audit in all areas and 100% compliance with 72 hr review of antibiotic prescriptions.
- There was a low number (four) of drug related incidents in the unit in 2016 and the process for reporting and investigation was good. We noted that an open and transparent approach was taken to sharing lessons learnt with the team. Teaching was delivered to the team during ward rounds and '5 point communication' opportunities in handover.
- We observed six prescription charts and allergies were clearly documented in all cases. There was a paper system with good documentation with the exception of three records where antibiotic prescriptions did not have stop or review dates.

Records

- We reviewed three care records and three large ITU care charts. We observed the electronic and paper systems. The team were using both systems whilst learning to use the electronic patient record (EPR) system in practice. Entries in the records were complete and in line GPICS (2015) and professional General Medical Council (GMC) and Nursing and Midwifery Council (NMC) standards. We noted that NMC/GMC numbers did not accompany signatures. The three patients received a daily review and treatment plans.
- Matron documentation audits across the trust identified continuous action was needed for improvement and achievement of compliance against the trust standards for documentation.
- Notes were stored securely at the bedside and the electric versions were accessed on computers on trolleys with appropriate password protection as per trust policy. There had been no incidence of confidentiality breach in the unit. Staff did report issues with internet access which led to staff being unable to access the electronic record on occasions.
- Staff attended information governance training as part of mandatory training, 75% had attended at the time of inspection, with a plan for all new staff to attend in 2016, however it was reported that the training and continued support for the new electronic system could be improved.

Safeguarding

- The trust safeguarding policy was available to staff and the unit had an organised approach to provision and staff attendance of safeguarding training to protect vulnerable adults and children, with good planning by senior staff to ensure staff were up to date. ITU at RLI had staff attendance compliance of 98% for level one safeguarding training for adults and children, which was above the trust target and 86% for level two, with remaining staff booked into sessions.
- Staff we spoke with told us that they understood the safeguarding processes and could identify staff to contact to escalate any concerns for vulnerable adults and children. We were not given examples in practice by staff at the time of inspection. Staff could access minutes from safeguarding board meetings and case reviews and matrons and clinical leads would share any learning in team meetings.
- Safeguarding resources and information was available in the unit and on the intranet.

Mandatory training

- The trust had a mandatory training compliance target of 95% for staff attendance and senior nursing staff we spoke with had an organised approach to achieving the targets for unit staff across the year.
- Senior clinical leads we spoke with reported overall 91.3% achievement at the end of August 2016 and had plans in place to achieve greater than 95% by December 2016. There had been an issue with provision and completion of Basic Life Support and Immediate Life Support (BLS/ILS) training in the unit and a block booking with a key trainer, who was a member of the critical care team, was put in place to ensure staff could attend, receive an update and the trust target be achieved.
- The trust provided core elements in mandatory training to include, fire, conflict resolution, BLS, ILS, equality diversity and inclusion, infection prevention and control, information governance, health and safety,

safeguarding adults and children, and manual handling. However, fire training attendance was poor across the directorate with 67% of critical care staff attending at RLI to the time of inspection.
- Staff could access mandatory training in a number of ways, online eLearning modules and face to face sessions delivered by key trainers.

Assessing and responding to patient risk

- Patients had a range of risk assessments completed on admission to critical care. We observed good compliance with completion for Malnutrition Universal Screening Tool (MUST) assessment, moving and handling, tissue viability, VTE, delirium, infection control and falls risk. If a patient was identified as having an elevated risk the action required to reduce it was evident in the care plan and practice.
- There was not a designated Critical Care Outreach Team (CCOR) at the trust however there was an effective educational model of CCOR and this included patient follow up after discharge to wards, provided by nurses in the unit. However, staff we spoke with told us that they were not always able to provide follow up within 36 hours of discharge when the unit was busy and the appointment of the supernumerary coordinator would improve meeting this target in future.
- There were additional posts across the trust and directorate that supported the key elements of the CCOR role for example, an Acute Kidney Injury (AKI) nurse and Sepsis specialist nurse. The resuscitation team and acute care matron were responsible for delivering training in recognition and treatment of the acutely ill patient. Practice Educators (PED's) were in each directorate, and the Hospital at Night (HAN) team was well established.
- There had been significant 37% reduction of all and avoidable cardiac arrests reported from April 2014 to September 2016. All cardiac arrests were discussed in patient safety summits, and initially reported as moderate or major incidents. There was an ongoing commitment to continuous improvement as part of Commissioning for Quality and Innovation (CQUIN) targets.
- The trust had introduced the National Early Warning Score in 2016. It had previously used an Early Warning Score System (EWS) as part of recording patient physiological observations, for over 15 years. The previous advanced nurse practitioner in critical care had supported implementation and ongoing management of the former EWS and POTTS (patients observation track and trigger system). Training for staff was in place and the Acute Life-Threatening Events: Recognition and Treatment (ALERT) course was well attended by staff across the trust and critical care.
- NEWS audit for critical care was comparably good across both sites with 91% to 100% compliance.
- Directorate PED's delivered once a month training sessions as part of a 'listening into action' (LiA) project. These included Basic Life Support (BLS), Acute Kidney Injury (AKI), National Early Warning Score, (NEWS), sepsis and fluid balance sessions and could be booked in the Training Management System (TMS) by staff across the trust. The delivery of and attendance by staff to these key sessions were part of the approach to assessing and responding to patient risk.
- The trust had implemented a Situation, Background, Assessment and Recommendation (SBAR) approach to handover communication when escalation of acutely ill patients was required at ward level. There are escalation policies in place and staff we spoke with were aware of good practice.
- Staff told us about a Critical Care whiteboard project which was underway to improve assessment of patient 'status at a glance'. This project was expected to support post discharge patient follow up, identifying delays and those patients at risk in wards and critical care that can be identified and tracked daily.
- As part of a critical care staff project, tracheostomy patients were cared for on specific wards (33 and 37) at RLI to reduce risk and be able to support patient care, follow up and staff training. Care plans had been developed for patients and this had been shared across the LSCCCN. Bedside emergency equipment boxes had been standardised for wards. The strategy supported reducing the need for patients to require level 2 care in the unit. Critical care had recruited a patient representative to the teaching team and they helped to deliver sessions to staff four times a year.
- Staff we spoke with told us that transfer of patients was well managed. A trust and LSCCCN policy was in place. There was zero incidents to report as part of critical care transfers. Nursing staff told us that cross site retrieval of patients was infrequent, and gave one good example of care and transfer of a patient who had experienced a

heart attack whilst having a routine procedure. The LSCCCN STaR (Safe Transfer and Retrieval) training programme uptake and delivery was led by the clinical lead in ITU.

Nursing staffing

- Nurse staffing in the unit at the time of inspection was good. We did not see any evidence of reducing qualified nurse to patient ratios below critical care staffing guidance (GPICS, 2015) of 1:1 for Level 3 patient care and 1:2 Level 2 patient care during day or night shift. There were two vacant nursing posts at the time of inspection and planned recruitment was making progress, with good use of established bank nurses covering any shortfalls in the rota.
- There was a positive approach to managing team rotas and nurse clinical leads and senior nursing staff were knowledgeable about the challenges and shortfalls when they occurred. Staff addressed risks on a daily basis and proactively as part of an efficient approach to managing the unit. Clinical leads attended trust bed management meetings. We observed rotas during our inspection and gained assurance that the actual staffing numbers were as planned.
- The eRoster system ran alongside the trust 'dashboard system' and senior teams had access to acuity of patient information across the wards and departments. There was a 100% compliance with updating the acuity dashboard, which had been based on the 'Safer Nursing Care' Shelford Group tool. Site managers were visible and attended the unit in person when they needed to request staffing support from critical care to ward areas.
- The unit had funding to support a supernumerary unit coordinator across a seven day week and 12 hour day shift pattern in line with GPICS (2015) standards for eight bedded units. In addition to achieving this standard, recruitment for a supernumerary clinical educator across site was in progress.
- Staff sickness was below the trust target of 4.3% at 3.34% between June 2015 and May 2016. Clinical leads understood the new policy and approach for managing staff sickness. The trust had developed a system to send secure text messages to established staff to offer additional shifts when cover was required at short notice and this was reported as working well in ITU. The use of agency staff was minimal, and there had been an example of agency staff being recruited successfully to the unit. A local induction was in place for any staff new to the department.
- Nurse handovers were well organised and effective with a five point communication system approach. All nursing staff we spoke with told us about the 5 point system and its use in practice.
- The unit had a nursing apprentice and health care assistants in post.
- Nursing staff we spoke with were positive and morale appeared to be good. All staff reported that they felt supported and enjoyed working in the unit. Staff told us that staffing levels and recruitment had been continuously improving this year.

Medical staffing

- Care was led by a consultant in intensive care medicine and rotas had been developed to support competent medical cover and patient continuity, with an improved 'consultant of the week' approach. Consultant staff to patient ratios were in line with GPICS (2015). There were consultant led unit ward rounds and patient review twice daily. Attendance by the Multidisciplinary Team (MDT) was encouraged by the consultant team.
- The historical anaesthetic staffing levels (24/7) for intensive care services, obstetrics, anaesthetics and emergency surgical services across the trust had not met the required national recommendations and standards. This was well understood by the executive and senior team and clinical staff. We reviewed finance meeting minutes from September 2016 where it was outlined that current staffing posed a risk to the delivery of safe and quality anaesthetic services at RLI and FGH. The trust, as part of their Better Care Together strategy, had committed to recruiting three consultants at FGH and five consultants at RLI to ensure safe staffing levels and mitigate risks. We reviewed documents to confirm that recruitment was well underway.
- The five additional consultants proposal at RLI would allow dedicated resident anaesthetic cover for maternity services and also allow for support of trainees.
- We spoke with the lead consultant about plans to develop advanced critical care practitioner (ACCP) roles. The first cohort was planned for 2017 February and recruitment to the programme had commenced.

- We spoke with a junior doctor who gave us positive feedback about training and support in critical care. There was good opportunity to participate in ward rounds and attend the FY2 teaching programme.
- A good approach to handovers were observed during inspection. There was consistent attendance by doctors, pharmacy and nursing staff Monday to Friday, with a reduced attendance at weekends. The physiotherapist and dietitian were not able to attend due to staffing resources. The consultant microbiologist had a daily visit to the unit and discussion with the lead consultant in critical care about specific patients. It was noted that teaching was an embedded aspect of the daily round.

Major incident awareness and training

- Major incident and business continuity plans were in place as policy was clear and available to staff on the intranet and in paper copy in senior staff offices. Staff had attended training to test the plans and escalation processes in critical care as part of the surgical and anaesthetic directorate.
- Staff we spoke with told us that there had been no incidence to test the policy in practice, but they were aware of a range of scenarios that had been included in the training that could disrupt business continuity.

Are critical care services effective?

Good

We rated effective as 'good' because:

- During this inspection and our 2015 inspection we found patient care was planned and delivered by staff who were knowledgeable and aware of implementing current evidence based guidance and standards.
- Patient outcomes were comparable or better than national and local critical care unit performance. Unit mortality had improved since our last inspection and was low in comparison to other units as reported to ICNARC. The patient readmission rate within 48 hours of discharge from the unit was also low and better than the national average.
- Commitment to education and training was improved since 2015, with supernumerary induction for new nursing staff, and a sustained performance in ensuring 50% or more nursing staff had a post registration award in critical care or were working towards achievement at local universities. Continued commitment to nurse appraisal was evident and agreement to fund and recruit a supernumerary practice educator across sites, improving the overall compliance with standards in line with GPICS (2015). Staff were knowledgeable and committed to critical care education.
- Patient's pain was well managed. We observed good examples of Individual patient nutrition and hydration needs being met, and we observed a person centred approach to assessment and planning of care.
- There was a good culture of discussion, documentation of decisions and challenge from nursing staff around MCA and DoLS. Consultants were knowledgeable and engaged with the process.

However:

- Physiotherapy staff were unable to provide a full service against GPICS (2015) standards for multidisciplinary working and rehabilitation of patients after critical care, due to staffing constraints, and staff we spoke with told us this had been escalated to managers in the therapies directorate. Critical care should meet the GPICS (2015) standards for rehabilitation and provision of physiotherapy services to patients.

Evidence-based care and treatment

- We reviewed policies and guidelines in the unit, on the intranet and in paper copies and found all to have review dates. The unit used a combination of national guidelines and policy to determine the care and treatment they provided. These included guidance from National Institute for Health and Care Excellence (NICE), Intensive Care Society, the Faculty of Intensive Care Medicine and the LSCCCN.
- We reported in 2015 that we were not clear if adherence with NICE CG83 pathway for rehabilitation after critical care was supported fully and had a lead for rehabilitation. During this inspection we saw evidence of a partially met standard. Collection of data to measure if assessment and rehabilitation prescriptions were documented within the first 24 hours of admission and pre-discharge showed good performance for patient admission, but pre discharge plans were documented in as low as 60% of cases from April to July 2016 across both units. It was not clear who was leading against the rehabilitation standard.
- Patients at risk of VTE were risk assessed and prescribed prophylaxis in accordance with NICE QS3 quality

statement and pathway. Audit and monitoring was carried out to ensure compliance targets were maintained in critical care and across the directorate improvement work was a current priority.
- ICU delirium and sleep study information was displayed as part of an ongoing project in critical care.
- We spoke with nursing and medical staff and observed that a range of local and national audit had continued since our last inspection. Results were shared, work was ongoing to contribute to reducing sepsis as part of the trust targets. There was good involvement with the LSCCCN in terms of benchmarking.
- The nationally recognised care bundle to reduce the risk of ventilator – acquired pneumonia (VAP) is implemented and audit work was ongoing to improve compliance. VAP bundle compliance had been adopted as part of the trust quality ambassador programme to reduce incidence of infection and improve implementation of the care bundle.

Pain relief

- We reviewed three care records and bedside care charts and six prescription charts and observed that pain was assessed and pain scores recorded in the unit. All patients we spoke with told us that staff paid attention to their pain and comfort needs.
- We observed pain scores and patient assessments being discussed in the ward round by the MDT and conversations were led by the consultant.
- Staff administered prescribed analgesia regularly and as required. We observed nursing and medical staff reviewing the daily plan of care and patients would be given pain relief as part of planning to support their comfort when they are mobilised out of bed.
- Patients received visits from the specialist nurse pain team when they had epidural and intravenous pain relief in progress post operatively. Unit staff were able to make referrals to the pain team for advice.
- We observed a patient who was waking from sedation and appeared 'agitated' having a thorough assessment of pain by the consultant and nursing staff as part of planning his overall care and treatment.

Nutrition and hydration

- Patients admitted to critical care had a malnutrition universal screening tool (MUST) assessment. Patients who are malnourished, at risk of malnutrition or obese were identified using this tool. In all three care records scores were documented.
- A dietitian was dedicated to the unit and had expertise in critical care in order to support patients effectively. Patients were commenced on feeding regimes as soon as possible. We observed patients receiving total parenteral nutrition (TPN) and Nasogastric (NG) feeding.
- We saw excellent fluid management and hourly documentation of fluid balance. There was good training provision for fluid balance management for staff in the unit.
- We observed nursing staff taking time to assist patients with oral nutrition and when they required support at mealtimes. Patients whose condition had improved were offered drinks by staff and assisted as needed. Nutritional intake was documented.

Patient outcomes

- The unit could demonstrate continuous patient data contributions to the Intensive Care National Audit and Research Centre (ICNARC). Dedicated staff were in post to support ICNARC data collection and reporting.
- ICNARC supports critically ill patients by providing information and feedback data on specific quality indicators as part of its case mix programme (CMP). Critical care units can benchmark their practice and services against 90% of other units. This was in line with the recommendations of the Faculty of Intensive Care Medicine Core Standards (FICM). We also saw a 'partially met and unmet' 2015 benchmarking activity against National D16 commissioning service specifications for critical care services, which is underpinned by GPICS (2015) within the Lancashire and South Cumbria Critical Care Network (LSCCCN).
- Since our 2015 inspection risk adjusted hospital mortality ratio had improved and was comparable with national reporting at 1.0 – 1.1 across both units at UHMB. Risk adjusted mortality ratio for patients with a predicted risk of death of less than 20% was 1.0 at RLI. Mortality was reported as a percentage of all discharges, deaths and transfers out of the unit. It was reported that mortality was comparable or lower than expected range within the ICNARC CMP.
- Unplanned patient readmission to ITU within 48 hours after discharge was better than other units in the

reporting period April to August 2016 at 1.0%, and comparable to units in ICNARC 2015-2016. Over the year July 2015-2016, we noted that across 9 months of the year there were zero readmissions to the unit. There was an increased 5% rate in readmission in November 2015, with no significant themes.

- We also noted that against regional units the 'post unit in hospital survivorship' was better than the LSCCCN average.
- A snapshot audit was performed by physiotherapy staff in November 2015 to evidence reasons why patients did not 'sit out of bed' before midday in the ITU. Results were collected for 71 patients, with 38% of reasons for not getting out of bed being stated as 'potentially reversible'. The audit was used to support patient rehabilitation and direct patient care to support patients to benefit from early mobilisation in critical care.

Competent staff

- Staff we spoke with told us that they received trust induction and we noted that 100% had attended. Appraisals had been carried out for 77% of staff at the time of inspection, and we observed a plan was in place with new staff booked in for appraisal to achieve 100% in 2016.
- GPICS (2015) outlines that critical care units should have a supernumerary educational coordinator. The funding had been agreed and the process of recruiting an educator to work across the two hospital sites had begun.
- We observed that the two band 7 clinical leads also had an 80:20 management to clinical role ratio and they supported a good culture of learning and education in the unit.
- New nursing staff to the unit were given a local induction and six to eight weeks supernumerary period whilst they achieved critical care competencies essential for safe practice. Junior staff were supported by working alongside senior skilled nurse mentors in the unit.
- Fifty percent of staff should hold a post registration award in critical care nursing, in line with GPICS. At the time of reporting 41% of nursing staff on ITU (17 of 41 staff) had achieved this target, and a further 5 staff were currently studying or booked to commence the course at local universities. This would achieve 54% (22 of 41 staff) against the target when staff had completed. There was good access locally to the course and staff were supported to attend.
- There was also a commitment to the Critical Care Steps programme for staff with good levels of achievement. 71% of staff had achieved level 2.
- We observed examples of the nursing, pharmacy and medical staff teaching junior members of the team at the bedside and during handovers and ward rounds. Band 6 nursing staff we spoke with told us that they had been supported to take time out from clinical practice to develop education and supervisory models for the unit.
- Nurses we spoke with told us clinical supervision was available and the trust had a supportive strategy in place for revalidation. We saw nursing staff sharing the processes for revalidation in the unit.

Multidisciplinary (MDT) working

- We observed good working relationships and commitment to critical care between members of the MDT.
- Physiotherapists were an essential part of the critical care team and the unit had a plan for twice daily cover from a team of qualified physiotherapists Monday to Friday, however staff we spoke with told us that cover could be reduced to 9am to 10.30am for eight patients. We spoke with physiotherapists and the current establishment of 0.9 WTE did not provide opportunity to be involved in the consultant led ward round and MDT handovers, and reduced the opportunity to work in a coordinated way with the ITU team to plan care for complex and long stay patients. Staffing provision was found to be, 0.3 WTE at band 7; 0.3 WTE at band 6 and 0.3 WTE band 5.
- Physiotherapy lead staff were supporting other services outside of critical care due to staff vacancies across the team. The team however were essential in supporting respiratory assessment, review and rehabilitation from critical care and provided treatment for patients requiring passive movements to prevent muscle contracture during periods of restricted mobility. GPICS (2015) supported a minimum rehabilitation standard of 45 minute sessions, admission and discharge prescriptions and staff were not able to consistently deliver this during weekdays or weekends. These issues were documented on the directorate risk register.

- We spoke with the dietitian and speech and language therapy (SALT) staff during the inspection. The dietitian had a daily visit to the unit and took referrals on unit attendance or by telephone. They did not attend ward rounds. SALT had a referral system and attended to patients as required.
- The units had dedicated administrative ICNARC support to ensure consistent data collection and reporting. We spoke with staff across site who were well supported and valued and provided an essential service in critical care. The level of understanding of ICNARC data was very good and presented at the critical care delivery group. There was evidence of developing further audit to supplement the ICNARC data for local use and improvement, for example the collection of utilisation of theatre recovery space for patient admission.
- Members of the MDT were all aware and involved in the '5 points communication' approach when available at handover.

Seven-day services

- Consultant anaesthetists were available 24/7 through an on call system to support the junior team. Daily consultant ward rounds were embedded with documented daily reviews. The critical care unit provided services 24/7.
- There was an on call physiotherapy and pharmacy service out of hours and at weekends.
- Critical care did not have access to services that supported 7 day working. Staffing was significantly reduced across the MDT at weekends. Access to some specialist diagnostic testing, for example endoscopy and echocardiography was not routinely available at weekends. Admissions to critical care of emergency and unplanned patients can be at any time of day or night, in the case of critical emergencies consultants directed diagnostic tests and reporting of results.

Access to information

- Information could be accessed in electronic and paper systems. Since our inspection in 2015 the trust had implemented an EPR. We observed staff using the new electronic care record system and this was making good progress, although access was reported as inconsistent in the unit based on issues with internet connection and training support had been reduced.
- Staff involved in the critically ill patients care pathway at every stage could access the information that they needed in a timely manner. We saw good evidence of access to transfer and discharge summaries in paper and electronic versions. It was noted that staff had a degree of duplication which was ongoing until the full electronic patient record system was implemented.
- We observed safe transfer and handover processes and had assurances for staff we spoke with that practice was consistent.

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

- We observed good decision making by two consultants in critical care and staff we spoke with would seek independent mental capacity advocate (IMCA) advice when required. There was a good culture of discussion, documentation of decisions and challenge from nursing staff around MCA and DoLS. Consultants were engaged and one had an MSc in Ethics which supported learning in the team.
- There was varied levels of understanding of the MCA and DoLS in critical care by the junior nurses we spoke with. Staff had attended training with an 86% attendance rate against the trust target, however junior staff could not explain experiences of application in practice in the critical care environment. Senior staff were more knowledgeable, however all staff we spoke with knew how to seek advice and could access guidance in paper and intranet resources.
- We observed good assessment of consciousness, delirium and confusion with use of Glasgow Coma Scale (GCS) and Richmond Agitation Sedation Scale (RASS) and the Confusion Assessment Method, CAM-ICU, all recorded on the daily observation chart and care plan. These validated measures supported assessment of patient confusion, delirium and subsequent level of mental capacity in the unit.

Are critical care services caring?

Outstanding ☆

We rated caring as 'outstanding' because:

- From our observations, evaluation of data and conversations we had with families, patients and staff

we judged the critical care unit at the RLI to have a strong visible person centred culture. Staff were positive and motivated and without exception delivered care that was kind and promoted peoples dignity.

- Senior staff had developed an electronic tablet 'app' as a cognitive tool to be used by patients during their stay in critical care as a response to patient feedback in follow up clinics. This would be tested in the RLI unit and shared with the FGH unit and across the LSCCCN if evidence of benefits to patients were good.
- The critical care team had developed a comprehensive approach to care for patients with tracheostomy who were cared for in wards. As part of the project a patient who had a laryngectomy was recruited to support delivery of staff training up to four times a year.
- The nursing team told us that they had planned and carried out role play exercises and involved patients in order to develop a depth of understanding of the experience of being a patient in each bed space. This approach supported a greater understanding of the patients perspective and helped to promote privacy and dignity of patients, noise reduction and discharge planning.
- Patients were invited and encouraged to be involved in decision making about services and staff listened to patients and focused improvements in practice with their suggestions.
- We saw good use of individual patient diaries to support care planning, rehabilitation and recovery in ITU.
- Survey responses from service users were consistently positive and the team and individual staff frequently received 'special mentions'. The unit at RLI had developed a specific critical care survey and this reinforced the consistent positive results found in the Family and Friends Test. During previous inspections we found that the unit were not gathering patient experience information consistently and the team have worked to achieve significant improvement.

Compassionate care

- We observed staff to be caring and compassionate with patients and their relatives without exception during the inspection. We observed episodes of care that promoted patient dignity and respect.
- We observed nursing, medical, allied health professionals (AHP's) and support workers caring for a patient with challenging and aggressive behaviour and the team communicated, without exception, demonstrating sensitivity and a supportive attitude.
- We observed letters and cards of thanks from patients and relatives on display and filed in the staff room. Senior staff shared positive messages and any examples of concerns or complaints from patients in team meetings, on noticeboards in staff and public areas and during one to one opportunities with staff.
- The NHS Family and Friends Test (FFT) data was collected in critical care and there was a commitment to continuous improvement to response rates. Display was consistent with the trust approach in a format that is easy to understand by staff and visitors. We saw positive results and comments.
- In September 2016 the unit rated in the top 6 departments at the RLI site with a 4.88 out of 5.0 result overall, with very positive feedback.. Elements (dignity/ respect, involvement, information, cleanliness, and staff) scored 5.0 out of a possible 5.0.One hundred percent of the eight respondents (which represented a 32% response rate to surveys in September) stated they would recommend the service. Critical care staff had devised and perfomed their own unit survey and questioned 87patients about their experience in 2015/ 16. Responses were very positive. The 14 questions asked around 'satisfaction with care' gathered a 95%-100% positive response . An additional 10 questions focused on family involvement in decision making, and this was also positive. There was a small number of mixed responses for the questions around family expressing feeling in control of decision making processes, but responses were very overall positive. The final part of the survey asked 3 more detailed questions to the 34 of 87patients who had experienced a relative or friend dying in the RLI critical care unit and responses indicated good support in ITU without exception.
- A 'special mentions' section of the 'how are we doing' board displayed thanks to those staff who had received patient compliments. Examples we observed had names of individuals from the MDT. The following quote represented the themes in many of the comments and compliments we observed; "The care I received was fantastic. I was kept informed at all times and before any

procedure was carried out. All the staff are wonderful, friendly, helpful and caring. They treat all the patients very well and made sure that they kept everybody's dignity and treated us with respect".

- We noted a very positive letter received by the critical care unit from an American patient who was admitted as an emergency whilst on holiday in the Lake District. Individual staff had been commended and thanked for their care.
- The nursing team told us that they had carried out role play exercises and had involved patients in order to develop a depth of understanding of the experience of being a patient in each bed space. Staff we spoke with told us that this supported the team to have a greater understanding of the patients perspective and helped to promote privacy and dignity of patients, noise reduction (which led to further work by nursing staff to support sleep and reduce noise in the unit). The staff we spoke with said that it supported understanding the experience of the patient and planning individual care for times when bed pressures across the trust led to the delay in patients discharge to a ward.
- We spoke with three patients and one relative who all had positive feedback about the nursing, medical and MDT staff in ITU. They told us that when they experienced pain and discomfort staff responded appropriately with different approaches, for example repositioning, pain control and medication and caring reassurance.

Understanding and involvement of patients and those close to them

- We observed staff communicate with patients and their families and friends in approaches that supported their understanding of care and treatment in critical care. We observed good examples of documented discussions between medical staff and patients and families in care records.
- We saw evidence of use of patient diaries in critical care. Patients were asked to bring diaries to follow up appointments after discharge from hospital and a critical care admission. This supported the patient in better understanding of their experience, which supported recovery and rehabilitation.
- Nursing staff supported individual care plans and we noted an example of support put in place for a patient who, when waking from sedation expressed concern for his pet dogs that were alone in the house. The team contacted support agencies and realtives and were able to reassure the patient that the pets were cared for.
- Staff we spoke with told us that they could access specialist advice for a range of support services in the trust or externally. This included specialist nurses and teams for organ donation and language interpretation services at the trust.
- Senior staff had developed an electronic tablet 'app' as a cognitive tool to be used by patients during their stay in critical care as a response to patient feedback in follow up clinics. This would be tested in the RLI unit and shared with the FGH unit and across the LSCCCN if evidence of benefits to patients were good.
- The critical care team had developed a comprehensive approach to care for patients with tracheostomy who were cared for in wards. As part of the project a patient who had a laryngectomy was recruited to support delivery of staff training up to four times a year.

Emotional support

- The spiritual needs of patients takes priority in critical care and the trust had good access and provision of spiritual, religious and pastoral support. We saw evidence of information about services in the visitors room. We observed individual needs of patients recorded as part of assessments and reviews in the care records. A 95% positive response was noted from 34 patients in the critical care survey, when families were asked if they had felt supported when a family member had died.
- Emotional support was given as part of the post discharge home follow up appointment, post critical care admission. Additional psychological support was assessed on an individual basis. General Practitioner (G.P) referrals to a psychologist could made when required as recommended by the senior nurse in the clinic.
- The unit operated a flexible approach to visiting times for family and friends to promote the emotional support of patients. We observed nursing, medical, support workers, security staff (whilst supporting a patient who was agitated after waking from sedation) and members of the MDT talking to relatives and patients and it was evident that they had established positive, supportive relationships.

Critical care

Are critical care services responsive?

Good

We rated responsive as 'requires improvement' in 2015, however, during this inspection we found improvement and rated responsive as 'good' because:

- Discharges out of hours (between 22:00 and 07:00) have been proven to have a negative effect on patient outcome and recovery. RLI critical care discharges out of hours were 2.0%, which is consistently better than the national average of 2.3% as reported by ICNARC for 2015/16.
- The critical care team were skilled in managing patients with complex needs and we saw evidence of individual care planning and treatment. We saw excellent individual care and management of patients isolated with infection, those requiring one to one support and security/police supervision, those with learning disabilities and sight impairment, patients with critical level 3 needs, and those that were level 1 because of a delayed discharge to wards. It was clear that under busy circumstances staff did not lose sight of the individual needs of their patients.
- The team worked to ensure it met needs of local people and individuals when trying to make improvements or develop services. It was clear that the opinion of patients and relatives was valued.
- Follow up clinics, in line with GPICS (2015) were in place at the RLI for critical care patients who had experienced a stay in critical care of longer than 4 days. This gave the patient opportunity to gain further explanation of events, access screening for critical care complications, including psychological, physiotherapy or pharmacological support required. We observed good use of patient diaries.
- There were no formal complaints in critical care and when people did complain at a unit level action staff knew how to respond. The policy and processes for managing complaints was good and understood by all staff we spoke with.
- Patients received timely access to critical care treatment, a low number of critical care elective admissions were cancelled and this exceeded national targets. Patients were not transferred out of the unit for the non-clinical reasons and readmission rates were low.
- Bed occupancy in critical care was around 85% overall. The team recognised the need for the plan to refurbish and extend critical care services at the RLI and this was included in future service planning.
- Delayed discharges at the RLI were measured by the unit as delays greater than 4 hours from the decision to discharge. These delays had steadily increased in 2015/16, from approx. 50% to 75% of all discharges delayed greater than 4 hours. However, ICNARC data for 2015/16 reported greater than 8 hour delays and the unit in RLI had comparable performance against other units nationally. We did not see evidence of delays preventing the patient from receiving the care and treatment they needed and staff paid attention to patient dignity when single sex accommodation breaches occurred.
- We have previously reported concerns with the admission of critical care patients (also known as outliers) to theatre recovery in 2014/15. During this inspection we found arrangements to be much improved. We found there was a recorded three to five critical care patients in theatre recovery each month in 2015/16, with 24 admissions for the year at RLI, all short stay, mostly level 2 and nil overnight stay admissions, around a 50% reduction in admissions from previous reports. Patients were admitted as per policy with activity and acuity closely monitored by senior staff. There was a focus on preventing any ‘gaps in care’ and priority for the patient to be in a ‘place of safety’ existed amongst staff we spoke with. Critical care training had been increased for staff in theatres. Nurse skill mix in the critical care unit was not compromised to cover the theatre recovery activity, as previously reported. We did not see any incidents associated with demand for critical care beds and staff did not report any concerns with the current arrangement.

Service planning and delivery to meet the needs of local people

- Critical care service planning and delivery was managed as part of the Surgical and Anaesthetic Directorate in the trust. There was evidence of consistent and collaborative working during our inspection and in the review of minutes of senior meetings.

- There was involvement in the LSCCCN and good practice and learning was shared across the region.
- Follow up clinics, in line with GPICS (2015) were in place at the RLI for critical care patients who had experienced a stay in critical care of longer than 4 days. This gave the patient opportunity to gain further explanation of events, access screening for critical care complications, including psychological, physiotherapy or pharmacological support required.
- Consultants we spoke with had aspirations to develop a respiratory and ventilation or weaning support service and with additional consultant recruitment the possibility to have the resources to deliver this service for local patients may be achievable. Staff had begun to scope the opportunity and planned visits to other successful units. The team were positive about being able to make progress to benefit patients who currently had to travel out of region for care. The restrictions in providing respiratory equipment to local people on discharge home was recorded in the risk register with discussion taking place around establishing provision for patients.

Meeting people's individual needs

- The critical care team were skilled in managing patients with complex needs and we saw evidence of individual care planning and treatment. We saw excellent individual care and management of patients isolated with infection, those requiring one to one support and security/police supervision, those with learning disabilities and sight impairment, patients with critical level 3 needs, and those that were level 1 because of a delayed discharge to wards. It was clear that under busy circumstances staff did not lose sight of the individual needs of their patients.
- Patient diaries were introduced as part of a LiA project. The project had been implemented in early 2016 and all level 3 and 2 patients had opportunity to complete with support from staff, as part of promoting rehabilitation after critical care admission.
- Patients were supported with open visiting arrangements, overnight stay and a small kitchen facility. Patients and relatives spoke highly of the support given by staff during our interviews and in surveys. Individual and person centred care was a priority. Staff were aware of the 'care passport' and gave examples of when this had been used to document patients individual needs, likes and abilities.
- A range of information leaflets and specific guides were on display in the unit for visitors and an orientation folder for patients was available in the visitors area.
- Staff we spoke with were clear about the range of services available at the trust to support patients individual needs, from supporting a long term patient to access a haircut or seeking specialist nursing advice for pain relief and dementia care. The trust advocated the 'butterfly system' as part of a broader approach of good practice for patients with dementia.
- The trust had a robust system for access to translation services through switchboard as either an on-call or pre-booked service.

Access and flow

- The unit had written operational policy for admission and discharge.
- GPICS (2015) states admission to critical care should be timely and within four hours from the decision to admit for emergency patients, to improve their outcomes. The unit was reported as having 'partially met' this standard as a small number of patients were admitted to theatre recovery whilst a critical care bed was made available. Consultant reviews were performed within 12 hours of admission in line with GPCS (2015)
- There was a recorded three to five critical care patients admitted to theatre recovery each month in 2015/16, with 24 admissions for the year at RLI, all short stay and not overnight. Staff in theatre recovery reported that a LiA project supported a 'no gaps in care' approach and each incident was recorded in the electronic system with data collected by the ICNARC data administration team**.** Staff we spoke with in critical care and theatres did not express concern about risk to patients when admissions took place and staff had not reported any incidents of harm as a consequence. This was an improved arrangement since our last inspection, with a 50% reduction in admissions. Critical care training had been increased for staff in theatres. Nurse skill mix in the critical care unit was not compromised to cover the theatre recovery activity, as previously reported.
- Discharges out of hours, between 22.00hrs and 07.00hrs have been proven to have a negative effect on patient outcome and recovery. RLI critical care discharges out of hours were 2.0% which is consistently better than the national average of 2.3%. It was however noted that in June 2016 the evening time threshold for reporting discharge was lowered to 19.59hrs by the unit and as a

consequence the data showed a peak in incidence of around 25% of discharges in RLI. This could indicate that a large percentage of patients were discharged earlier in the evening, between 8pm and 10pm, and this was being monitored.
- RLI bed occupancy over a 12 month period to May 2016 ranged from 54% to 87%. There was a consistent average occupancy of around 85% from October 2015.
- Activity was monitored closely and 'mixed sex accommodation' breaches were included on the risk register. Patients who were ready for transfer to wards but whose discharge was delayed were declared as a 'mixed sex accommodation breach' after the decision to discharge had been made. The unit did not have capacity to provide the privacy of single rooms. Staff managed to support patient dignity when breaches occurred with good use of privacy curtains around the bed space and documented assessment of patient needs.
- There were zero transfers to other units for non-clinical reasons in 2015/16.
- The proportion of elective surgical critical care bed bookings cancelled due to lack of availability of a post-operative critical care bed was generally low across both RLI and FGH sites. RLI had rare cancellation from July 2015 – May 2016 (1) with a peaked increase over April to July 2016 (32), when longer term patients and delayed discharges had an impact on bed availability.

Learning from complaints and concerns

- The UHMB had a Patient Advice and Liaison Service (PALS) and we observed patient information leaflets in the relative room areas.
- The surgical and anaesthetic directorate had good processes for the management of complaints. Staff we spoke with were aware of the complaints policy and process.
- We did not see any evidence of formal complaints in critical care for 2015/16. We spoke with senior managers who told us that concerns were resolved locally and not escalated to formal complaint in critical care.

Are critical care services well-led?

Good

We rated well-led as 'good' because:

- The governance framework in critical care at the RLI was clear and the service was managed by an knowledgeable and motivated team. They understood and provided solutions for the challenges of providing high quality care in critical care
- Improvement was achieved by working closely together at all levels. Staff felt valued and it was evident from conversations we had with staff that patient centred, quality of care was the priority. Staff we spoke with across the team were passionate about their roles and proud of their trust.
- The investment in leadership programmes was good as it was clear the learning was shared, staff had a shared purpose and made an impact in practice. Leadership development was a key strategy and priority in the UHMB trust for all levels of staff. Staff we spoke with reinforced that the strategy was applied to practice and clinical leaders were supported to attend NHS Leadership Academy programmes and other external courses.
- We found a positive, open culture with confident, knowledgeable staff at all levels. Staff were encouraged to share concerns or comments they had about patient care, colleagues or the service. We did not hear of any complaints or conflict amongst staff in critical care. The team communicated very well with one another and with partners across the trust and network. Staff were supported with ideas and innovation and opportunity to make improvements

Vision and strategy for this service

- All senior staff we spoke with in critical care were knowledgeable about the trust vision, values and strategy and junior staff told us that patient safety and quality of care was a priority. During the inspection we observed a commitment by critical care staff to the five trust values of patients, performance, progress, partnerships and people.
- It was clear that progress against the strategy and vision for the service was a priority for all staff we spoke with. Critical care priorities were given proportionate and appropriate attention as part of the larger surgical and anaesthetic directorate. The findings on this inspection, particularly around the environment in ITU and plans for consultant anaesthetic cover were clear in strategic plans, with realistic timescales and actions for improvements to deliver good quality care to patients.

- There was evidence of innovation and staff we spoke with were enthusiastic and positive about the challenges in critical care and felt involved.

Governance, risk management and quality measurement

- Governance arrangements were clear. Critical care was represented at board and trust level and information was shared across the service.
- Guidelines and policy were consistent across both sites and units.
- Dedicated data administrators produced the critical care ICNARC submission, by working closely with the consultants and clinical team. There was consistent submission of information to the ICNARC CMP.
- The service measured itself against the GPICS (2015) standards, which underpins the D16 service specification used by LSCCCN to provide a benchmarked peer review.
- The risk register for critical care was detailed with progress and ownership being documented as part of the surgical and anaesthetic directorates overall risk register. We saw reviews and action plans associated to risk and felt that the items on the register reflected what we observed and discussed with staff during inspection as their concerns.
- There was an embedded approach to sharing performance information with staff in way that could be understood and interpreted as part of improving quality, safety, experience and activity. This included 'WESEE' reports and bulletins. Matrons and senior staff shared information in a variety of ways to reinforce the quality agenda with good effect.
- The matrons performed weekly audits and monthly (QAAS) ward rounds for quality assurance. This approach was consistent and the feedback communication to the team in ward meetings was evident.

Leadership of service

- The senior team structure was established and understood by staff we spoke with and consistent across critical care sites. There was good leadership support and clear line management, with an emphasis on 'cross bay working' and support.
- The senior team were identified in photographs on the unit display boards visible to the junior team and patients. Staff visiting the unit as part of their duties, approached inspectors to give positive feedback about senior staff across both sites.
- We interviewed the senior individuals responsible for critical care units at both sites and they consistently reported that they felt supported by the executive team. There was a Clinical Director in intensive care, and experienced senior nurses. The appointment of a supernumerary clinical coordinator was planned to further support the team, although visible senior staff had been in place and had been supportive of staff in ITU prior to this appointment.
- Leadership development was a key strategy and priority in the UHMB trust for all levels of staff. Staff we spoke with reinforced that the strategy was applied to practice and clinical leaders were supported to attend NHS Leadership Academy programmes, e.g. the Nye Bevan and Mary Seacole leadership programmes, and post graduate certificates (PgC) in healthcare leadership. There was an ongoing commitment to staff attendance and critical care clinical leads had attended the Lancaster University, Centre of Excellence for Training and Development (CETAD) PgC Professional Practice (Clinical Leadership) course, which was delivered by the trust.
- Examples of application of improvement in practice were numerous with a culture of sharing learning from programmes, implementing change and commitment to 'Listening into Action' (LiA) projects and Ambassador and Champion programmes for improving quality of care.
- The clinical leads we spoke with demonstrated a "health and wellbeing" approach to managing the short and long term sickness experienced by the nursing team, and reported good support from human resources. An example of which was a referral to physiotherapy before a member of the team had elective surgery in order to support and improve post-operative recovery which was given as an example of a supportive approach.
- During interviews with staff, they told us the division had strong leadership and senior managers were visible on a daily basis or available for one to one discussions. Senior managers told us that the executive team were

equally supportive. This reflected the vision and values of the division and the trust. We interviewed number of staff on an individual basis and held group discussions throughout surgical wards, theatres and units.

Culture within the service

- Morale was good amongst the 17 staff we spoke with.
- There was an open and transparent culture. Staff were encouraged to share concerns or comments they had about patient care, colleagues or the service. We did not hear of any complaints or conflict amongst staff in critical care.
- Collaboration was good within the surgical and anaesthetic directorate, the wider trust team and across the region in the critical care network (LSCCCN).
- Staff we spoke with, without exception told us that they were proud to work for the trust, and in particular they were proud of the improvements and vision that had taken priority over more recent years. Staff used positive statements to describe the culture in critical care.

Public engagement

- We observed how experiences of patients influenced staff to improve care and develop new services. We saw examples of this from the follow up clinic (use of technology in ITU) and involving people who use the service in teaching clinical staff,(Tracheostomy care). Staff were engaged with seeking patient feedback and acting on results.
- It was important to consultant staff to be able to deliver services locally to people in the community, especially in view of the rural location. There was concern around patients travel commitments across sites and for appointments to services at larger regional hospitals which were further away. An example of this was supporting home ventilated patients in the local community, with a plan for improving services for patients.

Staff engagement

- The trust recognised that ongoing work was required to continue improvement in employee engagement and employee recognition, however we saw good progress in critical care units.
- As part of a first wave LiA the trust developed a Behavioural Standards Framework (BSF) to underpin its vision and values. The BSF was embedded and staff we spoke with in critical care had a good awareness of how it had been incorporated into values-based recruitment, induction, appraisal and leadership strategy and training.
- Ten percent of trust employees responded to a 2016 pilot of the Barrett Cultural Values Assessment Tool. The 10 top personal values selected by employees presented “a strong and positive picture of caring, empathetic employees, with a can-do attitude, dedicated and committed to fairness.” As reported in the trusts September 2016 Organisational Development Strategy Update meeting. These values were evident during the inspection amongst the critical care team.
- There was investment in staff in critical care. We spoke with members of the team who felt valued and had opportunity to develop professionally.
- We spoke with the lead consultant about plans to develop advanced critical care practitioner (ACCP) posts, in line with other units where the strategy had been proven to work well to support the care and treatment of critical care patients. This strategy would be an opportunity for skilled and knowledgeable nursing staff to develop their roles and initial team feedback about the approach was positive. The first cohort was planned for 2017 February and recruitment to the programme had commenced.

Innovation, improvement and sustainability

- Senior nursing staff we spoke with had developed an I-pad selection of ‘brain training apps’ to aid patient’s cognitive function. This was as a direct response to two patient stories in the clinic of using similar approaches at home to improve post ITU memory loss and reduced cognitive function. Staff worked with the speech and language therapy team, had support from IT staff and senior staff for funding, and whilst recognised that there was no proven research evidence to support the project in clinical practice, there was a plan to test the benefits to patients in the RLI unit and present any findings and share across both units and the LSCCCN.
- The comprehensive approach to caring for patients with tracheostomy had been adopted and shared by Lancashire and South Cumbria Critical Care Network (LSCCCN) Staff had received a trust ‘Health for Heroes’ award for the work achieved in 2016.

Critical care

- A ‘Sleep Well’ project had been undertaken to decrease the noise and light disturbance to patients on the unit by introducing ear plugs and blindfolds. Although this was reported to us by staff we did not have opportunity to observe this during inspection.
- Critical care had introduced patient diaries to allow patients to process the impact of critical illness, improve memory recall and support staff to respond more holistically to patient's needs.
- The intensive care outliers LiA project to ensure there are ‘no gaps in care’ when a patient is cared for in theatre recovery on a temporary basis was an improvement to support sustaining safety and quality of the critical care admission experience.
- The unit continued to be an active member of the LSCCCN. Membership of the network enabled the unit to work collaboratively with commissioners, providers and users of critical care to focus on making improvements.

Maternity and gynaecology

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

Information about the service

Royal Lancaster Infirmary (RLI) offered midwife-led and obstetric consultant-led care for high risk and low risk women and a range of gynaecology services.

There were 28 maternity beds and 10 gynaecology beds, a labour ward, an early pregnancy assessment unit, and day assessment unit. The central delivery suite had seven delivery rooms (including the birthing pool room), one dedicated maternity theatre, and one gynaecology theatre which was larger and so used for multiple deliveries if required.

Between April 2015 and March 2016, there were 1,974 births at RLI. Across the trust the percentage of births to mothers aged 20-34 and the percentage of births to mothers aged 20 and under was slightly higher than the England average.

During our inspection, we visited the antenatal clinic, antenatal and postnatal ward, labour ward andgynaecology ward. We spoke with 16 women and 54 staff, which included, midwives ward managers, matrons, doctors, consultants, senior managers and support staff. We carried out staff focus groups for midwives. We observed care and treatment and looked at 17 care records. We also reviewed the trust's performance data.

Summary of findings

At the last inspection, in July 2015, we rated maternity and gynaecology services as requiring improvement for being safe and well-led, particularly about checking of equipment, medicine management, assessing and responding to risk, embedding governance and risk processes, joint working and culture. During this inspection, we found good progress had been made in these areas and rated Royal Lancaster Infirmary as good because:

- Staff understood their responsibilities to raise concerns and record patient safety incidents. There were processes to ensure reviews or investigations were carried out and action taken.
- Staff were aware of the procedures for safeguarding vulnerable adults and children, the infant abduction policy had been tested.
- There were processes for checking equipment and arrangements for managing medicines.
- Medical, nursing and midwifery staffing levels were similar or better than the national recommendations for the number of babies delivered on the unit each year.
- Systems were in place for assessing and responding to risk. Staff received training that enabled them to identify and act in the instance of a critically ill woman. There was improvement in the use and completion of the surgical safety checklist compared to the last inspection.

Maternity and gynaecology

- Women's care and treatment was planned and delivered in line with current evidence-based practice, which was audited to ensure consistency of care and treatment pathways.
- Care outcomes were meeting expectations in most areas, and where improvements were required the service had identified action.
- Women were positive about their treatment by clinical staff and the standard of care they had received. They were treated with dignity and respect.
- Services were planned, delivered and co-ordinated to take account of women with complex needs, there was access to specialist support and expertise.
- The leadership team understood the challenges to the service and actions needed to address these. Improvement had been made to ensure staff and teams were working together to promote a culture of learning and continuous improvement. A culture of openness was evident.
- There were many examples of how people's views and experience was used and acted on to develop and delivery maternity care.

However:

- Not all care records were fully completed, dated and signed. This included inconsistent recording on cardiotocographs (CTG) which was not in line with the trust fetal monitoring policy. These areas were audited and recommendations made.
- Although there was a plan, which set out the principles, and governance arrangements for a strategic partnership with Central Manchester and Lancashire further work was required to effectively capture and monitor outcomes.

Are maternity and gynaecology services safe?

Good

We rated safe as 'good' because:

- Serious incidents were reported in line with national frameworks. The number of reported serious incidents compared to the last inspection had improved. Processes were in place to review serious cases by using a multi-disciplinary approach and external peer review. There were changes made to the delivery of care because of leaning from incidents.
- There were processes for checking equipment and medicines. Standards of cleanliness and hygiene were maintained.
- The service assessed staffing numbers and skill mix using an acuity tool. Medical, nursing and midwifery staffing levels were similar or better than the national recommendations for the number of babies delivered on the unit each year.
- Systems were in place for assessing and responding to risk. Staff received training that enabled them to identify and act in the instance of a critically ill woman. There was improvement in the use and completion of the surgical safety checklist compared to the last inspection.
- Staff were aware of the procedures for safeguarding vulnerable adults and children. The service had carried out practical tests of the child and infant abduction policy.

However:

- Intravenous drugs were stored in the same cupboard as local anaesthetic drugs in the operating theatres; this did not follow the guidance of the Royal College of Anaesthetists.
- There were some entries in clinical records where the signature and identifiable name of staff was illegible.
- There was inconsistent recording on cardiotocographs (CTG); this included entries with missing signatures at the beginning and end of the trace, no classification of the traces, no reason for commencing or discontinuing the trace and recording of the maternal pulse during first stage of labour. This was not in line with the trust fetal monitoring policy.

Maternity and gynaecology

Incidents

- In accordance with the Serious Incident Framework 2015, the maternity services at Royal Lancaster Infirmary reported no serious incidents (SIs) which met the reporting criteria set by NHS England between September 2015 and August 2016.
- Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. Between September 2015 and August 2016, the trust reported no incidents, which were classified as Never Events for maternity services.
- Trust policies for reporting incidents, near misses and adverse events were effective in maternity services. All staff we spoke with said they were encouraged to report incidents, and were aware of the process to do so. Staff said they received feedback about incidents they had reported with details of the outcomes of any investigations.
- There were 1384 incidents reported for maternity and gynaecology across all hospital sites between September 2015 and September 2016. The majority of incidents were reported as low or no harm, 25 (2%) were moderate, one severe and one death. The service completed Root Cause Analysis (RCA) reports including external peer review. We found evidence of discussion and learning shared with staff.
- There were quarterly joint perinatal mortality and morbidity meetings across the three hospital sites. All serious cases, including stillbirths and neonatal deaths, were reviewed by a multi-disciplinary peer group which included obstetricians, paediatricians, midwifes, medical students and risk management leads. Minutes for September 2015 to June 2016 showed that recommendations to improve practice had included changes to practice and guidelines. The March 2016 minutes showed that there was a plan for Consultants from Burnley and Preston to attend perinatal mortality meetings to maintain links with tertiary centres. The June 2016 minutes show that a consultant obstetrician from Preston attended.
- We looked at two RCA reports following incidents, which showed that duty of candour regulations, were followed. There was evidence to show women and families were involved in the investigation process, and informed of the outcomes.

Safety thermometer

- The maternity services used the national maternity safety thermometer. This allowed the maternity team to check on harm and record the care.
- A snapshot of the maternity safety thermometer for August 2016 showed that 94% of women did not experience any of the four physical harms at the trust (infection, perineal trauma, PPH>1000mls, Apgar<7 (term only) or transfer (term only)). 100% of women did not express concern over their perception of safety and 94% of women did not experience any of the combined harms at this trust.
- The safety thermometer information was not displayed in clinical areas but was available on the maternity website.

Cleanliness, infection control and hygiene

- There were no cases of hospital-acquired Methicillin-Resistant Staphylococcus Aureus (MRSA) or Clostridium difficile (C. difficile) in 2016/17.
- Observations during the inspection confirmed that all staff wore appropriate, personal protective equipment when required, and they adhered to 'bare below the elbow' guidance in line with national good hygiene practice. All clinical areas were clean.
- Hand hygiene audits showed between 86% and 100% compliance for maternity wards and the gynaecology clinic.
- Environmental audits were carried out as part of the trust Quality Assurance Accreditation Scheme (QAAS). The QAAS showed that standards were being met and where areas for improvement were identified, action was taken.
- Training records showed that 100**%** of maternity and gynaecology staff had completed Infection Prevention and Control (Core Skills) Level 2 training.
- The CQC Survey of Women's Experience of Maternity Services (2015) showed that the service scored 'about the same' as other trusts for cleanliness, infection control and hygiene.

- The wards, theatres and recovery areas were visibly clean and tidy. This included the corridors, bathrooms, offices and storage rooms.
- Staff within the theatre environment wore appropriate clothing. We observed staff following the local policy and procedure when scrubbing, gowning and gloving prior to surgical interventions.
- We saw staff adhering to procedures in line with national guidance to minimise the risk of infection to patients undergoing surgical procedures, for example, skin preparation and the use of sterile drapes, (skin preparations had expiry dates on them)
- The theatre lead said theatres were deep cleaned weekly or more regularly if a known infection risk present. Air filtration for theatres was serviced regularly.

Environment and equipment

- We checked stock items in cupboards and on trolleys. These were all in date apart from seven venepuncture vials.
- There was adequate equipment on the wards to ensure safe care, specifically cardiotocograph (CTG) and resuscitation equipment. Staff confirmed they had sufficient equipment to meet women's needs.
- All community midwives had emergency equipment bags. These were standardised across areas with checklists so that staff could access the correct equipment for home births.
- Access to wards and theatre was secure.
- There are two theatres and two recovery bays. Gynaecology used one of these theatres. When elective caesarean section lists were running, there was another theatre available for emergencies. There were two entrances to theatres; maternity patients come in through labour ward and gynaecology patients through another entrance, which was separate to maternity.
- Resuscitation equipment was available in both the labour ward and theatre areas for adults and neonates. Records showed daily checks.
- Daily checks were carried out on the anaesthetic machines and equipment in line with Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines. This meant anaesthetic machines and equipment were in working order and safe to use.
- Protocols were in place for transferring women out of the birthing pool in an emergency. Staff told us there was a formal protocol. Staff used four tube inflatables (neck, back, knees, and ankles) to help lift the patient and slide a sling underneath to help lift and slide onto the bed. A practice took place in January 2016. The disposable slide sheets were kept in a cupboard opposite the birthing poolroom. The inflatables were kept in the same room as the birthing pool.
- There was a 'hover jack', which is a piece of equipment, which enables patients to be carried down the stairs in the event of a lift breaking down. Not all staff had received training to use this yet. Staff were unsure where this equipment was kept but advised that a porter would bring the hover jack to them if requested.
- We checked 13 pieces of equipment across theatre and the labour ward. Equipment was routinely checked for safety and maintenance.
- Processes and procedures were in place for the management, storage and disposal of general and clinical waste, disposal of sharps such as needles.

Medicines

- Drugs and IV fluids were stored appropriately on both the labour and post-natal ward. The medicines trolley on the post-natal ward was locked and secured. All emergency drugs were stored in tamper proof boxes.
- Controlled drugs (CD) were checked in line with trust policy. We checked the CD stock against the entries in the CD book, all were correct.
- We looked at two prescription charts. One of which did not record if a controlled drug had been counter signed on the chart, a dosage was not recorded and some regular medication had been omitted without a reason recorded.
- Intravenous drugs were stored in the same cupboard as local anaesthetic drugs within operating theatres; this did not follow the guidance of the Royal College of Anaesthetists.

Records

- The service used the standardised maternity notes developed by the Perinatal Institute. We reviewed 17 records, the majority of which were completed to a good standard. Each record contained a pathway of care that described what women should expect at each stage of their labour.
- On the post-natal ward, we reviewed seven separate CTG recordings. Four of which were documented according to trust policy. Three showed that the maternal pulse was not recorded, there were no signatures, date, or time for completion and there were

no classifications. An audit of CTG recording between February and May 2015 showed similar findings. Recommendations included to share the audit with staff through the WESEE meetings, ward managers effectiveness meeting, senior leadership meeting, monthly audit update report for clinical staff, and to feed audit results to the education team to add results to the CTG teaching session.

- There were some examples of records where signatures were illegible or staff designation was not included.
- A cross-bay record keeping audit was completed between April and July 2016. The audit sample of 30 records showed that some areas required improvement. Action plans were completed and showed areas of good practice. Staff attended mandatory study days for record keeping and a new e-learning package was developed for completion of Maternity Early Obstetric Warning charts.
- Standard operating procedures and care pathways were included in records for care of women with diabetes, epilepsy, hypertension or a high body mass index (BMI) in pregnancy.
- In one case record showed that the management of pregnancy-induced hypertension followed guidelines appropriately.
- A venous- embolism risk assessment form was completed at booking with obstetric referral as indicated.

Safeguarding

- There was a named midwife for safeguarding and a full time safeguarding specialist midwife. Both worked across all sites. There was good liaison with other specialist midwives such a teenage pregnancy, mental health, domestic violence and substance misuse.
- The safeguarding midwife carried out a snap shot audit of safeguarding records. The latest audit showed 80% compliance against a target of 95%. There was a trigger sheet to prompt staff to ask questions about social and family circumstances. There was an alerting system for vulnerable women and babies attending maternity, children's services or the emergency department.
- Safeguarding supervisors had protected time. A formalised system was being developed which included an additional safeguarding training day incorporating an hour of supervision. Data showed 76% of midwives had received safeguarding supervision and 75% of community midwives.
- The service had employed a social worker experienced in child sexual exploitation (CSE). Staff received information about CSE through case study, conferences and newsletters. There was close working with the CSE nurse in Blackpool.
- There was a safeguarding trigger tool used for women attending termination of pregnancy. Children aged 13 to 16 were asked about their sexual activity and referred to the appropriate agencies where required. Girls under 13 years of age were automatically referred to the safeguarding team.
- Women were asked about abuse at booking and when they were alone. Midwives tried to see women alone at least twice in their pregnancy. The safeguarding and domestic violence midwives were reviewing recording of domestic abuse conversations with women and providing further training for staff.
- Staff had access to an independent domestic and sexual violence advisor.
- There was a process for reporting cases of female genital mutilation (FGM) in response to the Department of Health's multi-agency guidance. There were two midwife FGM champions.
- The trust had carried out practical tests of the child and infant abduction policy in July 2016. There were no issues identified.
- Training figures showed 86% of staff had received training at level 1 for safeguarding vulnerable adults and children; 98% of staff had completed training for safeguarding children level 2; and 67% level 3. Schedules showed remaining staff were booked to attend before the end of the year.

Mandatory training

- Mandatory training was provided using either e-learning or study days. Staff accessed e-learning through a trust-wide training system which sent email prompts when learning was due.
- There was a dedicated practice development midwife who monitored attendance and organised training sessions. A monthly attendance repot was sent to the divisional monthly assurance committee.
- Mandatory training included moving and handling, infection prevention, equality and diversity, information governance, conflict resolution and basic life support. The trust's target compliance rate was 95%. Data provided by the trust for Royal Lancaster Infirmary showed training compliance rates were mostly in line

with the trust target apart from adult basic life support (77%), out of the 13 staff who were non-compliant 6 members of staff had been booked to attend training on the week of the inspection.
- At the time of our inspection, there were three mandatory midwifery study days. These would increase to four in the following months.

Assessing and responding to patient risk

- The service used an early warning assessment tool known as the 'Maternity Early Obstetric Warning System' (MEOWS) to assess the health and wellbeing of women who were identified as being at risk. This assessment tool enabled staff to identify and respond with additional medical support. We looked at 17 records, 15 showed a set of observations were recorded on admission to the unit and an early warning score was calculated in line with trust guidelines, recording of observations were increased when MEOWS increased. However, one record used for a pre-eclamptic patient, showed observations were recorded without being scored. One of these observations, (blood pressure) was not recorded on MEOWS and there was no corresponding record in the notes, although medical staff were already aware of the patient. In another set of records, we saw not all observations were scored. We raised this with staff during the inspection and the service included our findings the following morning in the three-minute safety briefing across all hospital sites.
- The service was not commissioned to provide anything above level 1 care for women in maternity services and therefore there was a low threshold for transfer to HDU/ ITU. However, staff did undertake training that enabled them to identify and act in the instance of a critically ill woman. Trust data showed that 100% of community midwives and 90% of staff on the maternity ward had completed Acute Life Threatening Events Recognition and Treatment (ALERT) training. The care of critically ill obstetric cases were also picked up through 'PROMPT' (Practical Obstetric Multi-Professional Training); a evidence based training package for obstetric emergencies.
- At the last inspection, we found that the 'five steps to safer surgery' procedures (World Health Organisation safety checklist (WHO)) were not completed consistently. During this inspection, we found improvements in this area. A range of audits from January to July 2016 showed that compliance was 100%. We observed the theatre team completing and documenting the five steps to safer surgery correctly.
- There were clear processes in the event of maternal transfer by ambulance, transfer from homebirth to hospital, and transfers postnatally to another unit.
- The unit used the 'fresh eyes' approach, a system which required two members of staff to review fetal heart tracings. However, we saw that documentation of CTG recordings were not consistent with trust policy for fetal monitoring.

Midwifery staffing

- The service met the national benchmark for midwifery staffing set out in the Royal College of Obstetricians and Gynaecologists (RCOG/RCM) guidance 'Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour' with a ratio of 1 midwife to 23 births, which was better than the RCOG recommendation of 1 midwife to 28 births.
- The service assessed staffing number and skill mix using the acuity tool Birth-rate Plus Intrapartum Score card. This reviewed intrapartum, postnatal and antenatal activity three times a day in the unit. If required staff were asked to provide care in a different area to which they were allocated if further midwifery cover was required due to activity. This was used in line with the trust escalation policy.
- There was a band 7 senior midwife on duty at all times on the labour ward. The planed and actual staffing levels were displayed on notice boards on each ward. On the days we inspected the wards, there were no shortfalls in planned staffing levels.
- Over the last 12 months, midwives in post had increased by 9.6 WTE (whole time equivalent) and by head count; this had increased by 15 midwives. The residual midwifery vacancy rate was 6.2%.
- Internal staff were offered unfilled shifts six weeks in advance. Bank shifts were paid at the top the grade as an incentive for internal staff to fill.
- There were three vacancies in community midwifery. Staff said this was not affecting safety but sometimes affected continuity of care because of increased on-call with less staff to cover the rota. However, there was

cross-bay working to help with the rota and a plan that community midwives would only need to be on-call when home births were planned. Caseloads were around 60-70 women per midwife.

- In antenatal clinic (ANC), there was one 30-hour band 6-midwife one working 16 hours. There was one full-time healthcare assistant (HCA) and 0.5 HCA from gynaecology. The manager said that both band 6 midwives did ultrasonography and therefore could not work many hours in ANC, which meant full staffing was difficult to maintain. Staff also raised concerns about staffing levels in the day pregnancy assessment unit. They felt staffing did not match the increase in activity. Currently there was one midwife and a healthcare support worker.
- Staffing in ANC had been escalated to managers, it was agreed to move some staff from Furness General Hospital to support, and new staff appointments were expected. The Director of Midwifery acknowledged staffing was not correct in these areas. There was additional recruitment and the service was developing an antenatal support worker role.
- A multidisciplinary handover took place on the labour ward. All women were discussed, including women under midwifery led care who may require obstetric input. There was good communication observed between midwives and medical staff. There was a further bedside handover between midwives.
- At September 2016, there was ten agency staff at Royal Lancaster Infirmary, which had worked over six months. There was an action plan to reduce agency spend trust-wide this included interviews planned for November 2016 to recruit to one Labour ward Co-ordinator post and there were 5 applicants for Band 6 Midwives and two for Band 5. All suitable applicants would be appointed and all applicants were external.
- Nurse staffing in gynaecology was assessed twice a day using a safe staffing acuity tool. Nurse to patient ratio was 1:8.

Medical staffing

- The service provided 84 hours of consultant cover on the labour ward. This was in line with the recommended RCOG safer staffing standards for a service delivering less than 3,000 births per year.
- There was consultant presence from 9am to 5pm five days a week. On-call service began at 5pm but consultants were happy to stay until all women at risk were seen and managed. There were four resident consultants from 9pm until 9am (48 hours)
- The current arrangement for anaesthetics was for the registrar to cover maternity and intensive care. The on-call anaesthetist told us this generally worked well but sometimes it could be a strain. Morning and day shifts included dedicated anaesthetic presence. A proposal had been developed to extend this to afternoons. . A business case for the recruitment of five additional consultant anaesthetists was submitted to the trust Finance Committee on 26 September 2016.
- There was a cross-hospital handover each say using a video conferencing facility.
- Locum use in gynaecology was 16%. Three new consultants were recently appointed.

Major incident awareness and training

- There were clear escalation processes to activate plans during a major incident or internal critical incident such as shortfalls in staffing levels or bed shortages.
- Medical staff and midwives undertook training in obstetric and neonatal emergencies at least annually.
- Business continuity plans for maternity services were in place. These included the risks specific to each clinical area and the actions and resources required to support recovery.

Are maternity and gynaecology services effective?

Good

We rated effective as 'good' because:

- Women's care and treatment was planned and delivered in line with current evidence-based practice, which was audited to ensure consistency of care and treatment pathways.
- Care outcomes were meeting expectations in most areas, and where improvements were required the service had taken action.
- The service participated in local and national audits and external reviews to improve care.

- Staff had the correct skills, knowledge and experience to do their job. Training ensured medical and midwifery staff could carry out their roles effectively. Competencies and professional development was maintained through supervision.
- Women had their pain effectively managed. There were processes to support women to feed their babies.
- There was improvement to ensure teams worked together across all hospital sites. Communication between medical, midwifery and nursing staff was described as good in the unit. There were good working relationships with other services including neonatology and paediatrics.
- Consent practices were monitored and reviewed and women were involved in making decisions about their care and treatment.

Evidence-based care and treatment

- From our observations, records and through discussion with staff we found that care was in line with the National Institute for Health and Care Excellence (NICE) and Royal College Recommendations.
- Records showed women received care in line with NICE Quality Standard 22, covering antenatal care of pregnant women up to 42 weeks of pregnancy, in all settings that provided routine antenatal care, including primary, community and hospital based care.
- For women who planned for or needed a caesarean section, this was managed using NICE Quality Standard 32.
- Care of women was in line with Royal College of Obstetricians and Gynaecologists (RCOG) guidelines (including 'safe childbirth: minimum standards for the organisation and delivery of care in labour'). These standards set out guidance about the organisation, safe staffing levels, staff roles, and education, training and professional development.
- A baseline assessment of Intrapartum Care: Care of healthy women and their babies during childbirth (CG190) showed 100% of recommendations were met.
- The service used assessments of how it compared with NICE statements through a range of quality standards. Completed assessments included: maternal and child nutrition (QS98), diabetes in pregnancy (QS109), and antenatal and postnatal mental health (QS115). Action plans (July 2016) showed these were partially compliant.
- Staff were consulted on guidelines and procedures, which were regularly reviewed and amended to reflect changes in practice. We looked at six guidelines, found these were in date, and in line with evidence based practice.
- There was a case-based caesarean section meeting each week.
- A clinical audit lead and dedicated audit lead midwife covered all three sites. The service participated in local and national audits and external peer reviews to improve care. There was a three-year audit programme, additional audits were completed following any learning from incidents, and case reviews.
- Audits showed action was taken when risks were identified. For example, the maternity dashboard showed a significant increase in the number of post-partum haemorrhage (1500mls) in January 2016. A thematic review was carried out which showed all cases with the exception of one case followed PPH guidance and managed appropriately. The one case was escalated to a root cause analysis investigation due to delay in recognition and treatment.
- The service used evidence based birth centile charts from the Perinatal Institute, which identified which babies required enhanced observations.
- The Screening Quality Assurance Visit Report NHS Cervical Screening Programme (Public Health England June 2016) showed there were no immediate concerns for improvement. Four high level issues were identified relating to guidance and data; progress against the action plan for these areas would be monitored by NHS England Screening & Immunisation Team Lancashire and Cumbria

Pain relief

- Women were provided with information to make them aware of the pain relief options available to them. Most women we spoke with said they had received sufficient pain relief.
- The maternity dashboard showed that between February and July 2016, the average of epidural deliveries was 14% against a trust target of 20%.
- An audit of the 'Epidural in Labour Guideline' May 2016 showed that anaesthetist response times within 30 minutes for epidural analgesia was good.
- There was a system of patient controlled epidural infusions. Although medical staff gave a bolus dose, this was needed infrequently.

- There was access to various types of pain relief for birthing women, which included drug-free methods such as hypnobirthing. There was access to a new birthing pool. Data showed there was a 3% water birth rate.

Nutrition and hydration

- Breastfeeding initiation rates for deliveries that took place in the trust for February 2016 to July 2016 varied between 56% and 64% against a trust target of 61%.
- At the time of inspection, the trust had not registered intent to undertake the United Nations Children's Fund (UNICEF) Baby Friendly Initiative (BFI) Accreditation Scheme. However, there was an infant feeding guideline and the service was involved in a 'Listening in Action' (LIA) project to develop an infant feeding strategy.
- Breastfeeding support was included in mandatory study days and preceptorship training for newly qualified midwives.
- Formula milk was available. Breastfeeding peer supporters attended the ward to support women.
- Snacks were offered to women 24 hours a day as required, and staff were able to order extra food and snacks for pregnant women as required.
- Women told us they had a choice of meals and these took account of their individual preferences including religious and cultural requirements. Women we spoke with said the quality of food was good.

Patient outcomes

- There were no risks identified in: maternal readmissions; emergency caesarean section rates; elective caesarean sections; neonatal readmissions or puerperal sepsis and other puerperal infections. (Hospital Episode Statistics April 2012 to May 2015).
- Between April 2015 and March 2016, the number of caesarean sections was similar to expected. The standardised caesarean section rates for elective sections were similar to expected. The rates for emergency caesarean sections were similar to expected.
- The normal vaginal delivery rate was 56%, which was worse than the national average of 60%.
- Between 1 April and 30 September 2016, there were 49 admissions to the special care baby unit. The common primary diagnosis for admission for babies born at term was due to respiratory distress (3 cases) and infection (3 cases). For the same period, there were two at term admissions, transferred outside of the trust.
- Between 1 April and 20 September 2016, there were four maternal admissions with a level 2 HDU or Level 3 ITU critical care period.
- Between October 2015 and September 2016 there were seven still births at Royal Lancaster Infirmary.
- Between October 2015 and September 2016 the average number of women sustaining serious perineal trauma during birth was two per month, which was lower (better) than the trust target of nine per month.
- Between October 2015 and September 2016 the average number of women, sustaining a post-partum haemorrhage >1500ml was four per month, which was worse than the trust target of two a month.
- The 'National Neonatal Audit Programme 2015' (NNAP) showed Royal Lancaster Infirmary met or was above the NNAP standard for two of the five indicators. This indicator was 'do all babies of less than 29 weeks gestation have their temperature taken within an hour after birth' and are all mothers who deliver babies between 24+0 and 34+6 weeks gestation given any dose of antenatal steroids?' . The remaining three indicators were worse than the NNAP standards. There was an action plan with timescales in response to the findings.
- The NHS screening programme sets key performance indicators (KPI) for antenatal and new-born screening programmes. The trust was meeting acceptable levels within six of the eight KPIs for which data was submitted for April to July 2016. The trust provided a copy of their action plan and we saw that steps had been taken to improve performance, for example, a change of equipment and continued staff education to reduce the number of avoidable repeat new-born blood spot tests.

Competent staff

- Newly qualified midwives completed a comprehensive two-year preceptorship programme. This included protected study days, one morning per month. Preceptorship packages were individualised and provided a framework to develop staff from a band 5 to a band 6 in maternity care. This included rotation across all sites.
- Staff told us they received a yearly appraisal. Trust data showed that 84% of medical staff, 88% of band 1-7 and 93% of Band 8a midwifery and gynaecology staff had received a yearly appraisal.
- The 'North of England Local Supervising Authority's (LSA) annual report to the Nursing and Midwifery Council September 2016' showed the trust had met all

LSA standards. Recommendations from the audit included a review of SoM caseloads, which were not evenly distributed, and SoMs seeking assurance from the trust that recommendations made following investigations had been actioned.

- The caseloads held by supervisors of midwives were in line with the recommended ratio of 15 midwives for each supervisor. All midwives had 24-hours access to supervisors. The LSA report confirmed that for the practice year 2015/2016 100% of annual reviews had been completed. This provided assurance that midwives had met the NMC requirements for practice.
- There was a full time dedicated SoM. Three midwives have completed the Preparation of Supervisor of Midwives (PoSoM) programme at Manchester City University with appointments from the LSA to take place in October 2016.
- All student midwives had access to supervision; a full time supervisor of midwives facilitated this.
- Junior doctors attended protected weekly teaching sessions and participated in clinical audit. They told us they had good support from seniors and could approach them for advice at any time. There was a weekly trainee forum where doctors could raise any training issues.
- Junior doctors said they were very happy with the training and support they received, particularly that given by consultants. There was a good induction process and mandatory training was provided. All junior doctors had educational and clinical supervisors who met with they regularly. Doctors who required additional experienced rotated to areas for further training. Doctors did not express any concerns with workloads.
- The results of the General Medical Council National Training Scheme Survey 2016 showed that the trust was 'within expectations' for clinical supervision and adequate experience and 'above expectations' for a supportive environment.

Multidisciplinary working

- Communication between medical, midwifery and nursing staff was described as good in the unit. We observed good working relationships with other specialties including neonatology and paediatrics.
- Specialist midwives worked closely with their colleagues across all hospital sites and had regular meetings to discuss practice issues.
- Staff confirmed there were systems to request support from other specialities such as pharmacy, allied healthcare professionals and physicians.
- Newcastle was a referral centre for high-risk women requiring an antenatal review. There were systems to receive advice and staff said this was supportive.
- Some community midwives had regular meetings with GPs to discuss cases. A quarterly meeting was held with community midwifery and health visitor leads for the area. There were good relationships with the hospital and good referral pathways for antenatal visits. Community midwives had an office in the maternity unit at Furness General Hospital.
- The gynaecology multi-disciplinary (MDT) meetings were cross-bay; the colposcopy MDT was held once a month.
- There was a new birth screening operational group, chaired by the Director of Midwifery who met quarterly. The group included staff from the laboratory's, child health, sonographers and paediatricians. There were positive outcomes for example previously there had been inconsistent coding of abnormalities by sonographers across the trust, this was now standardised and had improved coding.
- Records showed communications with GPs summarising antenatal, intrapartum and postnatal care.
- The post-natal ward had no formal transitional care facility for babies requiring additional support; however, staff said they worked closely with the neonatal unit to care for babies who required additional clinical interventions.
- There were joint education meetings with the neonatal unit and multidisciplinary obstetric skills and drills training days.
- Safe active birth specialist midwives worked closely with women's health physiotherapists to plan and deliver the active birth sessions available to women. Physiotherapists delivered sessions to band five midwives as part of the preceptorship programme.

Seven-day services

- 'Out-of-hours' services were available in emergencies. All women could report to the hospital in an emergency through either A&E or maternity reception.
- There was seven-day medical cover provided with the minimum of a resident middle grade doctor, and at times a resident consultant.

- A supervisor of midwives (SoM) was available 24 hours a day, seven days a week through an on-call rota. This on-call system provided support to midwives at all time and was available to women.
- There were no sonographers available at weekends. The head of ultrasound had completed a capacity and demand exercise for staffing in antenatal clinics. Actions were agreed at the Antenatal and New-born Operational Group in May 2016 which was to pursue a 'Listening into Action' approach, and the work with Lancashire Teaching Hospitals to introduce midwife led obstetric sonography.

Access to information

- All local and national policies were available on the trust intranet for staff to access. Senior staff informed us they were responsible for updating pathways when new policies were approved. We reviewed five guidelines relating to maternity care; all were in date and followed evidence based practice.
- All community midwives had mobile phones and could access guidelines by ringing the unit or use PCs in GP surgeries.
- The GP and health visitor received a copy of the delivery summary to inform them of the outcome of the birth episode.
- There was a system in place to ensure women's medical notes were transferred to their chosen maternity unit at 36 weeks of pregnancy. Service leads told us they made arrangements to transfer medical notes by courier in the event women were diverted to a different maternity unit.
- Staff told us there were processes to ensure medical and hand held records travelled with women in the event of a transfer.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Women confirmed they had enough information to help in making decisions and choices about their care and the delivery of their babies.
- Consent forms for women who had undergone caesarean sections detailed the risk and benefits of the procedure and were in line with Department of Health consent to treatment guidelines.
- There was a system to ensure consent for the termination of pregnancy was carried out within the legal requirements of the Abortion Act 1967. We looked at a sample of consent forms during our inspection and found these records met legal requirements.
- Staff had an awareness of Deprivation of Liberty Safeguards. The safeguarding midwife gave two examples where women required mental capacity assessments. This was carried out in line with the Mental Capacity Act (MCA) and involved multidisciplinary input including support from the learning disability nurse.
- The MCA and Deprivation of Liberty Safeguards were included in mandatory study days.

Are maternity and gynaecology services caring?

Good

We rated caring as 'good' because:

- Maternity and gynaecology services were caring. The NHS Maternity Friends and Family Test for August 2016 showed the number of women who would recommend the maternity service was similar or better than the national average.
- We observed staff interacted with women and their relatives in a polite, friendly and respectful way. There were arrangements to ensure privacy and dignity in clinical areas.
- All women we spoke with were positive about their treatment by clinical staff and the standard of care they had received. Women told us they had a named midwife. They felt well supported and cared for by staff, and their care was delivered in a professional way.
- Women were involved in their choice of birth at booking and throughout the antenatal period. Women said they had felt involved in their care. Supervisors of midwives and the consultant team were involved in agreeing plans of care for women making choices outside of trust guidance for example requesting homebirth with either a current or previous high-risk pregnancy.
- There were effective and confidential processes for women attending the gynaecology ward. Women

received emotional support where required; appropriate specialist bereavement and midwifery support was provided which met the individual circumstances of women.

Compassionate care

- Between August 2015 and August 2016 the trust's Maternity Friends and Family Test (antenatal) performance (% recommended) was generally similar to than/ to the England average. In latest month, September 2016 the trust's performance for antenatal was 96% compared to a national average of 96%.
- The trust's Maternity Friends and Family Test (birth) performance (% recommended) was generally similar to than / to the England average. In latest month September 2016 the trusts performance for birth was 95% compared to a national average of 96%.
- The trust's Maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally better than the England average. In latest month September 2016 the trusts performance for postnatal ward was 100% compared to a national average of 94%.
- The trust's Maternity Friends and Family Test (postnatal community) performance (% recommended) was generally similar to the England average. In latest month September 2016 the trust's performance for postnatal community was 97% compared to a national average of 98%.
- The trust scored 'about the same' as other similar size trusts in all 16 indicators in the CQC Survey of Women's Experience in Maternity Care 2015.
- Women we spoke with were positive about their treatment by clinical staff and the standard of care they had received. Women told us they had a named midwife. They felt well supported and cared for by staff, and their care was delivered in a professional way.
- Six months of the safety thermometer/open and honest data showed that for four months 100% of women said that 'they were not left alone by midwives or doctors at a time when it worried them during labour or birth'. Two months of the data showed that 10% to 16.7% of women stated that they were left alone. The reasons from this was not specified but may include preparation of analgesia or equipment, making appropriate referrals to obstetricians, allowing privacy or seeking advice from senior colleagues. There were no incidents or complaints reported regarding failure to provide 1:1 care in labour during this period.
- We observed staff interacted with women and their relatives in a polite, friendly and respectful manner. There were arrangements to ensure privacy and dignity in clinical areas.
- We observed that the midwife call systems were within reach and women said that staff responded to the call bells quickly.
- One women who had a planned elective caesarean section for twin pregnancy said she was pleased with the level of care provided and support given by midwives on the post-natal ward.
- One woman had long-standing medical problems, which required hospital admission out of hours. Midwives had explained the reasons for admission and plan of care. The woman attended labour ward, there were no delays in waiting for review or admission.
- We received one negative comment about the continuity of care provide by community midwives.
- Partners were very complimentary about the care and support provided by staff. They felt included and were offered the option to stay overnight.
- We observed a caesarean section. Staff protected the woman's dignity at all times and displayed a caring attitude towards her and her birthing partner. The scrub nurse sent all unnecessary staff out of the room while anaesthesia was sited. The woman was covered with a sheet to promote privacy. A paediatrician came into the room and introduced herself to the woman, explaining whom they were and what was going to happen.

Understanding and involvement of patients and those close to them

- Women were involved in their choice of birth at booking and throughout the antenatal period. Women said they had felt involved in their care; they understood the choices open to them and were given options of where to have their baby.
- Two women said they felt safe and supported. Both understood why complications in their labour had occurred.

- Supervisors of midwives and the consultant team were involved in agreeing plans of care for women making choices outside of trust guidance for example requesting homebirth with either a current or previous high-risk pregnancy.
- Results from the CQC Maternity Service Survey 2015 showed the trust scored about the same as other trusts for 'women being involved enough in decisions about their care during labour', and for 'the partner being involved as much as they wanted'.

Emotional support

- Bereavement policies and procedures were in place to support parents in cases of stillbirth or neonatal death; two specialist midwives supported families from their initial loss, throughout their time in hospital and when they returned home.
- There were effective and confidential processes for women attending the gynaecology ward. Staff supported women to make informed choices about their termination of pregnancy options.
- Specialist midwives for substance misuse, mental health, safeguarding and domestic violence provided support to women in clinics and at home.
- There was ongoing assessment of women's mental health during the antenatal and postnatal period. Referral could be made to the crisis team and adult mental health team.
- The service has a 'Listen to Mother' birth afterthoughts service, which provided women with an opportunity to have unresolved issues about their pregnancy or birth experience answered.

Are maternity and gynaecology services responsive?

Good

We rated responsive as 'good' because:

- The service was working in partnership with other organisations to implement an integrated maternity care pathway and worked closely with the Maternity Services Liaison Committee to design services to meet the needs of women and their families.
- Access and flow such as clinic waiting times were managed appropriately. There was access to investigation, assessment, treatment and care at all stages of the maternity pathway.
- Services were planned, delivered and co-ordinated to take account of women with complex needs, there was access to specialist support and expertise.
- There were processes in place for women to make a complaint. There was learning and improvements were made to the quality of care because of complaints and concerns.

However:

- Staff told us that due to capacity issues, patients from other specialties were cared for on the gynaecology ward. This was identified at the last inspection and was on the divisional risk register. Nurses were happy to look after non-gynaecology patients but problems occurred if patients deteriorated and they could not get medical doctors to review them, however in the last 12 months there had been a marked improvement in doctors coming to see patients more regularly.

Service planning and delivery to meet the needs of local people

- The service worked closely with commissioners and other stakeholders to build stronger relationships through the trust strategy 'Better Care Together' projects. This included implementation of an integrated maternity care pathway, equitable provision of midwife led services, options for birth and provision of neonatal transitional care in acute and community settings.
- The service was aware of its risks and the need to ensure that services were planned and delivered to meet the increasing demands of the local and wider community.
- Through the Maternity Services Liaison Committee (MSLC), the service was working with North West ambulance service to increase awareness amongst ambulance crews of women's specific maternity needs.
- The service was working in partnership with Healthwatch and MSLC colleagues in developing the Healthwatch Maternity Matters Survey for the RCOG Implementation Review.

Access and flow

Maternity and gynaecology

- Between quarter one 2015/2016 and quarter 2 2016/2017 the bed occupancy levels for maternity were lower than the England average, with the trust having 62% occupancy in quarter 1 2016.2017 compared to the England average of 60.6%.
- Between January 2015 and June 2016, there were no closures of the maternity unit at Royal Lancaster Infirmary. There were contingency plans for the delivery suite in the event of the unit becoming full.
- Women received an assessment of their needs at their first appointment with the midwife. The midwifery package included all antenatal appointments, ultrasound scans and routine blood tests. Midwives were available on call 24 hours a day for advice. Community midwives were integrated into the service. Women with high-risk pregnancies attended consultant-led clinics.
- Between October 2015 and September 2016 the percentage of women booking for antenatal care before 20 weeks was between 95.3% and 99%, which was better than the trust target of 90%.
- Staff in ante-natal clinic said capacity had increased in diabetic clinic because of the rise number for women with a BMI of 30. This was flagged on the risk register.
- A four bay maternity assessment unit saw approximately 8000 attendances a year. The unit was well run by dedicated midwifes with medical staff involvement from the delivery suite. Women could self-refer to the unit.
- The early pregnancy assessment unit was nurse led. It was open Monday to Friday and aligned to scanning slots. There were eight appointments a day. There was a plan for have nurses trained in scanning.
- Each site had a colposcopy co-ordinator who worked very well as a team.
- The gynaecology assessment unit ran from 1pm to 8pm Monday to Friday. The unit took referrals from GP's and community midwives. Bereavement midwives checked the admissions book weekly to ensure patients were already booked. Staff said the DOM had improved the profile of gynaecology in the women and children's division.
- Staff told us that due to capacity issues, patients from other specialties were cared for on the gynaecology ward. Data for September 2016 showed there were 10 medical patients, 34 surgical, 9 orthopaedic and 5 urology patients on the gynaecology ward.
- Staff said gynaecology patients were often transferred to the day surgery unit as patients from other specialities occupied beds on ward 16. Women were still operated on the list but their post-operative care was undertaken in the day surgery unit. There were no complaints because of having to transfer patients, but it involved a long walk for women to the day surgery unit.
- There was an escalation process; staff said they could escalate up to 18 beds, which meant that two nurses and one support worker were looking after 18 patients overnight. Approximately two incident forms per month were completed regarding this. Nurses were happy to look after other patients but problems occurred if patients deteriorated and they could not get medical doctors to review them, however in the last 12 months there had been a marked improvement in doctors coming to see their patients more regularly.
- The termination of pregnancy service ran from the gynaecology clinic. Consultants saw women on Friday morning. Women undergoing surgical terminations were seen on the surgical day unit. The designated consultant on EPAU saw medical terminations.
- Between January and July 2016, the service achieved 90% of booking appointments for delivery before 12 completed week's gestation against a target of 90%.
- In response to women's requests to see a Community Midwife after 5pm, the service set up an out of hours Community midwifery clinic Monday evening 5pm to 8pm. The clinic was facilitated by the community midwives and offered a drop in session and appointment option. It provided non-urgent antenatal care for women within the locality.

Meeting people's individual needs

- Staff valued women's emotional and social needs, for example, the service had developed the dragonfly logo. The aim of this was to develop visual aids to alert staff that a woman had had a previous pregnancy loss. There were memory boxes available with items to serve as a memory of the baby.
- Bereavement services included the provision of a private room, access to an outdoor space and use of cold cots to keep the baby with parents for as long as the parents required. Staff offered women the chaplaincy service to provide extra support.

- Women using maternity services could access specialist midwives for the following aspects of care: domestic violence, teenage pregnancy, substance misuse and mental health. The service was recruiting a public health midwife for smoking cessation and obesity.
- Women had the opportunity to meet with a supervisor to discuss their birth experiences. Information promoted SOM and birth choice clinics and post birth reflection.
- New fathers and birthing partners were being offered the opportunity to stay overnight with their partners and new-born babies, as part of a national pilot scheme.
- There were two 'safe and active birth' midwives to promote active birth.
- Women could access antenatal education run by midwives and included active birth sessions with women's health physiotherapists. These were practical sessions where women could learn about positions for active birth and management of pregnancy associated musculoskeletal conditions.
- There was a range of information leaflets available to women. Staff told us these leaflets were available in different languages if required. There was access to interpreters or use of a translation phone service for women who did speak English.
- Women could access a joint consultant led diabetes clinic with support and advice being available from a diabetic nurse and dietician. There was recent approval for a specialist diabetic midwife post.
- There were processes to identify women with learning disabilities. The service liaised with the learning disability nurse and staff encouraged family and key workers to be involved in the care pathway.
- There were processes to ensure disposal of pregnancy remains were handled sensitively. Women were provided with a choice of how they would like to dispose of pregnancy remains, following pregnancy loss or termination of pregnancy.
- Flu and pertussis vaccinations were offered in the antenatal clinic to women after 20 weeks.
- The implementation of the new-born screening hybrid model showed that 99.6% of screens were completed in 4 weeks and 100% of screen completion to attended assessment within 4 weeks or 44 weeks gestational age.

Learning from complaints and concerns

- Between 27 October 2015 and 27 October 2016 there were 50 complaints about Maternity and Gynaecology. The trust took an average of 24.48 days to investigate and close complaints. This is in line with its complaints policy, which states that complaints should be dealt with within 35 days, unless a different timescale has been agreed with the complainant. The trust hads seen a steady increase in the number of complaints received over time. At November 2016, nine complaints were open and 14 had been reopened.
- There were 24 complaints about RLI maternity and gynaecology services during the 12 month period. The labour ward had received the highest number of complaints (11). The main themes related to clinical care and staff attitude/communication.
- Monthly and weekly governance and risk management meetings, seniors meetings and handovers discussed learning from complaints and concerns. Learning from complaints included; a pilot project for partners to stay overnight, changes to guidelines, closer monitoring of high-risk women during induction of labour and improved communication.

Are maternity and gynaecology services well-led?

Good 

We rated well-led as 'good' because:

- There was a clear vision and strategy for the service, which was linked to the National Maternity Review 2016. Governance structures and processes had improved. There was an effective governance framework to support the delivery of the strategy and good quality care. Performance measures were reported and monitored and action was taken to improve services.
- The leadership structure had changed since the last inspection. Leaders understood the challenges in the service and could identify the actions needed to address these. Most staff said leaders were visible and approachable.
- Improvement had been made to ensure staff and teams were working together to promote a culture of learning and continuous improvement. A culture of openness was evident.

- There were many examples of how women's views and experience was used to shape and improve the service and culture. Women and their families were involved in decision-making and in the planning and delivery of maternity care.

However:

- Although there was a plan, which set out the principles, and governance arrangements for a strategic partnership with Lancashire Teaching Hospitals NHS Foundation Trust and Central Manchester University Hospitals NHS Foundation Trust further work was required to effectively capture and monitor outcomes. The trust acknowledged that partnership working was still evolving with developments needed to formalise the midwifery placements and extend the partnership to include paediatrics and anaesthetics.
- Results from the Cultural Assessment Survey May 2016 for obstetrics and gynaecology showed that some staff perceived that current organisational values needed to be better. The personal values for the service were overall positive and a divisional plan was being developed to address the organisational values.

Vision and strategy for this service

- 'Better Births Together' was the Maternity Strategy for 2016/17. The key focus was to provide, compassionate, high quality, evidence based and safe maternity services, which met the needs of all women and their families. This would be achieved by working as a multi-professional team with communities to improve physical, social, mental and emotional health for women entering pregnancy.
- The strategy included a newly developed integrated maternity pathway for women and families across Morecambe Bay to ensure individualised person centred care. The use of the pathway was one of the priority projects for 2016/2018.
- The creation of a new maternity building with theatres and delivery suite in response to the Kirkup Report had commenced with a completion date of December 2017.
- As part of the maternity improvement plan, the service had developed a strategic partnership with Lancashire Teaching Hospitals NHS Foundation Trust and Central Manchester University Hospitals NHS Foundation Trust. The clinical lead for obstetrics said that a memorandum of understanding was in place with both tertiary centres. The MOU set out the principles of the partnership and governance arrangements. Consultants and almost all of non-training grade doctors in obstetrics and gynaecology had honorary contracts with Central Manchester.
- The clinical director and clinical lead for obstetrics said they had attended clinical audit and effectiveness days and Human Factors training. Positive feedback was received. The attendance was extended to include midwifery staff and non-training grade doctors.
- In a paper presented to the Trust Board in September 2016 a schedule of clinical placements had been agreed with the first taking place on 7 October 2016. This would provide the opportunity for clinical observations, ward rounds and attendance at complex clinics in areas of interest for medical staff. The activity would form annual appraisal and personal development plans. The paper acknowledged that partnership working was still evolving with developments needed to formalise the midwifery placements and extend the partnership to include paediatrics and anaesthetics.

Governance, risk management and quality measurement

- Clinical governance business partners were introduced into post in February 2016. This was an independent role providing a bridge between the corporate governance team and the women and children's division. The business partner reported to the director of governance. The governance partners sat outside of the division and covered cross-bay.
- There was a full time risk midwife and clinical lead to support the governance process.
- There was a weekly patient safety summit chaired by the medical director and chief nurse to review all moderate and above incidents and near miss, cases. Re-grading of incidents occurred where required to ensure accuracy.
- Moderate and above incidents (even if no harm) triggered a rapid review by a multi-disciplinary team.
- A three-minute briefing took place each day and included clinical outcomes, learning from incidents, complaints and any concerns. The brief was available on notice boards, and placed in a folder for community midwives to access.
- There were four levels of governance meetings using the trust standardised WESEE approach (workforce, experience, safety, effectiveness and efficiency). Monthly meetings were held at ward level, by managers across

the service and by matrons and heads of service. These meetings fed into the divisional governance assurance group who in turn produced a monthly report to the trust board. We reviewed a copy of a monthly report from August 2016 and saw it was RAG rated (red, amber and green) and included training, staffing, incidents, complaints, risks, financial performance and effectiveness.

- The divisional governance and assurance group was attended by obstetric and paediatric leads, nursing and midwifery staff, director of midwifery and matrons. Attendance trackers were reviewed at each meeting to monitor attendance in line with the meetings terms of reference.
- There was regular review of the divisional risk register. Actions taken were visible and the process completed by removing risks from the register. Minutes showed staff discussed risks at ward meetings. Maternity managers we spoke with had a good understanding of the risks to the service.
- The wards managed low-level incidents. At the time of inspection, 70% of level1 and 2 incidents were reviewed in 20 days against a target of 80%. Plans were in place to improve timeliness.
- Performance and outcome data was monitored using a maternity dashboard. The dashboard followed the RCOG guidance. There were some outcomes such as admissions to intensive care and special care and Hypoxic-ischemic encephalopathy (HIE) not included. The governance team acknowledged that the dashboard was 'work in progress' and gave assurance that audit and incidents would flag areas of risk.
- The educational midwife received learning from audits and incidents. The education programme reflected this.
- Supervisors of midwives attended governance and risk meetings. The maternity risk management strategy described the framework of statutory supervision and the role of a supervisor of midwives.
- SoMs were involved in incident investigations. At the time of inspection there was one SoM investigation completed. The SoM investigation aligned with the trust investigation. SoMs were involved in investigations for other trusts.
- Band 5 midwives and new starters were encouraged to spend a day with the governance and audit team during their induction and supernumerary period.
- The clinical director said they had attended a clinical audit and effectiveness meeting at Central Manchester where guidelines and a never event was discussed. The learning was brought back and processes at Morecambe Bay quality assured.
- There were quarterly labour ward forum meetings. Minutes showed that obstetric, anaesthetic and paediatric issues were discussed. There was good multidisciplinary attendance.

Leadership of service

- The leadership structure had changed since the last inspection. The Women's and Children's Division was led by a clinical director (CD) who reported to the trust medical director. The director of midwifery and gynaecology (DOM) reported to the executive chief nurse. A divisional general manager supported the directors.
- The DOM said they attended the North West head of midwifery group for external support however, it was not clear what external peer review was provided.
- There were three maternity matrons and a gynaecology matron covering each site that were accountable to the DOM.
- The clinical lead for obstetrics and gynaecology was accountable to the clinical director.
- Staff said they had regular access to the matron and manger that was on site every day. Some midwives on the wards said that they had not seen the DOM on the ward. The DOM said she would like to be more visible and work clinically two days. The aim was to spend more time at Royal Lancaster Infirmary one day a week.
- Medical staff said they had good support from the clinical director. Consultant job plans were completed.
- Divisional leads had regular meetings with the matrons; the DOM met with them weekly and there were other regular meetings with the clinical director and the divisional general manager. Matrons said they were supported, well informed and could escalate their concerns to divisional leads.

Culture within the service

- Staff said they were engaged and well supported by managers. There was a feeling amongst teams that they were working more effectively with all grades of staff and cross-bay.

Maternity and gynaecology

- Medical staff said there was joint working with Furness General Hospital. This was evident in multi-disciplinary meetings in gynaecology, audit, perinatal mortality and morbidity meetings and clinical handovers. There was a joint anaesthetic audit meeting twice a year.
- All band 5 midwives rotated cross-bay. Middle grade doctors provided cover across sites if required.
- All staff reported that a 'no blame' culture was more evident in the trust. Staff said they could report errors or omissions of care and use these to learn and improve practice. Staff were encouraged to reflect on incidents as soon as possible.
- Trainee doctors were positive and said there was good working relations and support. The working environment was described as 'friendly.' They said interaction with paediatrics was good at registrar-to-registrar level. Junior doctors attended ward and governance meetings regularly.
- We spoke with three agency midwives. They said they were happy at the trust and felt part of the team. One midwife had a supervisor and attended mandatory training. Long-term agency staff had access to IT systems and received updates on changes to guidelines.
- Ancillary staff told us they felt part of the team. Each had received a trust induction and said they could raise any concerns with their manager.
- 98% of staff had completed Equality Diversity and Inclusion training against a trust target of 95%.
- A positive culture group was being introduced. Results from the Cultural Values Assessment May 2016 showed results for obstetrics and gynaecology were overall positive for personal values with some perception that current organisational values needed to be better. A divisional plan was being developed to address these areas.
- Staff sickness rates between April 2015 and March 2016 for Royal Lancaster Infirmary was 4.6% against the NHS North West target of 4.3%.
- Between April 2015 and March 2016, the trust reported a turnover rate in the Women's and Children's Division of 9.38% for all staff groups. The trust reported that turnover is reducing in key areas and hot spots are being acted on at a divisional level.
- Data provided by the trust from May 2015 to April 2016 showed women and children's division attendance was 95%. This was slightly lower than the trust target of 96% but was an improvement on the previous year's figure of 94.2%.

Public engagement

- The service took account of the views of women through an active Maternity Services Liaison Committee (MSLC). The minutes from January to July 216 showed areas such as breastfeeding, performance, antenatal education, and patient experience were discussed.
- Members of the MSLC told us there had been a significant and positive change in public engagement within the previous year.
- Maternity services were part of an 'Always Event' pilot site by NHS England in November 2015. The project was co-designed with those who used maternity services and frontline NHS staff to identify an area of improvement that mattered to women and families. This included a pilot for partners to stay for 24 hours after the birth.
- Open and honest care stories were included in the monthly women and children' newsletter. Stories came from "listen with mother" birth afterthoughts service, which provided women with an opportunity to have unresolved issues about their pregnancy or birth experience answered.
- The SoMs worked closely with the MSLC chair. For example, a mystery shopper audit was developed to review how long it took to contact a SoM for debrief.
- There were many examples of service user involvement, such as co-designing the new maternity unit, interviews of recruitment of new staff including midwives and matrons and the development of guidelines and strategies.
- There were four user representatives on a group to develop the breastfeeding strategy. The chair of the MSLC was attending a MDT infant feeding 'Big Conversation' to represent a wide range of service user experience.
- There was service user representation on the National Maternity Review and the Better Births Transformation programme.
- The Down Syndrome Association provided a "tell it right" workshop for MDT staff in relation to breaking bad news.

Staff engagement

- The practice development midwife told us that the strategic partnership had led to a 13-month development programme for labour ward co-ordinators. Co-ordinators would work closely with the maternity unit at Lancashire.
- The Director of Midwifery met with matrons and ward managers each week.
- A site senior meeting took place each fortnight. Medical, nursing and midwifery staff attended this. Operational issues such as staffing, equipment, and training were discussed.
- Whiteboards were up in all departments covering information on the division's top three priorities. There was a divisional newsletter, which included good news stories and celebrating success.
- There were unit meetings held each month chaired by the ward manager and matron. Staff due to work pressures poorly attended some meetings. Staff had introduced a 'niggles and concerns' box where staff could anonymously raise concerns or improvements. A newsletter reflecting the issues was sent to staff.
- The trust provided data from the June 2016 staff survey for women and children's division. The survey showed 84% of staff would recommend the trust as a place to recommend treatment and 66% would recommend the trust as a place to work. Although there was a low response rate, these figures had significantly improved from September 2015, where the responses were 67% and 40% respectively.
- Staff were involved in Listening into Action projects to improve the quality of maternity services. There were a number of projects such as developing a strategy for breastfeeding, scanning capacity and fluid rehydration for Hyperemesis (severe nausea during pregnancy). Staff said they were encouraged to implement new ideas and ways of working.

Innovation, improvement and sustainability

- The service showed good progress against its maternity improvement plan. For example, the development of the maternity strategic partnership was progressing and monitored by the Maternity Strategic Partnership Committee. A paper to the Trust Board (September 2016) acknowledged this work was still evolving with developments needed to formalise the midwifery element of the placements with Central Manchester and Lancashire and extending the partnership to include paediatrics and anaesthetics.
- The service was one of three trusts who were successful in securing funding to pilot a maternity experience communication project. This was a patient based, communication improvement-training tool for multi-professional groups in maternity services. The project had the potential to be adopted nationally if learning outcomes and measurable improvements were made for women using maternity services.
- The trust had recently appointed 'safe active birth' specialist midwives. Staff told us they would be focusing on developing pathways to help reduce the caesarean section rate. They had a regular slot on the mandatory study days to support and promote their approach to midwives across the trust.

Services for children and young people

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

Information about the service

Services for children and young people at the Royal Lancaster Infirmary (RLI) consist of a children's unit, with 21 inpatient beds, an eight bedded day care unit, a six bedded assessment unit, a children's outpatient department, and a 10 cot neonatal unit (NNU). The neonatal unit is a Level 2 unit, providing high dependency care and short term intensive care.

Between April 2015 and March 2016 there were 8,378 admissions to the children and young people's service across the trust.

During the inspection we visited the children's unit, children's outpatients, and the NNU. We spoke with 21 members of staff, including nursing staff, medical staff, play therapists, support workers, and administration staff. We interviewed the service leads and matrons. We spoke to ten parents/carers and reviewed ten sets of records.

Before and after the inspection we reviewed data provided by the trust.

Summary of findings

Following our previous inspection in 2015 children and young people's services were rated as 'requires improvement'. Issues were identified with the reviewing of incidents, medical staffing levels, the design and layout of the neonatal unit, insufficient resuscitation trolleys on the children's unit, and the abduction policy had not been tested.

At this inspection we found that the majority of these issues had been resolved with the exception of the design and layout of the neonatal unit. Incidents were reviewed appropriately, medical staffing levels had improved, although we found that not every child was seen within 14 hours of admission, there were sufficient resuscitation trolleys and the abduction policy had been tested.

Overall, we rated the services for children and young people at RLI as 'good'. Effective, caring, responsive and well led were rated as 'good'. We rated safe as 'requires improvement'.

- Staff were aware of their responsibility to report incidents and appropriate systems were in place. Staff received feedback about incidents and learning was shared.
- Staff were clear about their responsibilities if there were concerns about a child's safety. Safeguarding procedures were understood and followed. Staff had completed the appropriate level of training in safeguarding and received safeguarding supervision.

Services for children and young people

- A paediatric early warning system was used for early detection of any deterioration in a child's condition and appropriate transfer arrangements were in place for those children requiring more specialised care.
- Staff had access to evidence based policies which were compliant with national guidance.
- There was a programme in place for local and national audit.
- Feedback from children, young people and their parents was positive.
- Services were planned to meet people's needs. Facilities were provided for parents.
- There were governance systems in place to ensure that quality, performance and risks were managed and information could be cascaded between senior management and clinical staff.

However:

- Not all children were seen within 14 hours of admission in line with Royal College of Paediatric and Child Health (RCPCH) standards.
- Staffing was not always compliant with British Association of Perinatal Medicine (BAPM) and Royal College of Nursing (RCN) guidance.
- The layout of the children's unit meant that staff could be isolated when working in the assessment unit.
- The NNU had limited space and there was not always a member of staff present in the special care room.

Are services for children and young people safe?

Requires improvement

At a previous inspection, in 2014, we had identified that there was only one resuscitation trolley for the whole of the children's unit, and it was located in a side room. The special care room on the neonatal unit did not always have a member of staff present, there were significant nursing and medical vacancies and the abduction policy had not been tested. At our 2015 inspection we saw that there were two resuscitation trolleys.

At this inspection there were, again, two easily accessible resuscitation trolleys available, the abduction policy had been tested, and there were fewer nursing and medical vacancie. However the service was not always meeting Royal College of Nursing (RCN) and British Association of Perinatal Medicine (BAPM) guidelines for staffing or Royal College of Paediatric and Child Health (RCPCH) standards.

We rated safe as 'requires improvement' because:

- Not all children with an acute medical problem were seen by a consultant within 14 hours of admission. Royal College of Paediatric and Child Health (RCPCH) standards say that a consultant paediatrician should see all children with an acute medical problem within 14 hours of admission.
- The Neonatal Unit (NNU) was not meeting British Association of Perinatal Medicine (BAPM) guidelines for staffing on every shift. Out of 92 days reviewed, the unit was not compliant on every shift with BAPM guidelines for 31 days on 22 days there was no shift co-ordinator within the numbers, although there were appropriate numbers and skills of staff for direct patient care; and on 9 days the staffing numbers were not compliant with the necessary level for direct patient care.
- The children's unit was not meeting recommended RCN ratios for staffing on every shift. Out of 92 days reviewed, 49 days had at least one shift where the recommended ratios were not met. Whilst the RCN document 'Defining staffing levels for Children and young people's services 2013' was used to plan the workforce establishment of the unit, the nursing staff worked to the Hurst tool when recording acuity 3 times per day. This gives a score of 1, 2 or, 4 for each patient, dependent upon condition,

enabling matching of nursing levels with patient acuity. The unit held safety huddles 3 times per day, one being a multidisciplinary huddle. At each huddle the acuity was discussed, and the potential need to escalate the situation would be assessed, with action taken appropriately. One possible action would be the ward manger or matron working clinically to maintain safety. On 20 days out of 92 the Hurst ratios were not met on every shift.

- The environment on the children's unit meant that if one member of staff was working on the assessment unit they were isolated from the rest of the team. The distance from the children's unit to day case theatres meant there could be a risk if a child deteriorated on the return journey from theatre.
- The neonatal unit (NNU) had limited space; cots were pushed up against walls, which meant there was not all round access to all cots. There was not always a member of staff present in the special care room. This had been identified as an issue at our previous inspection.
- Morbidity and mortality meetings were not held for children and young people, however perinatal meetings were held.

However:

- There were systems in place for incident reporting, staff knew how to use them and learning was shared.
- Safeguarding systems were in place and staff knew how to report concerns. Staff were trained to the appropriate level and had supervision.
- A paediatric early warning system was used for early detection of any deterioration in a child's condition and transfer arrangements were in place for those requiring more specialised support.

Incidents

- Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. Between September 2015 and August 2016 the trust reported no incidents which were classified as Never Events for children's services.
- In accordance with the Serious Incident Framework 2015, the children's services directorate reported one serious incident (SI) at RLI, which met the reporting criteria set by NHS England, between September 2015 and October 2016. This incident was reported under the incident type 'disruptive/ aggressive/ violent behaviour meeting SI criteria'.
- Between August 2015 and July 2016 there were 197 incidents reported, the majority were low or no harm. It had been identified that there were a number of medication errors. This issue had been placed on the risk register and weekly prescription audits were undertaken.
- Staff were aware how to report incidents via the electronic reporting system and were encouraged to do so.
- Staff told us and we saw evidence in team meeting minutes that they received feedback and learning from incidents via email and at team meetings.
- Staff gave an example of a change in practice as a result of an incident. An error had been made with administration of an IV medication and they had introduced a risk bundle for administering the medication to avoid further errors.
- We reviewed senior leaders meeting and divisional governance meeting minutes. Incidents were a standing agenda item for discussion.
- Perinatal morbidity and mortality meetings took place quarterly. Morbidity and mortality data for children and young people were discussed in the same meeting, due to the infrequency of such events. The regional Child Death Overview Panel (CDOP) would also review any child deaths.
- Staff we spoke with had varying degrees of understanding of the term 'duty of candour'. However, all staff told us of the need to be open and honest with parents. Whilst on the NNU one parent told us how the staff had been honest and admitted a mistake about giving her baby the wrong milk.
- The risk manager for children and young people ensured that any Duty of Candour cases were followed up using a formal process. The incident reporting form contained a trigger for Duty of Candour.

Cleanliness, infection control and hygiene

- All areas that we visited were visibly clean. Hand gel and handwashing facilities were available with notices asking visitors to clean their hands. We saw staff washing their hands appropriately.
- Parents we spoke with all said they felt the ward areas were clean and they saw staff washing their hands.

- Staff adhered to the bare below the elbows policy and were seen wearing appropriate protective equipment to carry out procedures and personal care.
- Data provided by the trust for hand hygiene showed that all wards and departments for children and young people were below the target of 100% and below the threshold of 95%. The children's unit had achieved 90% in May 2016, 89% in June 2016 and 80% in July 2016. The outpatients department had achieved 92% in May 2016, 85% in June 2016 and 75% in July 2016. The neonatal unit had achieved 83% in May 2016, 91% in June 2016 and 85% in July 2016.
- However, hand hygiene results displayed on the wards indicated that the children's unit had achieved 100% in September 2016 and the NNU had achieved above 95% from April to September 2016.
- Environmental audits showed that the children's services had consistently scored above the trust target of 95%.
- There had been no cases of Meticillin-resistant Staphylococcus aureus (MRSA) or Clostridium difficile (C. Difficile) in the last year.
- Staff attended infection prevention and control training. Figures for the Women's and Children's directorate showed that 99% of staff were up to date with their training, this was better than the trust target of 95%.

Environment and equipment

- The NNU had limited space. Cots were pushed up against walls and this did not allow for all round access. Space in the neonatal bays did not comply with Department of Health standards (Health Building Note 09-03, 2013). One of the parents we spoke with on the unit said they felt it was cramped and there was not a lot of room for the nursing staff to access the incubator when she was sat at the side. The environment of the neonatal unit had been recognised on the risk register.
- The special care room was separate from the HDU room and staff said it was not always possible for a member of staff to be present in the special care room. This meant that babies and parents in this room could be quite isolated. Staff said they had acted on feedback from parents and tried as much as they could to place a member of staff in this room but it was not always possible.
- The children's unit consisted of an inpatient ward, a six-bedded assessment unit, and an eight-bedded day care unit. The assessment unit and day care unit were separated from the inpatient ward by rooms in the middle, such as utility rooms and bathrooms. This configuration was due to change in March 2017, with building work planned to better incorporate the ward and assessment unit.The assessment unit was not visible from the inpatient ward and often only had one member of staff present. There was therefore a risk that this staff member was isolated and did not have the support needed in an emergency. A staff member at Furness General Hospital (FGH) told us that they had been placed on the assessment unit when they had travelled to RLI to cover a shift, and had felt isolated and unsafe. They had escalated their concerns and a second member of staff was allocated to work on the assessment unit. However, the ward office was in close proximity, and staffed by ward clerks, and the seminar room, where the doctors based themselves when not seeing patients, was also nearby. The day care unit was open Monday to Friday and staffed with at least one registered nurse and a ward clerk, who could offer support if required. The emergency call bells were tested daily and could be heard clearly on the children's ward. Additionally, when staff from other areas were transferred to work within the children's unit they were allocated a workload based on their skills and knowledge, and supported by the children's unit staff as necessary, and during the shift there were safety huddles, at which concerns can be escalated and addressed.
- Plans were in place to redesign the children's unit, with the aim of increasing the visibility between the two areas.
- Resuscitation equipment was available in every area and daily checks took place. We saw records to indicate this checking had taken place. At our previous inspection, there was only one resuscitation trolley for the children's ward, assessment unit and day care and it was kept in a side room. At this inspection there was a resuscitation trolley in the inpatient area and a separate one near the assessment unit and day care. Both trolleys were easily accessible.
- All equipment we saw had been electronically tested and all testing was up to date.
- In main theatres there was a separate paediatric recovery room, however in day case theatres children and young people were recovered in the same area as adults. Curtains were used to screen children when adults were in the same area. The day case theatres

were a long walk from the paediatric unit. This could prove a risk if a child's condition deteriorated during the return from theatre. Staff told us that this concern had been escalated to the senior surgical managers.

Medicines

- If medicines are not stored properly they may not work in the way they were intended, and so pose a potential risk to the health and wellbeing of the person receiving the medicine. Fridge temperatures were checked daily, although minimum and maximum readings were not recorded. We saw completed checklists to indicate checks had been done. Staff could tell us the process to follow if the temperature fell outside the required range.
- Staff handled, stored and recorded medicines, including controlled drugs, in line with national guidance from the Royal Pharmaceutical Society of Great Britain. We observed medicines being stored safely and controlled drugs kept in separate locked cupboards with appropriate checks recorded.
- Pharmacy support was available and they visited the ward three times a week, however, the trust did not have a paediatric pharmacist.
- We reviewed eight prescription charts. All had a weight recorded which allowed for accurate medication prescribing. All charts had any known allergies documented.

Records

- We reviewed ten sets of records. Records were multi-professional which supported integrated care. Records were clear, accurate and legible. However, in five of the records there was no documentation of the grade of doctor reviewing the patient, which was not in line with professional standards. Nursing staff used stamps with their name and NMC number next to their signature.
- The electronic patient administration system used a flag system to indicate if a child was subject to a child protection plan, was looked after or had learning disabilities.
- The World Health Organisation (WHO) surgical safety checklist is a tool to improve the safety of surgery by reducing deaths and complications. We saw that those children who were surgical patients had completed WHO checklists within the records.
- Care plans contained within the nursing records were pre-printed care plans that were not individualised. Best practice would be for the care plans to be individualised and reviewed regularly.
- Records were kept securely in locked trolleys.

Safeguarding

- The trust had a safeguarding children policy that had regard to the statutory guidance Working Together to Safeguard Children (2015).
- Staff were aware of the process to follow if they had safeguarding concerns. They knew who the safeguarding leads were and could contact them when necessary. Each area had safeguarding champions who provided support.
- Safeguarding supervision was provided by the safeguarding team and safeguarding champions for each area. Attendance was yearly. Data seen on the children's unit showed that 76.7% of staff had attended safeguarding supervision.
- Consultant paediatricians attended peer review meetings monthly.
- We saw the safeguarding page that staff had access to on the intranet. This included information on female genital mutilation (FGM), lessons learned from reviews, domestic violence services, contact details for staff if they had any concerns, a referral pathway and guidelines. Staff we spoke with were aware of FGM and Child Sexual Exploitation (CSE).
- An abduction policy was available and was due for review in 2017. This contained a flowchart and clear processes to follow were identified. The abduction policy had been tested out in August 2016, lessons learned from this related to a staff member turning off the alarm when it sounded. This learning was cascaded to staff by the ward manager. Overall, the test went well and there was a good response by staff. We spoke with the resilience and emergency planning manager who said they were assured that the plan would have worked in a real situation.
- Access to the wards was via an intercom, this was used for people entering and leaving the wards, therefore minimising any unauthorised access.
- Figures provided by the trust showed that 89.7% of nursing staff and 67% of medical staff in the children

and young person's service had completed safeguarding adults and children Level 1 training and 100% had completed Level 2 safeguarding training. This was better than the trust target of 95%.

- The intercollegiate document 'Safeguarding Children and Young People: Roles and competencies for Health Care Staff' (2014) sets out that all clinical staff who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person should be trained to Level 3 in safeguarding. Data provided by the trust showed that 95% of nursing staff and 77% of medical staff had completed safeguarding Level 3 training. The trust target was 95%.

Mandatory training

- Mandatory training was available in subjects such as fire safety, conflict resolution, equality and diversity, information governance and manual handling.
- Staff told us they had enough time to complete training. Data provided by the trust showed that children's services were meeting the trust target of 95% for training attendance.
- Children's services staff attended specific training days; paediatric and neonatal development activity(PANDA). These days included safeguarding training, paediatric life support, neonatal life support and also covered some mental health problems such as self harm.
- Matrons reviewed the training management system weekly and produced monthly assurance reports concerning staff training.
- All new starters including agency staff attended a corporate induction programme and a local workplace induction.

Assessing and responding to patient risk

- Children's services used an early warning score tool, The Children's Physiological Track and Trigger System (CPOTTS). There were different charts for different age ranges and they included information to assist nursing and medical staff as to the action to take in response to deteriorating scores. Charts we reviewed showed evidence of appropriate responses to changes in scores.
- The neonatal unit did not use an early warning score. Safety huddles helped identify babies at risk of deterioration.
- Safety huddles were held on the neonatal unit and the children's unit. We observed a safety huddle on the children's unit. Medical and nursing staff were present including a paediatric nurse from the emergency department. A proforma was completed and discussions included patient acuity, staffing, patients requiring CAMHS support, safeguarding concerns, infection prevention concerns, high dependency patients, any potential discharges and the situation cross site at FGH.
- Children requiring transfer to intensive care were stabilised on the ward where there were two high dependency cubicles. A regional paediatric transport service was used to transfer the children to other hospitals with paediatric intensive care facilities. This service also offered clinical advice on the management of high dependency children on the ward.
- Risk assessments were completed on admission. These included nutrition, infection risk and sepsis screening. Staff had completed training on sepsis.
- The children's ward regularly admitted children with mental health issues who needed child and adolescent mental health services (CAMHS) input. Assessments were completed to determine whether one to one support was needed which would be provided by an agency.
- Band 6 nursing staff were trained in advanced paediatric life support (APLS), this meant there was always an APLS trained member of staff on duty.

Nursing staffing

- The children's unit used the RCN document 'Defining staffing levels for children and young people's services' (2013) to plan staffing levels. However, this document recommends a nurse to patient ratio of one to three for children under two years old and one to four for children over two years old. The children's unit worked to a ratio of one nurse to four patients, this meant that the ratios for under two's may not be met.
- We reviewed staff rotas and bed occupancy data for three months from July 2016 to September 2016 and found that on 49 days out of 92 the RCN ratios were not met on every shift for under two's and over two's. Even working on a ratio of one nurse to four patients this was not met for every shift for 40 days out of 92. For example, on the 1st July there were 18 beds occupied at midday and 17 beds occupied at midnight. Working on a ratio of 1:4 would require five nurses on shift. There were four nurses on the early shift, three on the late shift and four on the night shift. On the 21st July there were 19 patients at midday and 14 patients at midnight. This

would require five nurses during the day and four nurses at night. The early shift had five nurses but there were only four on the late shift and three on the night shift. The 11th September had 17 patients at midday and 16 patients at midnight requiring five nurses during the day and four at night. There were three nurses on every shift that day. Whilst the RCN document 'Defining staffing levels for Children and young people's services 2013' was used to plan the workforce establishment of the unit, the nursing staff worked to the Hurst tool when recording acuity 3 times per day. This gives a score of 1, 2 or, 4 for each patient, dependent upon condition, enabling matching of nursing levels with patient acuity. The unit held safety huddles 3 times per day, one being a multidisciplinary huddle. At each huddle the acuity was discussed, and the potential need to escalate the situation would be assessed, with action taken appropriately. One possible action would be the ward manger or matron working clinically to maintain safety. On 20 days out of 92 the Hurst ratios were not met on every shift.

- The neonatal unit used British Association for Perinatal Medicine (BAPM) guidelines for staffing. These require one nurse to one patient for intensive care, one nurse to two patients for high dependency care and one nurse to four patients for special care.
- We reviewed staffing rotas and cot occupancy rates for July 2016 to September 2016 and found that out of 92 days there were 31 days when they were not BAPM compliant on every shift.
- Data provided showed that the fill rate for August 2016 was 88% for days and 95% for nights for trained staff on the children's unit. For September 2016 the fill rate was 106% for days and 71% for nights.
- The children's unit had 5.3 whole time equivalent Band 5 vacancies. There had been recent job advertisements and there were three applicants.
- The neonatal unit had two vacancies.
- The assessment unit had six beds. It was staffed by one registered nurse and one support worker between the hours of 09:00 and 22:00, when available. The Hurst tool was used as part of its the safety huddle and acuity taken into account when assessing safety, and the need to escalate, as part of the children's unit as a whole. Overnight, a staff member from the inpatient ward would see any children attending the assessment unit.
- An escalation policy was in place for when staffing numbers were not met. Staff could be moved between the neonatal unit and children's ward and cross site to cover for vacancies. Staff from the neonatal unit told us they had been moved frequently recently due to sickness on the paediatric unit. The matron would work clinically if needed to support staff when busy.
- Agency staff completed an induction form. In order to give IV medication they had to produce an IV certificate and were observed twice before been allowed to administer IV medication. The paediatric unit had a regular pool of agency nurses that would work on the ward.
- The shift supervisor was not supernumerary in line with RCN guidance (2013) and frequently had to work clinically.
- There were no paediatric trained nurses in theatres. The RCN (2013) says that at all times there should be a minimum of one registered children's nurse on duty in recovery areas.

Medical staffing

- There were nine whole time equivalent acute paediatricians, with no vacancies. Consultants were present in the hospital until 9.30pm on Mondays to Thursdays, 5pm on Fridays and 3pm at the weekend. They were on call after these times.
- Medical cover was provided by consultants, middle grades and intermediate grades. There was a minimum of two doctors on site, one middle grade and one intermediate grade, at all times.
- Cover for the assessment unit was provided by the medical staff covering the inpatient ward which meant that at times children had long waits if the medical staff were doing a ward round or dealing with other patients.
- Consultants worked two 'hot weeks', one week on the paediatric ward and one week on the neonatal unit.
- During our inspection, we observed a ward round. The medical staff split in to three groups to conduct the ward round and joined together to discuss cases at the end. This meant that not all children were seen by a consultant paediatrician, although they were discussed with them.
- Out of ten records that we reviewed there was no review by a consultant within 14 hour of admission in four of them. We checked with one of the consultants and on reviewing the records he agreed that they had not been seen within that time period by a consultant. The Royal College of Paediatric and Child Health (RCPCH)

standards (2015) say that every child admitted to a paediatric department with an acute medical problem should be seen by a consultant paediatrician within 14 hours of admission.

Major incident awareness and training

- A paediatric major incident plan was available that provided clear instructions for the process for staff to follow in the event of a major incident.
- Data provided by the trust showed that 100% of children's unit and children's outpatient staff had attended Emergency Planning and Preparedness Response facemask fitting training, however only 33.3% of neonatal unit staff had attended.
- The children's unit increased their nursing establishment to cover the winter months. Staff were encouraged to take annual leave in the summer months.

Are services for children and young people effective?

Good

We rated effective as 'good' because:

- Policies and guidelines were up to date and were based on national guidance, and staff were able to access them on the intranet.
- There was evidence of audit at local and national level, with action plans produced in response to the results.
- Appropriate pain assessment tools were in use.
- Staff were competent and learning needs were identified. Care was delivered in a co-ordinated way.

However:

- Patient outcomes were somewhat worse than the national average, however, this had been recognised by staff and plans put in place to address it.
- Documentation referred to Fraser guidelines when discussing consent rather than Gillick competence. Fraser guidelines only relate to consent for contraceptive or sexual health advice.

Evidence-based care and treatment

- Staff had access to policies, procedures and guidelines on the trust intranet.
- Policies and procedures were evidence based and based on national guidance such as National Institute for Health and Care Excellence (NICE) guidance. We saw policies for jaundice, early onset sepsis, paediatric UTI's and constipation that were all in line with NICE guidance. All policies we reviewed were up to date.
- The children's services did not participate in accreditation schemes such as You're Welcome (DH) or Baby Friendly (UNICEF), but the neonatal unit was working towards the Bliss baby charter. The Bliss baby charter is a practical guide to help hospitals provide the best possible family centred care for premature and sick babies. This approach places parents at the centre of their baby's care.
- A clinical audit programme was in place for 2016-2017 including national and local audits. These included audits of NICE guidance such as fever in under 5's, headaches in over 12's and obesity.

Pain relief

- Records we reviewed contained pain assessments. Appropriate pain relief was prescribed.
- Child friendly pain assessment tools were used including one for young children and those children unable to communicate their pain verbally.

Nutrition and hydration

- The neonatal unit had a milk room that had a designated fridge for expressed breast milk. This was organised with individual trays for each baby on the unit for storing the milk. However, the milk room and the fridge were not locked meaning anyone could access the feeds.
- A Listening into Action project had been started for infant feeding and was looking at developing an infant feeding strategy.
- In the records we reviewed, appropriate nutrition and hydration management plans were provided for those patients that needed them.
- Feedback we received from staff and parents was that the menu did not provide healthy choices.

Patient outcomes

- Between March 2015 and February 2016 there was a higher percentage of under ones readmitted following an emergency admission (5.8%) compared to the

England average (3.4%), and a higher percentage of patients aged 1-17 years old readmitted following an emergency admission (3.9%) compared to the England average (2.8%).

- Between April 2015 and March 2016 the trust performed better than the England average for the percentage of patients aged 1-17 years old who had multiple readmissions for asthma, with a readmission rate of 13.3% against an England average of 16.6%.
- An audit in to the management of children with asthma was carried out in May 2016. An action plan was completed which included teaching for paediatric doctors, referring GP's and emergency department staff.
- The trust performed worse than the England average for the percentage of patients aged 1-17 years old who had multiple readmissions for epilepsy. Data showed a readmission rate of 24.1% against an England average of 29.3%.
- Staff were aware of their readmission rates and were piloting a study in to how they could prevent readmissions. Some children were seen on the assessment unit and discharged but these children would be counted as an admission. Pathways for sick children with advice for professionals and parents had been developed and were due for release the week of our inspection.
- In the 2014/2015 National Paediatric Diabetes Audit the trust performed worse than the England average, 15% of patients had a HbA1c value of less than 58mmol/mol (indicating controlled diabetes) compared to the England average of 22%. A mean HbA1c value of 72 was similar to the England average of 71.
- An audit had been undertaken in to the management of children with high HbA1c and an action plan had been developed to raise awareness in the team, improve documentation in clinic consultations, follow up within certain timescales and increase use of dieticians.

Competent staff

- Data showed that 83% of staff in the women's and children's division across the trust had received an appraisal.
- No formal clinical supervision took place. The ward manager on the children's unit told us that they were planning to include supervision in the monthly teaching sessions.
- Monthly teaching sessions covered a different topic each time, staff were encouraged to identify areas they would like input on. Recent sessions included epilepsy and sepsis.
- Staff rotated from the children's ward to the emergency department, which gave them experience in emergency medicine and ensured there were paediatric trained nurses in the emergency department.
- Staff on the neonatal unit told us that when they were moved to the paediatric unit to cover a shift they sometimes felt vulnerable if they were asked to look after older children. The ward manager on the children's unit was aware of this and had plans in place to devise an induction package for each area of the children's unit, in the meantime neonatal staff would be allocated babies to look after when on the ward.
- The paediatric unit staff were not specifically trained to meet the needs of children and young people with mental health needs but they had received some training in areas such as self harm.
- Band 6 nursing staff had advanced paediatric life support (APLS) training. Data provided by the trust showed that 40% of nursing staff on the children's unit had APLS training and 85% of medical staff. The Royal College of Nursing (RCN) recommends one practitioner trained in APLS to be on shift at all times. The children's unit was meeting this standard.
- Clinical educators and practice educators supported the staff.

Multidisciplinary working

- Staff told us they had good relationships with paediatric physiotherapists and paediatric dieticians. There were good working relationships with other specialities, such as obstetrics.
- CAMHS workers would attend the ward frequently when there were CAMHS patients on the ward.
- Safety huddles were multidisciplinary.
- Nursing and medical handovers were separate. We observed a ward round and no nursing staff were present. Medical staff had discussions with nursing staff after they had seen the patients. There is therefore a risk that some information may be missed.
- Paediatric liaison specialist nurses were based on the children's unit. They facilitated links between the hospital and community services such as health visitors and school nurses.

- The community nurses and paediatric liaison nurses met daily with the play specialist to discuss ideas, patients and special requests.

Seven-day services

- Play therapy staff worked Monday to Friday during the day, this meant that there was no play therapy support out of hours on an evening or at weekends.
- X-ray and diagnostic facilities were available seven days a week.

Access to information

- The community paediatric service was waiting for a date when they would be able to access to the same computer system as the hospital. It had been recognised that a more robust electronic system was needed for sharing of information.
- Staff had access to policies and guidelines on the trust intranet.
- GP's could speak to a consultant or registrar on the phone for advice. GP's received electronic discharge letters.

Consent

- Initial assessment documentation contained a question for Fraser guidelines. However, Fraser guidelines relate specifically to contraception and sexual health. Gillick competence is the principle used to judge capacity in children to consent to medical treatment.
- We looked at five sets of records where the child could have been assessed for Gillick competence. One did not have any decision around Gillick competence noted. The documentation did not contain any information as to the rationale for the decision made about competence.
- One member of medical staff that we spoke with said that they never assess patients for Gillick competence.

Are services for children and young people caring?

Good

We rated caring as 'good' because:

- Children and parents spoke positively about the care they had received.
- Parents felt informed at all times and were involved in decisions about care.
- Play therapy staff supported children through procedures.
- Data reviewed showed positive results with the majority of people recommending the children's services.

Compassionate care

- Children and parents that we spoke with spoke positively about the care received.
- NHS Friends and Family Test data from August 2016 showed 80% would recommend the assessment unit, 83% would recommend day care and 95% would recommend the inpatient ward.
- Feedback displayed on the unit from I Want Great Care in September showed that from 13 reviews of the assessment unit 100% would recommend it, out of 52 reviews for day care 92.3% would recommend it and out of 59 reviews for the inpatient ward 86.4% would recommend it.
- Comments seen included those that said staff were friendly, helpful and reassuring. Staff explained everything and kept people informed at every stage.
- We saw screens used in the neonatal unit to provide privacy for those mothers that were breastfeeding.

Understanding and involvement of patients and those close to them

- Parents and carers we spoke with told us they felt involved in their child's care and the plan of care had been discussed with them.
- Parents on the neonatal unit were encouraged to participate in their baby's care.
- We spoke to a couple on the neonatal unit who told us that the staff had involved both of them in their babies care.

Emotional support

- Parents we spoke with said that the staff supported them emotionally. They told us they felt confident leaving their child in the care of the nursing staff.
- The diabetes team had input from a psychologist.
- Parents and staff told us that they would be taken to a private area to discuss their child's condition if needed.
- Play therapy staff supported children through procedures

Services for children and young people

Are services for children and young people responsive?

Good

We rated responsive as 'good' because:

- The children's unit had 'the den', a separate area for older children.
- Facilities were available for parents to stay overnight with their children on the children's unit and the neonatal unit had three bedrooms.
- The assessment unit meant that children could be reviewed without the need for inpatient admission.
- Children's services were meeting national referral to treatment times.
- Staff had developed a passport for children with special needs.

Service planning and delivery to meet the needs of local people

- The children's unit admitted young people up to the age of 16 years 364 days. Those aged 16-17 were given a choice as to whether they would prefer to be on an adult or children's ward. Seventeen to 18 year olds were nursed on adult wards with appropriate support for those with additional needs. Those young people with complex needs that were under the care of a paediatrician could be admitted to the children's ward up to the age of 19 years old.
- The children's unit had a playroom for younger children, which also had an outside play area and 'the den' for older children from 12 years old that contained a TV and games consoles. Children had access to the hospital WiFi so they could keep in contact with friends on Facebook.
- The children's unit had a parents sitting room where they could make hot drinks and had a microwave and fridge for them to make something to eat.
- Parents on the children's unit were able to stay overnight on a camp bed on the ward next to their child.
- The neonatal unit had three bedrooms for parents. These were used for rooming in when a baby was near to discharge and for breastfeeding mothers.
- Children seen in clinic were seen in a dedicated paediatric outpatient department. It contained a quiet room where breastfeeding mothers who wanted some privacy or children with sensory issues that needed somewhere quieter to wait could go.

Access and flow

- Children were seen in the assessment unit after referral from a GP or the emergency department. This meant that not every child would need to be admitted as an inpatient.
- A middle grade or consultant accepted referrals to the assessment unit. This allowed advice to be given to GP's and emergency department practitioners where needed and reduced the number of children that needed to be seen.
- A rapid access clinic had been set up for those children that needed to see a paediatrician but did not need to be seen straight away. Children were seen within 72 hours from referral.
- Between April 2015 and March 2016 the median length of stay for patients under the age of one was similar to the England average.
- Between April 2015 and March 2016 the median length of stay for patients aged 1-17 years old was lower than the England average.
- The children's outpatient department ran a clinic for blood tests that had improved the flow through the day case unit.
- The NHS constitution (2010) states that people with a referral from a GP should start their treatment within 18 weeks. The target is that at least 92% of people should spend less than 18 weeks waiting for treatment. Data provided by the trust showed that they were meeting this target and had not fallen below 96% from August 2015 to August 2016.
- No CAMHS support was available out of hours meaning children admitted on a Friday may not be seen by a mental health practitioner until after the weekend. Delays in obtaining beds in specialist units resulted in some children staying on the children's ward for a number of days. This issue was on the risk register and had been escalated to the clinical commissioning group (CCG).

Meeting people's individual needs

- The children's unit had a member of nursing staff who was a complex needs champion. A passport had been

developed for those children with complex needs. This included a list of the child's conditions, medications, methods of communication and their normal observations. A copy was kept with the child's records and the parents carried a copy. Input from parents with children with special needs was sought in the development of the passport.
- Specialist nurses were available for children with chronic conditions such as diabetes.
- The community paediatric service had been identified as a risk on the risk register. Their diagnosis of autism did not comply with NICE guidance as it was not multi-agency.
- Staff had access to interpreters if required.
- Children's services used the 'Ready Steady Go' documentation for transition. Children with chronic conditions such as diabetes would be under the care of paediatricians and adult physicians when they reached 16 years old and would alternate between the children's clinic and the adult clinic before full transition to the adult physician. Staff were looking at implementing a young person's clinic for those aged 19-25 years.

Learning from complaints and concerns

- We saw information displayed in every area we visited informing patients and parents how to make a complaint.
- Between April 2015 and March 2016 there were 11 complaints about children's services. The children's inpatient ward had the highest number of complaints and the main theme of complaints related to delays in diagnosis and treatment.

Are services for children and young people well-led?

Good

At our previous inspection it was found that there were no formal job plans in place for paediatricians and the division undertook rapid reviews on incidents meaning that not all significant incidents were subject to a thorough investigation.

At this inspection we found that paediatricians had signed job plans and all incidents were reviewed appropriately.

We rated well-led as 'good' because:

- There was a clear vision and strategy, although not all staff we spoke with were aware of them.
- Governance meetings were held monthly and there was a comprehensive risk register which was regularly updated. There were governance systems in place to ensure that quality, performance and risks were managed and information could be cascaded between senior management and clinical staff.
- Most of the staff we spoke with said that their immediate leaders were approachable.

However:

- Most of the staff we spoke with said they did not see the service leads or the executive team.

Vision and strategy for this service

- The Women's and Children's Division had a strategic business plan for 2016/2017 which had regard to the trust strategy. The division strategy was to move care out of hospital, reduce variations in quality and provide patient centred care.
- The vision was for more care to be community based and to reduce the number of admissions.
- Staff we spoke with said they did not know what the strategy was for the directorate, however they could tell us about the aim of reducing admissions.
- The trust's values were displayed in the areas we visited.

Governance, risk management and quality measurement

- Divisional governance meetings were held monthly. Discussions included incidents, audits, complaints and risks.
- Divisional performance reports were presented to the board.
- A governance newsletter was produced to keep staff informed about governance issues.
- A weekly patient safety summit was held to discuss incidents and look at root cause analysis (RCA).
- The division had a comprehensive risk register, which was reviewed regularly and action plans updated. Service leads identified their top three risks as recruitment of consultant paediatricians, community paediatrics and CAMHS.

- The matrons produced quality assurance reports monthly. They did regular audits such as hand hygiene and audits of CPOTT charts. Results of these were shared with staff.

Leadership of service

- Staff told us that the matron was very visible and was seen on the ward daily. They felt she was approachable.
- Staff spoke positively about their manager but a couple of members of staff said they felt the Band 6 nurses were more approachable. The ward manager acknowledged that she had had some feedback from a couple of staff members that they were scared to approach her, she had put in place respect champions on the ward for staff to approach if they felt they had concerns. It was planned to have team building days.
- The service leads told us they had increased their visibility with walkabouts and drop in sessions. However, the majority of staff we spoke with said that the service leads were not visible, although some said they saw the associate chief nurse and she was present at the CYP leaders group.
- Staff we spoke with knew who the chief executive of the trust was but most said they did not see the executive team. Staff received a weekly bulletin from the chief executive.
- At the time of our last inspection there were no formal job plans in place for the consultants. This had been addressed and all consultants now had signed job plans.
- There was a clinical lead for the children and young people's service.
- There were good relationships between paediatric and obstetric staff.

Culture within the service

- Relationships between nursing staff and medical staff were good, nursing staff felt able to challenge the medical staff if required.
- Staff told us they had seen big changes since the last inspection and most staff felt listened to more. However, a couple of members of staff we spoke to felt there needed to be more positive feedback.
- Staff told us that mo.rale could be low when staff members were asked to cover other areas or travel to FGH. It could cause some anxiety and stress due to unfamiliarity and not feeling well supported.
- We spoke with a student nurse who said that all levels of staff were approachable and had time to teach and answer questions even when busy. They felt that their learning needs were met on the unit.

Public engagement

- The children's services used 'I want great care' to get feedback from patients and their families. Forms were available in a child friendly format with smiley faces.
- The ward had acted on feedback received. Negative feedback about the curtains at the windows had led to them purchasing new blinds.
- The children's unit had used the 15 steps challenge to engage with young people. The 15 Steps Challenge is a way of thinking about our first impressions of healthcare. Local school children were invited to come and see the children's unit. Feedback received from the young people had led to a change of colour in the adolescent room.
- Two staff members on the children's unit were looking at starting a user group for parents and were hoping to start a children's user group as part of Listening into Action.
- Children were encouraged to draw pictures of their experience in hospital and these were displayed on the walls.

Staff engagement

- The children's unit had introduced a positive comments box for staff to post positive comments about other members of staff.
- The trust had implemented Listening into Action (LiA) to listen to and support staff to make changes.

Innovation, improvement and sustainability

- Staff had won a certificate of excellence award from RCPCH in recognition for 'the greatest project impact in Wave 2 of the Situational Awareness for Everyone (S.A.F.E) programme'. They won the award for the introduction of their multi-disciplinary safety huddles.

End of life care

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

Information about the service

The Specialist Palliative Care service (SPC) works across University Hospitals of Morecambe Bay NHS Foundation Trust (UHMB) on two main hospital sites at the Royal Lancaster Infirmary in Lancaster (RLI) and Furness General Hospital in Barrow (FGH).

Patients at the end of life were nursed on general hospital wards. Between April 2015 and March 2016 there were 25,360 in-patient admissions and 1,438 in-patient deaths across the three hospital sites within the trust as a whole. Between April 2015 and March 2016 there had been 960 referrals to the specialist palliative care team (SPC). Of those referrals 36% were for patients with a non-cancer diagnosis and 64% were for patients with cancer.

The SPCT delivered a Monday to Friday 9am-5pm service, with an out of hour's advice line service available from St Mary's and St John's Hospice.

The SPC team was made up of 1.7 whole time equivalent (WTE) consultants in palliative medicines posts, this included the lead consultant who was based at the Royal Lancaster Infirmary (RLI) and a new consultant post based at RLI There were four SPC clinical nurse specialists across the trust as a whole, two of which were based at RLI .The lead nurse was based at FGH and managerial responsibilities across the trust as a whole, including for those SPC nurses at RLI. The trust had a bereavement team which consisted of a bereavement nurse and a bereavement officer at both FGH and RLI.

During this inspection we visited a number of areas including oncology, stroke, acute medical unit, elderly care, general medicine and general surgery. Also, we visited the chapel, multi-faith room, the bereavement office, and the hospital mortuary.

We spoke with four patients and three relatives. We looked at the records of 10 patients receiving end of life care and of those 10, two patients were being supported using the care of the dying patient care plan (CDP).

We viewed twelve care records including two where patients were being cared for using the care of the dying patient (CDP) care plan. We spoke with three patients and three relatives.

We spoke with members of the SPC service, SPC consultant, nurse consultant, ward based staff including nursing staff, health care assistants and medical staff. In addition we spoke with the chaplain, bereavement office staff, mortuary staff and porters.

In total, we spoke with 16 staff members. We looked at policies and procedures and reviewed performance information about the trust.

End of life care

Summary of findings

In the last inspection of Royal Lancaster Infirmary, in July 2015, we rated end of life care services as 'good'. During this inspection we rated the end of life care service as 'outstanding'because:

- The trust had clear leadership for end of life care services that was supported at a senior level within the organisation. There was active involvement strategically from the deputy chief nurse and executive leadership at board level.
- End of life care services were very well led. There was a clear vision and strategy that focused on all people are treated with dignity, respect and compassion at the end of their lives.
- We saw evidence of proactive executive involvement in terms of the development of the end of life care strategy.
- There was very good public and staff engagement
- There was a commitment by the trust and this was underpinned by staff that patients were cared for in a dignified, timely and appropriate manner
- There were examples of innovation across the trust. During Dying Matters week, the trust had introduced death café's with an aim to raise the profile end of life care. This included the development of the bereavement service.
- Patients were cared for holistically and there was strong evidence of spiritual and emotional support being recognised for its importance within the trust. This was apparent through the development of 'death café's' where issues relating to death and dying were talked about openly.
- The staff throughout the hospital knew how to make referrals and people were appropriately referred to and assessed by the specialist palliative care team in a timely manner, therefore individual needs were met.
- Staff had access to specialist advice and support 24 hours a day from a consultant on-call team for end of life care.
- The chaplaincy and bereavement service supported families' emotional needs when people were at the end of life, and continued to provide support afterwards.
- The mortuary was clean and well maintained, infection control risks were managed with clear reporting procedures in place.
- The bereavement service had been nominated for a compassionate care award in 2015.
- The survey of bereaved relatives results were very positive relation to dignity and respect afforded to patients.
- The trust had recently introduced a Hospital Home Care Team, which meant that patients could be transferred to their own homes and supported by trust staff, where care packages were difficult to access in the community.
- An 'ease of access to hospital' group had been developed by the trust which included representation from the bereavement and chaplaincy service where initiatives were in place to improve access to the mortuary.
- DNACPR (do not attempt cardio-pulmonary resuscitation) records were generally completed well and the trust were making use of audits and learning from incidents to drive improvements.
- Mandatory training was in place and attendance by the specialist palliative care nurses exceeded the trust target.
- The care of the dying patient (CDP) document in use throughout the trust.
- The trust had introduced EPaCCS (electronic palliative care co-ordination system) onto one of the two acute hospital sites. The system was due to go live at the second acute hospital site in the near future. This enabled recording and sharing of people's care preferences and details about their care at the end of life.

However:

- Specialist palliative care was not provided across a seven day face to face service.
- An action plan was in place to address areas of the NCDAH where the trust had performed lower than average; however this did not include key responsibilities and timelines for achievement.

End of life care

Are end of life care services safe?

Good

We rated safe as 'good' because:

- There were systems for reporting actual and near miss incidents across the hospital. We saw lessons learnt following incidents, which were recorded in an incident log and safety briefings provided to ward staff.
- There were systems in place in the mortuary to ensure good hygiene practices and the prevention of the spread of infection.
- There were adult safeguarding procedures in place, supported by mandatory staff training. Staff knew how to report and escalate concerns regarding patients who were at risk of neglect and abuse.
- DNACPR (do not attempt cardio-pulmonary resuscitation) records were generally completed well and the trust were making use of audits and learning from incidents to drive improvements.
- Appropriate anticipatory prescribing of medicines was used at the end of life.
- There was evidence of good initial care provided by nursing staff working across the trust, supported by high levels of specialist palliative care input from very well qualified and skilled nurses and doctors.
- Medications were stored correctly and we saw staff competencies provided by the trust during our inspection in relation to syringe driver use.
- Mandatory training was in place and attendance by the specialist palliative care nurses exceeded the trust target.

Incidents

- Between September 2015 and August 2016 the trust reported no Never Events for end of life care. A never event is a serious incident that is wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- The specialist palliative care team could explain their responsibilities for reporting incidents. Staff told us that when an incident happened they recorded it on an electronic reporting system.
- Staff told us any incident relating to a patient at the end of life they involved the palliative care team in the investigation and subsequent learning as a result.
- Staff spoke with some understanding about the duty of candour regulations. They understood their responsibility to be open and transparent (with patients and carers).

Environment and equipment

- We viewed mortuary protocols and spoke with mortuary and portering staff about the transfer of the deceased. The mortuary was manned by at the Royal Lancaster Infirmary (RLI) with support as needed from porters.. Staff told us that the equipment available for the transfer of the deceased was adequate and we saw that this included bariatric equipment.
- The mortuary was secured to prevent inadvertent or inappropriate admission to the area. The temperature of the mortuary fridges was recorded on a daily basis and the fridges were alarmed with alerts directly to the estates department should the temperature fall outside of the normal range.
- The mortuary staff told us that they had not experienced any difficulties involving capacity.
- The trust used the McKinley syringe drivers. We saw that regular administration safety checks were being recorded. Ward staff told us that syringe drivers were available when they needed them.
- Staff told us that equipment was accessible within a few hours for patients at the end of life who were being discharged. Records showed equipment had been safety tested and serviced where required.

Medicines

- The trust had produced guidelines for medical staff to follow when prescribing anticipatory medicines. These were available on the intranet.
- Medicines for use at the end of life, including those for use in a syringe driver were readily available on the wards. Nursing staff said that end of life care medicines were accessible, including outside of normal working hours.
- Anticipatory end of life care medication (medication that patients may need to make them more comfortable).was appropriately prescribed. We saw that the specialist palliative care nurses worked closely with medical staff on the wards to support the prescription of anticipatory medicines.

End of life care

Records

- The 'Caring for the dying patient documentation' (CDP) continued to be rolled out within the trust. The (CDP) care plan that provided prompts and guidance for ward based staff when caring for someone at the end of life.
- Staff were able to refer to the SPCT directly with support and advice for complex patients
- Care plans reflected national guidance and included risk assessments such as those for the risk of anticipatory medication or pressure area damage.
- Patients' healthcare records were stored in a secure way that promoted confidentiality. They were stored at each individual patient's bed space.
- The trust had introduced EPaCCS (electronic palliative care co-ordination system). This enables recording and sharing of people's care preferences and details about their care at the end of life.
- The trust used a DNACPR (do not attempt cardio-pulmonary resuscitation) form that was used across North Lancashire and Cumbria. They had audited the use of the forms in April 2016 and had identified areas for improvement including the recording of discussions around DNACPR.
- Forms were kept in the front of patient notes, had documented decisions with reasoning and clinical information and had been signed by a consultant.
- Records within the mortuary were comprehensive and included processes for appropriate checking.
- Forms were kept in the front of patient notes, had clearly documented decisions with reasoning and clinical information and had been signed by a consultant.

Safeguarding

- The trust set a mandatory target of 95% for completion of mandatory safeguarding adults and children (level 1 and level 2) training and at July 2016 the trust completion rate was 91% for level 1 and 92% for level 2.
- We spoke with staff around safeguarding. Generally staff were knowledgeable about the trusts safeguarding policies and their role and responsibilities. Staff could give examples of what constituted a safeguarding concern and how they could raise an alert. Staff could give examples of what constituted a safeguarding concern and how they could raise an alert.
- All specialist palliative care staff working at Royal Lancaster Infirmary had attended mandatory safeguarding training for both vulnerable adults and children.
- Patients and relatives we spoke with did not highlight any concerns about aspects of safeguarding. They said they were well looked after and they felt safe on the unit.

Mandatory training

- The trust set a mandatory target of 95% for completion of mandatory training.
- Areas covered included equality and diversity, health and safety, infection control and information governance.
- The trust had achieved Gold Standards Framework accreditation (the Gold Standards Framework is a model that promotes good practice in the care of patients at the end of life), we saw ward based staff had received training specific to the model and the care of patients at the end of life.
- We also saw End of life care training was not mandatory training within the trust.
- Porters had face to face mortuary training that included the transfer of the deceased including promoting dignity and respect and an understanding of bereavement. Porters also receive refresher on dignity and respect.

Assessing and responding to patient risk

- We observed the use of general risk assessments on the wards, including those relating to the risk of falls, malnutrition and dehydration, the use of bed rails and the risk of pressure damage.
- We saw an early warning score (NEWS) which highlighted if escalation of care was necessary. Additionally, the SCPT used the trust's electronic system for recording patient's clinical observations. Patients recognised as being at the end of life had their care plans transferred to the 'are of the dying patient framework' plan when they were expected to die within a few days. Specialist palliative care was provided from 9am to 5pm, five days a week. Outside of these hours, and at weekends, advice was offered through a Hospice Advice Line, which also included the consultant on call. This service was available to all staff and patients should they need it.
- The Gold Standards Framework (GSF) also provided a guide for staff to support the recognition of patients in

the dying phase of life. This enabled staff to manage end of life care risks more proactively, for example in relation to keeping patients comfortable and ensuring that opportunities for meeting their wishes were taken.
- Ward staff provided care to patients requiring palliative and end of life care. Should a patient experience complex symptoms or additional support be required to meet patient needs, then ward staff would refer to the SPCT.
- Ward staff told us the SPCT team had a visible presence on the wards. Any changes to patient's conditions generally instigated a visit by the SPCT. We saw patient's daily notes by nursing, medical and therapy staff with updates on any changes recorded clearly.

Nursing staffing

- The specialist palliative care team across the trust included a lead specialist nurse and three clinical nurse specialists. Two clinical nurse specialists were based at Royal Lancaster Infirmary. The lead nurse was based at Furness General Hospital.
- Specialist palliative care was provided from 9am to 5pm five days a week. Outside of these hours and at weekend,
- After 5pm advice was offered through a 'hospice advice line'. This service was available to all staff and patients should they need it.
- EOLC was provided by all ward staff, with specialist support from SPCT.
- Specialist palliative care nurses worked closely with ward based nurses and some wards had end of life care link nurses. Ward 23 had achieved GSF accreditation and nursing staff on the ward had a thorough understanding of end of life care issues and care planning and support for patients.
- Staff told us they prioritised care for patients at the end of life as much as possible.
- Specialist palliative care and bereavement staff regularly attended ward rounds to provide support to ward staff around end of life care issues.

Medical staffing

- The palliative care consultants worked across the acute hospital, the community and the local Hospices (St Mary's and St John's Hospice) allowing for improved continuity and management of patients who were using more than one of the services.
- The Palliative Medicine Consultants were able to demonstrate continued professional development in line with the requirements of revalidation by the General Medical Council.
- Link nurses had been identified for most wards with an emphasis on medical wards.
- We saw that ward based doctors were supported to deliver end of life care by the specialist palliative care team and we observed the specialist palliative care nurses discussing prescribing guidelines with doctors on the wards.
- Medical staff we spoke with told us the specialist palliative care team were available for advice as needed and responded quickly to urgent referrals. All referrals were responded to within 24 hours.

Major incident awareness and training

- Major incident and winter management plans were in place. Senior staff had access to action plans and we saw that these included managers working clinically as appropriate, staff covering from different areas and prioritisation of patient need.
- Specialist support was available from the specialist palliative care team when required and out of hours specialist advice could be sought via telephone.
- Staff had an understanding of the major incident plan.

Are end of life care services effective?

Good

We rated effective as 'good' because:

- The care of the dying patient (CDP) document was developed and in use throughout the trust.
- Appropriate medication was available in the ward areas, and there were examples that anticipatory prescribing was being managed effectively.
- The trust participated in the End of Life Care Audit: Dying in Hospital 2016 results showed seven out of the eight indicators had been achieved. There was comprehensive use of the Gold Standards Framework (GSF) in a number of wards and there was clear evidence of accreditation positively impacting on end of life care.
- Cross Bay MDT meetings were held bi-monthly, where specialist palliative care staff from both Furness General Hospital and Lancaster Royal Infirmary would meet.

End of life care

- We saw guidance documentation by the EOLC team that could be accessed by ward staff.
- Staff we spoke with had a clear understanding of consent, Mental Capacity Act and Deprivation of Liberty Safeguards.

However:

- Specialist palliative care was not provided across a seven day face to face service.
- An action plan was in place to address areas of the NCDAH where the trust had performed lower than average; however this did not include key responsibilities and timelines for achievement.

Evidence-based care and treatment

- Ward 23 at the Royal Lancaster Infirmary had been awarded Gold Standards Framework (GSF) accreditation.
- The 'caring for the dying patient' (CDP) care plan was now fully developed and available across the trust. This had been developed from strategic clinical network guidance and was based on national guidance. Sources included the Leadership Alliance for the Care of Dying People, the Department of Health End of Life care Strategy, and the National Institute of Clinical Excellence (NICE).
- The document held guidance for staff in identifying patients at the end of life and included a holistic assessment, and advance care planning documentation. Additionally, it provided staff tools? to develop coordinated care, enable the involvement of the patient and those close to them and the management of pain and other symptoms.
- Policies and procedures relating to care of the dying patient and the use of the Gold Standards Framework (GSF) were available on the trust intranet and staff we spoke with knew how to access these.
- All staff we spoke with were positive of GSF project and how they had been involved in the work to achieve accreditation and how this had benefitted both staff and patients.

Pain relief

- Staff told us there were adequate stocks of appropriate medicines for end of life care and that these were available as needed both during the day and out of hours.
- Doctors we spoke with were aware of the guidance around prescribing for key symptoms at the end of life. They knew they could access the guide on the intranet and also seek support from the specialist palliative care team.
- Appropriate medication was available in the ward areas, and there were examples that anticipatory prescribing was being managed.
- Staff told us there were adequate stocks of appropriate medicines for end of life care and that these were available as needed both during the day and out of hours.
- Care plans included pain assessment prompts and clear records of pain assessments.
- Patients at the end of life were prescribed 'Just in case' medicines.
- Results from the 2016 National Care of the Dying Audit in Hospitals (NCDAH) showed that 77% of patients had a record of anticipatory medicines for pain at the end of life being prescribed. This was somewhat higher than the national average of 71%.

Nutrition and hydration

- As part of trust policy, all patients had their nutrition and hydration needs assessed as part of the core nursing care plans.
- Staff were clear that patients at the end of life should eat and drink as they wished and that staff would support them to do that. Staff were able to provide patients with hot and cold snacks outside usual meal times.
- Staff told us that patients were offered a food choice at mealtimes. They were not required to pre order and this was appropriate due to the patient's appetites changing frequently.
- Staff told us that snacks were available for patients throughout the day and night.
- We viewed examples of patient assessments of hydration needs at the end of life. The National Care of the Dying Audit in Hospitals (NCDAH) March 2016 showed that the trust performed below the national average in this area at 56% compared with the national average of 67%. Results from the audit did show that the trust was on a par with the national average where there was documented evidence of patients being supported to drink in the last 24 hours of life.
- We viewed examples of patient assessments of nutrition needs at the end of life. The NCDAH March 2016 showed that the trust performed below the national average in

this area at 49% compared with the national average of 61%. The trust was also lower than average in terms of the audit demonstrating evidence of patients being supported to eat in the last 24 hours of life at 29% compared with the national figure of 36%.
- The specialist palliative care team had drafted an action plan to address areas of the audit that were below average. This was generally focussed on a continued roll out of the Care of the Dying Patient document and supporting wards to achieve Gold Standards Framework accreditation. However, the action plan did not include key people responsible for implementation or timelines for achievement.

Patient outcomes

- The trust participated in the Gold Standards Framework accreditation scheme, including ward 23 at Royal Lancaster Infirmary.
- UHMB had participated in the National Care of the Dying Audit of Hospitals (NCADH) 2013/14. The trust did not achieve six of the seven organisational targets in the audit and performed worse than the England average for seven of the ten clinical indicators.
- The trust participated in the End of Life Care Audit: Dying in Hospital 2016 results showed seven out of the eight indicators had been achieved. The area not achieved related to providing the specialist palliative care services across seven days as opposed to the five days currently. The trust performed better than the England average for two of the five clinical indicators. For example, they scored higher than average in recognising that death was imminent in 89% of patients compared with the national average of 83%. They also performed better than average in discussing imminent deaths with relatives.
- The trust had produced an action plan to address areas where performance was lower than average. For example, areas such as improved nutrition and hydration assessments were being addressed as part of the roll out of the Care of the Dying care planning document.

Competent staff

- At July 2016, the trust reported that 71 % of leadership and 82% of all other staff had received an appraisal compared to a trust target of 100% for leadership and 95% for other.
- The palliative care nursing team were experienced and well qualified and had completed training in areas such as symptom management and advanced communication skills. The team received regular clinical supervision with a clinical psychologist every month.
- The specialist palliative care team provided a range of specialist training to general staff caring for patients at the end of life. This included training on symptom control, spiritual support, bereavement support and communication skills. The team also provided a training session for Surgical Band 7s on the CDP and Just in Case drugs.
- All the Specialist Nurses are independent prescribers and regularly attended the NMP Forum held by the NMP Lead as part of Continuing Professional Development.
- An end of life facilitator post had come to an end in July 2016 as the funding had run out. This post had been focused on the implementation of the Care of the Dying Patient (CDP) plan and the use of the Gold Standards Framework. Since this post ended elements of this role had passed to the specialist palliative care nurses. In addition practice educators within the trust worked alongside specialist staff to support training for ward staff around end of life care.
- Ward staff told us that the specialist nurses would support them in caring for patients at the end of life when needed, all staff told us the specialist team were accessible and supportive.
- The Specialist Palliative Care Team provided training sessions for Foundation Year doctors over the year including: Palliative care, GSF, Bereavement, CDP and Just In Case drugs, Nausea and vomiting, Breathlessness, Breaking Bad News and DNACPR.
- Porters received training on induction which was ongoing included aspects of dignity and respect and well as communication with the bereaved.

Multidisciplinary working

- Weekly MDT meetings were held at the local hospice where trust specialist palliative care staff would attend to discuss their most complex patients.
- Cross Bay MDT meetings were held bi-monthly where specialist palliative care staff from both Furness General Hospital and Lancaster Royal Infirmary would meet. This included palliative care consultants and nurses, bereavement nurses and chaplaincy staff.
- We saw specialist palliative care staff would attend regular ward based meetings including 'board rounds'

as part of their routine visits to review patients on the wards. Staff told us this was hugely beneficial as it enabled them to work closely with medical and nursing staff on the wards to support patients at the end of life.
- The specialist palliative care team worked closely with cancer and non-cancer specialist teams and Palliative care consultants would attend regular MDTs in relation to cancer and non-cancer specialist teams.
- The trust had introduced EPaCCS (electronic palliative care co-ordination system) on to one of the two acute hospital sites. The system on the second acute hospital site was due to go live in the near future. This enabled recording and sharing of people's care preferences and details about their care at the end of life.
- All Chaplains attended MDTs.

Seven-day services

- The trust provided access to Specialist Palliative Care 9-5 five days a week.
- A business plan for a seven day week SPC service had been submitted to the Executive Committee two years ago but was unsuccessful at the time. We were told there were plans in place to submit a further proposal aligned with local and regional strategic plans.
- There was on-call palliative care consultant cover out of hours across both acute and hospice services (St Mary's and St John's Hospice). In addition a 24 hour advice line was available out of hours should staff require specialist advice. However, not all staff we spoke with were aware of this option.
- Staff told us they felt it would benefit patient care if there was a seven day specialist care service

Access to information

- The CDP document provided a guide to clinical staff in the assessment and identification of patients' needs. Information was recorded in a clear and timely way so that staff had access to up to date clinical records when caring for and making decisions about patient care.
- We saw guidance documentation by the EOLC team that could be accessed by ward staff.
- Staff had access to a number of resources through the trust intranet. Staff we spoke with said this information was accessible and easy to use.
- Information regarding the fast track discharge and referral process was available on the intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with had a clear understanding of consent, Mental Capacity Act and Deprivation of Liberty Safeguards.
- We viewed DNACPR forms and saw evidence of clear recording of the patients' capacity. We saw evidence that the decision had been discussed with the patient's relatives and this had been recorded. We viewed 17 DNACPR forms when visiting the wards and found on 15 occasions these were recorded appropriately with discussions with the patient and relatives recorded where appropriate.
- We viewed assessment documents for patients identified as being at end of life. We saw prompts for guidance for staff to follow in relation to best interest decisions for patients who did not have capacity to make decisions about care and treatment, including in relation to nutrition and hydration.
- The specialist palliative care team had completed consent and mental capacity act training and this was repeated annually in mandatory training.

Are end of life care services caring?

Outstanding ☆

We rated caring as 'outstanding' because:

- There was a strong, visible, person-centred culture, and staff were motivated and inspired to offer care that was kind and promoted people's dignity.
- It was evident throughout the inspection how staff went the extra mile to provide care for patients who were nearing the end of their life and the level of dedication was obvious to all including friends, families and patients who could not fault the caring nature of staff.
- Patients were cared for holistically and there was strong evidence of spiritual and emotional support being recognised for its importance within the trust. This was apparent through the development of 'death café's' where issues relating to death and dying were talked about openly.
- The bereavement service within the trust was highly valued and there was evidence of trust investment in the service and offering bereavement support to patients and families was seen as a priority.

End of life care

- The bereavement team provided the Caring for the Dying patient packs and the care after death checklist. The service provided a single point of contact for families.
- The support available for families following the death of their relative was outstanding.
- The bereavement team, chaplaincy and specialist palliative care team worked together to promote compassionate care at the end of life. The mortuary department provided an out of hours support for families who requested a viewing of their relative.
- We saw a dedicated chaplain as well as access to chaplaincy volunteers who demonstrated a good understanding of the issues relating to end of life care and showed compassion and respect.
- All patients admitted to Royal Lancaster Infirmary were given the opportunity to discuss their wishes for their future care with staff.
- A survey of bereaved relatives carried out within the trust showed very positive results in areas of dignity and respect afforded to patients.
- A remembrance service was held by the chaplaincy every three months for those bereaved.

Compassionate care

- We observed staff interacting with patients on the wards with compassion.
- Patients and their relatives spoke highly of all staff. A relative we spoke with told us of how staff ensured they could stay with their father.
- Wards had quiet rooms available for relatives to use when available. Those relatives we spoke with told us that staff had gone out of their way to make them comfortable and provide support, including access to refreshments and where possible ensuring they had somewhere comfortable to rest.
- Ward 23 did have 4 side rooms and pull down bed for relatives. However, we were told the trust policy was that infection control was always prioritised so can be on occasion it could prove difficult to accommodate end of life patients.
- A retrospective bereavement survey was conducted annually with bereaved relatives to assess their opinions about the care their loved one received during their admission. For example, 96% had the opportunity to talk with doctors involved with the patients care. Ninety-three per cent felt their concerns were listened to. 96% felt symptoms were well managed.
- The bereavement service was opened in August 2013. The Coroners were based on site at RLI so contact between both services was easily managed. The bereavement service aim was to get the appropriate paperwork completed in 24 hoursthen aim to make contact with the family to collect death certificate and property. Additionally there was a quarterly bereavement service held at RLI.
- Free parking across the trust site was available for families with patients staying at the Royal Lancaster Infirmary, which relieved some of the pressure for relatives and carers.
- Ward staff were aware of patients who were receiving end of life care. They were able to discuss their needs and the support that they required. They showed a good understanding and demonstrated compassion and respect.
- During initial and pre assessments, the needs of the patient were identified and their wishes acknowledged and responded to.
- We saw information readily available offering advice for relatives with guidance on viewing arrangements, how to register a death, organ and tissue donation, funeral arrangements and a list of advice and support organisations and how to contact them.
- The trust were nominated as runners up in the Health Service Journal's 2015 compassionate care category for their bereavement service.
- Specialist palliative care nurses and bereavement nurses had been trained in advanced communication skills. Communication skills training was available for all staff.
- A bereavement service including bereavement nurses and officers to support relatives through the practical and emotional aspects of bereavement had been introduced by the trust.
- Support for relatives and patients around bereavement was embedded into practice within the trust and there was a culture of promoting care that was in line with patient and family wishes and delivered through compassion and kindness.
- There were a number of innovations relating to compassionate care for patients at the end of life. This included the use of canvas property bags with a dragonfly symbol so staff knew that the person had been recently bereaved. In addition bereavement staff sent out forget me not seeds to family members

following the death of a loved one. Families were also able to get casts of patient's hands which was a service provided by an external organisation with funding for this provided by the trust.
- The trust had adopted the dragonfly as the dignity in death symbol. This was used as a sign to alert non-clinical staff to the fact that a patient was at the end of life or had died. A card with the symbol could be clipped to the door or curtain where the patient was being cared for. By alerting all staff this meant that patients and family members would not have to face unnecessary interruptions and non-clinical staff knew to speak with clinical staff before entering the room. An information card had been produced for non-clinical staff explaining the difference between the dragonfly symbol (dignity in death) and the butterfly (dementia care).
- The bereavement team, chaplaincy and specialist palliative care team worked together to promote compassionate care at the end of life. A particular innovation relating to this had been the development of death cafes. A death café provided an opportunity for people to talk more openly about death and dying. The trust had held death café's for the public as part of dying matters week and also had used them to support staff to talk more openly about death and to promote better communication with patients and relatives at the end of life.

Understanding and involvement of patients and those close to them

- Royal Lancaster Infirmary operated an open visiting policy for patients friends, relatives and carers
- We saw that clinical staff spoke with patients about their care so that they could understand and be involved in decisions being made.
- There was evidence of patients and/or their relatives being involved in the development of their care plans. Results from a bereavement survey carried out by the bereavement service showed that 98% of relatives stated that they felt involved in decisions about care.
- We saw that the 'Caring for the dying patient document' used by the trust included prompts to assist staff with caring for patients and their relatives.
- Families were encouraged to participate in care and provide feedback through surveys.
- We saw that bereavement packs were available in the ward areas with information about access to support.
- Patients we spoke with told us they felt involved in their care. The use of the Gold Standards Framework (GSF) promoted patient and family involvement and discussion around end of life care wishes and choices.
- We saw advance wishes were discussed with patients and their relatives and recorded within the care planning documents.

Emotional support

- During our inspection, we visited patients who were in receipt of EOL care. Patients spoke positively about the way they were being supported with their care requirements.
- Throughout our inspection, we saw that all staff were responsive to the emotional needs of patients and their visitors.
- The chaplain was able to access families and patients directly to the counselling services.
- The chapel at the RLI was located quite a distance from patient areas which could be a problem for many wanting to visit the chapel.
- Staff were also able to access counselling support through the staff welfare scheme in the form of a bereavement leaflet that included contact numbers for relatives of a variety of support agencies they could contact should they need to.
- Staff told us bereavement-counselling services were offered for relatives and was also available via the bereavement service for patients.
- In 2013/14 the trust's score in the NCDAH for assessment of spiritual needs fell below national averages. In the 2016 audit we saw that this had improved and demonstrated that 30% of patients had been offered access to spiritual support which was higher than the national average of 27%.
- A remembrance service was held by the chaplaincy every three months for those bereaved. We were also told that 'shadow' funeral services had been delivered within the trust when patients had been too unwell to attend funerals of loved ones.
- Relatives were sent a condolence letter by the bereavement service a few weeks after the death of a loved one, support was offered at this time.
- Bereavement nurses worked closely with ward staff to provide support to both patients and relatives around

issues of loss and other support needs. There was a library of books available for families to borrow, for example in relation to supporting children through bereavement and loss.
- The chaplaincy service provided spiritual support for patients and their families and they had a multi-faith prayer room. A team of volunteers worked with the on-site chaplain to provide this. They had recently recruited an Iman as a chaplaincy volunteer.
- The aim of the chaplaincy service was to visit end of life care patients hospital once a week to offer support and raise the profile of the service.
- All chaplains were involved in delivering bereavement training to staff and attended they also attended MDT's. The chaplain at RLI also hosted the death cafes.
- The trust's bereavement service found that 92% of respondents felt they had received appropriate support from medical staff to deal with their feeling surrounding the death and 100% of respondents felt they had received appropriate support from nursing staff in this area.

Are end of life care services responsive?

Good

We rated responsive as 'good' because:

- EOLC services were very responsive to patient's individual needs and the wider needs of the local community.
- Fast track discharges were managed efficiently and in the patient's best interest and a proactive approach was taken to ensuring the support and safety of vulnerable patients.
- We saw evidence on how staff were meeting the holistic needs of palliative and end of life care.
- An 'ease of access to hospital' group which included representation from the bereavement and chaplaincy service had been introduced by the trust.
- We saw evidence within the care records observed that the patients preferred place of death is discussed.
- The bereavement service provided a service to complete paperwork within 24 hours for families.

Service planning and delivery to meet the needs of local people

- The Gold Standards Framework for end of life was now fully implemented to provide care in acute hospitals across two wards within the trust.
- The GSF aim is to promote the early identification of patient's at the end of life so as to allow for improved discussions with them and their families about their wishes and choices at the end of life.
- The GSF provided a platform non-specialist staff to deliver end of life care alongside specialist support in a cohesive and consistent way. We saw this at RLI, where staff demonstrated a clear understanding of the advantages of using such a framework and promoting good quality end of life care in general ward settings.
- The trust did not collect data in respect of supporting patients to die in their preferred location. However there was evidence that patient's from the CCG's (clinical commissioning groups) of the UHMB region were more likely to die in their usual place of residence than the national average. For example, the national average for patients dying in their usual place of residence between April 2015 and March 2016 was 45.8%. The local average for patients was 47.3% (Cumbria CCG) and 50.3% (Lancashire North CCG).
- Services were planned to meet the needs of the local demographic and a primary aim of the end of life group was to raise awareness of end of life issues and ensure that patients received care in line with their wishes and preferences.
- A nurse told us they could access support from specialist teams for, example dementia services, safeguarding team and best interest assessors.
- Interpreters were available within the trust and a nurse told us the system worked well.

Meeting people's individual needs

- Assessments were carried by staff of patients' needs at the end of life. This included their emotional and spiritual needs and their preferred place of care.
- Patients identified through the GSF were reviewed on a weekly basis as a minimum.
- Staff told us that they had been able to arrange rapid discharges for patients when required. The discharge liaison team were able to provide support with this when necessary. Staff we spoke with told us there was a proactive push for fast track discharge at EOL. Staff also told us South Lakes was more difficult as community services were affected by diminishing resources. Staff told us they can generally get patients home in 24 hours.

End of life care

- The trust provided a discharge service. Staff consistently told us that where care packages were accessible in the community they could get patient's home in a matter of hours if necessary.
- The chapel also had a multi-faith prayer room and there were plans in progress for extending the prayer room and improving facilities for patients, staff and visitors of multi-faiths.
- The SPCT provided phone advice and also frequently visits to ward.
- Deciding Right was implemented in the advanced care planning care plans across the trust.
- Patients who had been identified with dementia were supported and the trust had developed a 'butterfly' scheme so staff were aware of the support needs of that patient.
- The trust had introduced the dragonfly scheme to raise awareness of patients at the end of life.
- Cards for non-clinical staff were issued explaining the meaning of the symbols.
- The trust had developed a 'Hospital Home Care Team' that was designed to reduce the number of in-patients who were medically fit for discharge and could leave hospital by 50%. This service included the provision of community end of life care with the support from hospice at home and district nursing teams in the persons own home when care packages could not start in a timely way. Following a 90 day initial trial the trust extended the service in October 2016.
- Cross department partnership work and developments around dementia, palliative care, adult and ante natal bereavement was implemented by the chaplaincy team.
- The bereavement team told us that the bereavement leaflet had recently been translated into the braille.
- The chaplaincy had developed links with faith groups and introduced a service level agreement. This was to ensure that the needs of patients from different faiths would be met.

Access and flow

- Referrals to the specialist palliative care team came through by phone and in writing and a good deal were picked up through routine ward visits. Ward staff told us the team always responded promptly and that urgent referrals were seen within a short space of time on the same day.
- In total in 2014/15 there had been a total of 960 referrals to the specialist palliative care teams across both Furness General Hospital and Royal Lancaster Infirmary. Of those 64% were for patients with a cancer diagnosis and 36% were for patients with a non-cancer diagnosis. There had been a 4% reduction in non-cancer referrals since the previous year.
- We saw effective interaction between SPCT and ward nurses.
- The wards had a relaxed visiting policy for relatives to visit patients.
- Family members who wished to stay with their relatives were encouraged to do so.

Learning from complaints and concerns

- Staff told us that they received more compliments than concerns but that complaints were discussed at team meetings.
- For end of life and palliative care complaints and concerns, the trust's policy on complaints was followed.
- Bereavement nurses were available to provide support to patients and families in situation where they were dissatisfied with the care experienced. This role provided a support to ward staff as well when dealing with complex end of life care situations.
- Between April 2015 and March 2016 there were no complaints about end of life care services.
- Members of the specialist palliative care team told us they would be involved in investigations and supporting learning from complaints if these centred on patients at the end of life.
- Mortality review meetings were conducted with input from the specialist palliative and bereavement teams where opportunities to address concerns around the quality of end of life care were taken and learning explored.
- Information was available in the hospital to inform patients and relatives about how to make a complaint.

Are end of life care services well-led?

Outstanding ☆

We rated well-led as 'outstanding' because;

- The trust had clear leadership for end of life care services that was supported at a senior level within the organisation. There was active involvement strategically from the deputy chief nurse and executive leadership at board level.

End of life care

- End of life care services were very well led. There was a clear vision and strategy that focused on all people are treated with dignity, respect and compassion at the end of their lives.
- We saw evidence of proactive executive involvement in terms of the development of the end of life care strategy.
- Investment in end of life and palliative care services was apparent and staff we spoke with consistently told us they felt that end of life care was a priority for the trust.
- There was very good public and staff engagement
- There was a commitment by the trust regarding end of life care and this was underpinned by staff whose priority was for patients to be cared for in a dignified, timely and appropriate manner
- There were examples of innovation across the trust. Leading Dying Matters week the trust had introduces death café's with an aim to raise the profile end of life care. This included the development of the bereavement service.
- The trust had adopted the dragonfly as the dignity in death symbol. This was used as a sign to alert non-clinical staff to the fact that a patient was at the end of life or had died.
- Further innovations were seen in relation use of canvas property bags with a dragonfly symbol so staff knew that the person had been recently bereaved. In addition bereavement staff sent out forget me not seeds to family members following the death of a loved one.

Vision and strategy for this service

- The trust had rolled out the Care of the Dying Patient (CDP) plan and the Gold Standards Framework (GSF) accreditation.
- The trust's vision had been established where 'all people who die in the Morecambe Bay area are treated with dignity, respect and compassion at the end of their lives and that regardless of age, gender, disease or care setting they will have access to integrated, person-centred, needs based services to minimise pain and suffering and optimise quality of life'.
- A framework of 'Better Care Together' had been developed by the trust. This is a collaborative model where health care, social care and voluntary sector partners worked together to develop integrated community based services where patients would be cared for in their local communities as much as possible.
- The trust had made a commitment to the roll-out of the GSF framework.
- A three year strategy had been developed in June 2016 and included key priorities using the North West end of life model where objectives were classified according to different phases of the last year of life. This ranged from services available to patients with advancing disease, those with increasing decline, those in the last days of life, the first days after death and bereavement.

Governance, risk management and quality measurement

- Specialist palliative care reports within the directorate of medicine.
- The team held regular staff meetings locally named 'cross bay meetings,. Also in attendance were the bereavement team, chaplaincy and on occasion the assistant chief nurse.
- The service takes part in regular audits, locally and nationally. This included the external NCDAH and internal bereavement surveys. We saw an action plan had been compiled from the 2016 NCDAH and included action to ensure the ongoing roll out of the CDP (care of the dying patient document) and GSF accreditation.
- The bereavement service had introduced a bereavement survey. The survey was trust wide and was broken down to reflect findings from relatives who had been part of end of life care. An action plan following this was in the process of development at the time of our inspection.
- The trust-wide risk register showed that there were two risks specific to end of life care identified.
- SPCT attended mortality review meetings. Discussions included reviewing the quality of care and decision making at the end of life.

Leadership of service

- The medical director was the executive end of life care lead with support from the chief nurse. There was clear leadership from executive level through to nursing staff, chaplaincy and the bereavement service.
- The senior consultant in palliative medicine was the clinical lead and worked across boundaries with both the CCG and local hospice.
- The SPCT was based across both sites at UHMB. The lead specialist palliative care nurse was based at Furness General hospital

End of life care

- Bereavement nurses and chaplaincy staff had leadership roles in terms of end of life care and raising awareness of aspects of their service across the trust. This involved attending meetings and working collaboratively across services and departments to raise awareness of end of life care issues.
- We saw ward staff providing good end of life care for patients together with supporting family members. Ward staff worked closely with the SPCT on improving and developing end of life care within the trust.
- The SPCT was made up of two SPC nurses at Royal Lancaster Infirmary. The team may have changes in the near future that include anticipated retirement and changes to nursing hours. As a result of this the service delivered at RLI would require a change in support for the new incoming staff.

Culture within the service

- There was a commitment at all levels within the trust to raise the profile of death and dying and end of life care. This included improving ways in which conversations about dying were held and engaging with patients and their families to ensure their choices and wishes were achieved.
- Staff were proud of their work around end of life care. The specialist palliative care, bereavement, chaplaincy and mortuary staff demonstrated an enthusiasm and passion for continuously improving services to meet the needs of patients and families.
- Staff spoke highly of the way teams worked collaboratively and the support being good across all wards and departments.
- Ward staff felt supported by the SPCT and were particularly proud of the work which resulted in GSF accreditation.

Public engagement

- The trust had developed work from the Dying Matters Week in 2016 which was co-ordinated by the chaplain. This included death café's which are based on creating opportunities about more open discussions about death and dying to raise awareness and create a more open culture.
- The trust sent bereavement surveys sent out to relatives of patients who had received end of life care within the trust.

Staff engagement

- We saw effective communication between the SPCT and ward nurses in relation to patient care.
- Staff felt they felt confident they could raise issues upwards and they would be acknowledged.
- Specialist palliative care staff attended regular team and 'cross bay' meetings where they had the opportunity to input into the development of the service.
- All specialist palliative care staff had received an annual appraisal and a personal development plan as a result.

Innovation, improvement and sustainability

- Death cafés were introduced which provided an opportunity for people to talk more openly about death and dying. This was an initiative that fed out of Dying Matters week. This provided a platform support for staff to talk more openly about death and to promote better communication with patients and relatives at the end of life.
- The trust had introduced property bags with a dragonfly symbol. This indicated to staff so staff knew that the person had been recently bereaved. Also as part of the service bereavement staff sent out forget me not seeds to family members following the death of a loved one. Families were also able to get casts of patient's hands which was a service provided by an external organisation with funding for this provided by the trust.
- Discharge coordinators were available to support the process of rapid discharge at the end of life and the trust had recently implemented a community service where patients could be supported by trust staff in their own homes where care packages were difficult to access in the community.
- The trust provided Sage and Thyme communication training for all nurses. Staff at RLI spoke positively about the impact of this training.
- In July 2015 funding ceased for end of life care coordinator roles within the trust. These roles had been in place to implement and roll out the care of the dying patient (CDP) document and continued implementation of the Gold Standards Framework (GSF) across the trust. These responsibilities had since been passed to the specialist palliative care team with their additional roles and responsibilities. While we saw that work was continuing with the roll out of GSF and the CDP there was evidence of some delays in implementation due to staffing difficulties. The timeline for ongoing

implementation was unclear and while ward staff informed us that the specialist palliative care team were supportive, dedicated time for implementation was limited.

- Changes to the specialist palliative care team across the trust were forthcoming with near future retirements of post-holders. We were told that recruitment had begun for these posts and discussions had been held, however clear contingency plans were yet to be in place.

Outpatients and diagnostic imaging

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

Information about the service

The University Hospitals of Morecambe Bay NHS Foundation Trust provided outpatient and diagnostic services at the Royal Lancaster Infirmary, Furness General Hospital and Westmorland General Hospital. Between April 2015 and March 2016 there were 700,277 first and follow-up outpatient attendances at the trust. Royal Lancaster Infirmary provided 303,496 outpatient appointments.

Outpatient services were part of the core clinical services directorate. There were nurse led clinics for dermatology, diabetes, lung clinics, gastroenterology clinics, respiratory and rheumatology clinics. Outpatients offered 'one-stop' clinics for Breast, Cardiology, Respiratory, Thyroid and Urology. The outpatient service was responsible for the management of room scheduling and staff support to clinicians to enable the running of outpatient based treatment functions within the trust. We visited the main outpatients department, physiotherapy, audiology, ophthalmology and dermatology.

The trust had a Community Patient Contact Centre (CPCC) based at Westmorland General Hospital that dealt with outpatient bookings for the trust including Royal Lancaster Infirmary and two virtual booking centres in other parts of the trust. The patient contact centre dealt with around 12,000 calls a month.

Diagnostic imaging services were mainly provided from three locations: Royal Lancaster Infirmary, Furness General Hospital and Westmorland General Hospital with a limited service at Ulverston Community Health Centre and Queen Victoria Hospital at Morecambe. Diagnostic imaging at Royal Lancaster Infirmary provided plain film x-rays, ultrasound, CT, MRI, Nuclear medicine, breast screening, interventional treatments and a radio pharmacy. The acute clinical work including fluoroscopy was concentrated at the two main sites; Royal Lancaster Infirmary and Furness General Hospital that offered a range of diagnostic imaging, image intensifiers in theatres, and interventional procedures. The trust provided diagnostic imaging figures for all sites for each modality; 28000 CT scans, 16500 MRI Scans, 47,000 ultrasound scans, 21,400 obstetric scans, 2773 nuclear medicine procedures, 6413 fluoroscopy procedures, 150,707 plain film x-rays, 16,468 mammograms, and 140,000 breast screening mammograms (for those patients of the eligible screening population in South and North Lancashire).

The trust MRI provision was supplemented by private mobile MRI services at Royal Lancaster Infirmary and Furness General Hospital and managers were able to increase this provision at times of high demand. The trust core service management team managed outpatients and diagnostic services. The clinical director was also a consultant radiologist.

Diagnostic imaging services were available from 08:15 to 18:00 on weekdays for outpatients and patients referred by their GPs. CT and ultrasound were provided on weekend mornings and MRI scans on weekend afternoons. For inpatients and trauma there was a 24 hour, seven days a week, plain film service. A breast screening service was provided on weekdays. Diagnostic imaging services organised and booked appointments for procedures and follow ups.

Outpatients and diagnostic imaging

Pathology services offered biochemistry, haematology including transfusion and phlebotomy, and microbiology. Histology and immunology were provided by neighbouring acute trusts. The pathology service managed around five million tests a year and the provision and maintenance of all equipment had recently been transferred to a managed service.

Breast services provided screening for the National Breast Screening Programme for patients from areas including Morecambe Bay, North Preston, Blackpool, Fylde and Wyre every day as well as symptomatic breast assessment and treatment clinics on Monday, Wednesday and Thursday each week.

During the inspection at Royal Lancaster Infirmary we spoke with 10 patients, three relatives, and 30 staff, some of whom worked across the three hospital sites, including managers, doctors, nurses, allied health professionals and support staff. We observed the breast service, diagnostic imaging and outpatient environments, checked three paper based patient records and six electronic medical records, equipment in use and looked at information provided for patients. We received comments from people who contacted us about their experiences. We also reviewed the trust's performance data and looked at individual care records and images.

Records we reviewed confirmed that there continued to be a steady increase in demand for outpatients and diagnostic services.

Summary of findings

We rated Outpatients and diagnostic imaging services as 'good' because:

- During our last inspection we identified concerns with the timely availability of case notes and test results in the outpatients department. At this inspection staff and managers confirmed that the trust had reduced the use of paper records and implemented an electronic records system for most outpatient areas. This was still being rolled out across all departments but we found there had been significant improvements in the availability of case notes.
- Since the last inspection we found that there had been some improvements in staffing. CT scanning staff had previously raised concerns about shortage of staff and their access to knowledge and skills competencies. When we inspected this time the department continued to work with vacancies but a new rota system enabled the department to make improvements.
- During our last inspection we noted that there was no information available in the departments for patients who had a learning disability or written information in formats suitable for patients who had a visual impairment. We saw this time that there was a range of information available in different formats and staff had involved the public and groups including vulnerable people in producing information for use by patients.
- The service had previously experienced issues with effective team working and had challenges in building team resilience and communication. We found examples of strong local and senior leadership and staff from all departments commented on management improvements. Staff were proud of opportunities they had been involved in to drive forward service improvements and innovation.
- Outpatient and diagnostic services were delivered by caring, committed and compassionate staff.
- Patients were overwhelmingly positive about the way staff looked after them. Care was planned and delivered in a way that took account of patients'

Outpatients and diagnostic imaging

needs and wishes. Patients attending the outpatient and diagnostic imaging departments received effective care and treatment. Care and treatment was evidence based and followed national guidance. We found that access to new appointments throughout the departments had improved.

- The Breast Screening Service at this hospital had been the subject of an external review by an independent body. During this inspection we observed that recommendations from the review had been implemented and maintained.

However:

- However some staff told us that because of prolonged shortages in staffing they felt stretched with no room for additional work or stresses to the departments.
- Plans to improve the environment in the breast and physiotherapy services were still awaiting implementation. Delays had been due to cost and consideration of better utilisation of existing space.
- There remained a shortage of some staff groups including occupational therapists, radiographers and radiologists. Some CT staff raised concerns about the sustainability of the team under prolonged staffing pressures.
- Some medical staff in breast services remained concerned about team work and in particular 'cross-bay' working. Some staff felt that team leaders lacked sound management skills.
- Some referral to treatment targets in a small number of specialties were missed and follow up appointments continued to suffer backlogs and delays.

Are outpatient and diagnostic imaging services safe?

Good

We rated safe as 'good' because:

- The departments used an electronic system to report incidents. All the staff we spoke knew how to use the system if they needed to. Managers and governance leads investigated incidents and shared lessons learned with staff.
- Outpatient services were located in the main hospital and in smaller departments and buildings spread across the site. Departments were clean and hygiene standards were good. Equipment was checked and calibrated. Staff had enough personal protective equipment in all the areas we inspected and staff knew how to dispose of all items safely and within guidelines. Staff ensured equipment was clean and well maintained, so patients received the treatment they needed safely.
- The trust had reviewed its staffing investment to develop the allied health professional workforce to meet the growing demand for services. Diagnostic imaging were working proactively to train staff to work across modalities and to take on extended roles. National shortages meant that recruitment was difficult but there had been some improvements.
- During our last inspection we had identified some improvements with the timely availability of case notes and test results in the outpatients department. We found there had been sustained improvements following the rollout of the 'Paper Lite' project which ensured that electronic information was available for patients. This project was almost fully implemented and staff were very positive about the improvements in efficiency and effectiveness for outpatient services such as the availability of test results and timely access to information. We also found that improvements in the processes for reporting and learning from incidents were maintained.

- Staff knew the various policies to protect patients and people with individual support needs. Staff asked patients for their consent before treating them. Staff were clear about how to support patients when they lacked, or had changes in, mental capacity
- Staff in all departments knew the actions they should take in case of a major incident.

However:

- We noted that space was limited in some areas and the service provision was physically constrained by the existing environment. The physiotherapy and breast screening unit accommodation were under review by senior management with involvement of the estates department to identify better accommodation or change of use of some of the spaces. Plans were in place to develop space for both services.
- Some work to improve service accommodation across the hospital site had stalled and some was still being planned. Delays had been due to cost and consideration of better utilisation of existing space. Suitability of service premises for breast and physiotherapy remained on the directorate risk register.
- We found that although recruitment had been successful in some areas, there remained a shortage of occupational therapists, radiographers and radiologists.

Incidents

- The departments had systems to report and learn from incidents and to reduce the risk of harm to patients. The trust used an electronic system to record incidents and near misses. Staff we spoke with had a good working knowledge of the system and knew how to report incidents. They also confirmed they had received training in completion incident forms through the online system. Staff were able to give examples of incidents that had occurred and investigations that had resulted in positive changes in practice.
- Never events are serious incidents that are wholly preventable. There were no never events in outpatients or diagnostic imaging between September 2015 and August 2016.
- Root cause analysis was completed by the risk team once an incident had been entered onto the electronic system. Each incident had a 24-hour rapid review before proceeding to a full root cause analysis. Some staff had undertaken risk incident training and team leaders told us there were good links with the risk office at the trust.
- Outpatients and diagnostic services staff attended a patient safety summit which was a meeting held to discuss incidents and root cause analysis. Staff discussed serious incidents at a trust serious incident requiring investigation (SIRI) meeting. The outpatient services reported no serious incidents between September 2015 and August 2016.
- There were 251 reported incidents across the trust in outpatients between August 2015 and July 2016. Three of these were classed as severe, 9 of these were classed as moderate and 218 were classed as low risk or no harm. 21 were classed as near miss incidents.
- We reviewed outpatient meeting minutes from February 2016 and May 2016 and found that patient safety incidents were a standing agenda item at the meetings.
- Managers and staff told us staff were encouraged to report incidents. They received feedback from incidents and learning from incidents through a lessons learnt bulletin and through team brief which was sent out monthly. Managers confirmed they would share lessons learnt as required.
- Clinic staff told us they had reported some incidents in the outpatient department relating to clinicians not being available for clinics. Since clinicians were managed by their specialty directors, staff told us if this happened they would complete an incident form and this would then be sent to the speciality service providing the clinics.
- 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) ofcertain 'notifiable safety incidents'and provide reasonable support to that person. Staff had been trained and were aware of their responsibilities in terms of the Duty of Candour regulations and all staff described an open and honest culture. Staff told us about the policy and procedures they followed including writing letters to patients offering an apology and information regarding incidents and complaints.

Diagnostic imaging:

- There had been three radiological incidents reported under ionising radiation medical exposure regulations

IR(ME)R across the trust for the six-month period between January and June 2015. Managers told us that these were classified by their medical physics expert as low or no harm and were attributed to plain film and CT procedures and all were due to wrong exposure settings by the operator with larger than intended doses of radiation to the patients. The radiation protection adviser (RPA) report included guidance on prevention of recurrences. The department informed patients when unnecessary exposure to radiation had taken place and gave equivalent everyday examples where possible of how much radiation they had received. They ensured that Duty of Candour requirements were met and offered patients the chance to discuss incidents further if they wished.

- Radiology discrepancy incidents were discussed by case review with radiologists and reporting radiographers. Sonographers discussed discrepancies formally in their own meetings. Medical staff took the opportunity to learn and work as a multidisciplinary team with referrers and clinical teams. Outsourcing reporting companies carried out discrepancy and quality assurance reviews as part of their service level agreements (SLA) with the trust.

Cleanliness, infection control and hygiene

- We observed staff in all departments visited adhered to 'bare below the elbow' guidance.
- We saw, and patients reported, that staff washed their hands regularly before attending to each patient.
- Hand Hygiene results between February 2016 and June 2016 showed positive results for all outpatient areas except WGH main outpatients which missed the target of 96% twice. In April 2016 the score achieved was 70% and in June 2016 was 87%. All other areas between February 2016 and June 2016 achieved 100% compliance.
- Main outpatients at the Royal Lancaster Infirmary completion rate for infection, prevention and control mandatory training level 1 and level 2 and aseptic non-touch technique training was 100%. This was above the 95% target set by the trust.
- Personal protective equipment (PPE) such as gloves and aprons was used appropriately in most areas and available for use throughout the departments and, once used, was disposed of safely and correctly. We observed PPE being worn when treating patients and during cleaning or decontamination procedures. All areas had stocks of hand gel and paper towels.
- We saw that treatment rooms and equipment in outpatients were cleaned regularly.
- Staff told us if they had patients with a known infectious disease, they were aware of the process and actions to take. Staff said they would put these patients at the end of the clinic list then deep clean the room.

Diagnostic imaging:

- Diagnostic imaging equipment was cleaned and checked regularly. Rooms used for diagnostic imaging were decontaminated and cleaned after use. Processes were in place to ensure that equipment and clinical areas were cleaned and checked regularly and safely.

Environment and equipment

- The location consisted of multiple buildings spread across the site. Some of the departments were located within the original hospital buildings whilst others were in a purpose built environment. We noted that space was limited in some areas and the service provision was physically constrained by the existing environment. We visited the physiotherapy department in medical one unit which we found still to be cramped for space and in poor state of repair. However, staff and managers told us plans were underway to address cramped conditions by utilizing underused space more efficiently in the Breast Screening department and moving some of the physiotherapy service to another building.
- We saw, and staff confirmed that, there was sufficient equipment to meet the needs of patients within the breast, outpatients and diagnostic imaging departments.
- Staff who held early morning and evening clinics in dermatology explained the trust and local security policy and how they followed it for the safety of staff and patients.
- The Royal Lancaster Infirmary main outpatient department had two electronic check in desks and during our inspection two clinical service workers met and assisted people at reception. There was also a reception desk if patients wanted to check in there.
- The waiting area was tidy and there were enough seats for patients, families and carers. The department had five toilets including one disabled toilet, however the

disabled toilet did not have a call bell. There was a physical measurement room, phlebotomy room with its own small waiting area, eight consulting rooms and a treatment room. The department had a relative's room where patients, families and carers could sit. This room was clean and tidy. There was a specialist nurse room and podiatry room and two small waiting areas in the other parts of the department where patients would be transferred to whilst awaiting their appointment.

- The children's outpatient department was located separately on the main hospital site and there were no paediatric clinics held in main outpatients. However, there were children's areas with toys in the main waiting area and specialist areas. Toys were in good condition and staff told us they were cleaned weekly.
- Audiology held children's clinics and we saw two booths with child sized equipment.
- The dermatology department included two minor operations rooms and a biopsy theatre with a hyfrecator. All rooms had cleaning regimes and fully completed checklists, extraction and ventilation systems, and suction equipment. Staff used only disposable, single use instruments so no decontamination of equipment was required. We saw a completed COSHH assessment for surgical smoke. Staff explained surgical scrub procedures and used surgical face masks and visors.
- We checked the crash trolley in the Ophthalmology department and found the daily check sheet to be mostly completed. We raised the observation of missing signatures during our inspection with managers and they confirmed they would address it at their daily hand over to ensure it was signed daily. The crash trolley had the secure tag attached.
- Other trolleys throughout the departments were all locked and tagged and we saw checklists to show staff made regular checks of contents and their expiry dates.
- All areas we inspected were clean, and most were well maintained. Most areas were spacious and bright. Consulting, treatment and testing rooms were well stocked and equipment labelled as clean was clean.
- Staff told us they had reported the environment at the Ophthalmology clinic as a challenge. There was not enough space to facilitate all services in the clinic. For example there was no separate room for the eye testing corridor which was located next to the waiting area without a door, this reduced confidentiality in the area. Staff informed us during the inspection there were plans to move the department to help solve these issues.
- A previous inspection had highlighted concerns around the environment at the Royal Lancaster Infirmary physiotherapy department. During our inspection we visited the physiotherapy department and managers told us there had been some progression from the previous inspection. Plans were in place to develop a new therapies department in medical Unit 2 and these plans were progressing. A number of physiotherapy services had transferred over to medical unit 2. However, physiotherapy services were still offered in medical unit 1, and concerns regarding the environment remained.
- Equipment throughout the departments was calibrated, maintained and the estates department managed the maintenance contracts. We saw staff completed daily audiology equipment calibration checks and contracted annual external calibration on audiometers and auricle systems. We saw that staff recorded call bell checks in audiology booths weekly.

Diagnostic imaging:

- In diagnostic imaging, quality assurance (QA) checks were in place for all equipment. These were mandatory checks based on the ionising regulations 1999 and the ionising radiation (medical exposure) regulations (IR(ME)R) 2000. These protected patients against unnecessary exposure to harmful radiation.
- Prevous checks by the RPA and medical physics expert (MPE) had identified equipment that was reaching the end of its safe and reliable life and therefore required replacement. The trust had met this need and secured a managed contract for the supply and maintenance of diagnostic imaging equipment and had recently refreshed ultrasound kit across all sites. We observed a handover of equipment for the gamma camera following an urgent repair. We saw the engineer and radiology staff followed trust protocol.
- Staff wore dosimeters and lead aprons in diagnostic imaging areas. This was to ensure that they were not exposed to high levels of radiation and dosimeter audits were used to collate and check results. Results were within the acceptable range.
- The department provided local rules for each piece of equipment and we saw a user guide for each room.

- Risk assessments were carried out with ongoing safety indicators for all radiological equipment, processes and procedures. These were easily accessible to all diagnostic imaging staff.
- Staff in diagnostic imaging were able to demonstrate safety mechanisms to ensure patient doses for radiation were recorded.
- The design of the environment kept people safe. Waiting and clinical areas were clean. There were radiation warning signs outside any areas that were used for diagnostic imaging. Illuminated imaging treatment room no entry signs were clearly visible and in use throughout the departments at the time of our inspection.

Medicines

- Staff told us, and we observed they followed the medicines and storage policy. A hard copy of this was available in the out patients nurse manager's office. The department received a three monthly pharmacy visit and staff told us they checked expiry dates of stock weekly.
- We checked the storage and management of medicines and found effective systems in place. No controlled drugs were stored in the outpatients department. Small supplies of regularly prescribed medicines were stored in locked cupboards and where appropriate, locked fridges. We saw the record charts for the fridges that showed that staff carried out temperature checks daily and temperatures were maintained within the acceptable range. All medicines we checked were in date. Prescription pads were stored securely.
- We visited the Ophthalmology unit at the Royal Lancaster Infirmary and found that the medicines cupboard was secure and locked. Staff told us they rotated stock to ensure medicines were in date. The unit received a regular top up from the pharmacy department. All medicines we checked were in date. We checked the refrigerator temperature check sheet and found this to be mostly completed during between July 2016 and the inspection in early October 2016.
- We saw PGDs (patient group directions) for drugs and contrast agents used in the outpatients and diagnostic imaging departments were in place and had been reviewed appropriately.
- Two specialist nurses in dermatology were nurse prescribers. Senior staff had carried out a nurse prescriber audit in October 2016. They had checked twenty sets of records per nurse and results showed compliance with standard operating procedures for prescriptions, benefits to patients, service improvement and appropriate use of resources.

Diagnostic imaging:

- In the diagnostic imaging department some interventional procedures required sedation and pain relief and these included controlled drugs. These medicines were prescribed and administered by the consultant radiologist carrying out the procedure. All medication used was documented and a controlled drugs book was kept with patients during procedures. Monthly stock checks were made and expiry dates were checked. We saw evidence of dated and signed checklists and drugs we checked were all in date.

Records

- At previous inspections we told the provider they must ensure the timely availability of case notes and test results in the outpatients department. Outpatient departments had experienced difficulties in obtaining patient records in time for clinic appointments. Previous data provided by the trust was 96% availability for outpatient records and 98% for elective inpatients.
- The trust had almost completed the roll out of its 'Paper Lite' project which ensured that electronic information was available for patients. Staff were very positive about the improvements in efficiency and effectiveness for outpatient services such as the availability of test results and timely access to information.
- Case note availability audits were carried out on a monthly basis. Audit data between October 2015 and June 2016 showed that the trust consistently achieved above their set targets of case note availability in outpatients. Data from May 2016 showed that outpatients across the trust had 99.3% of case notes available and data from June 2016 showed that 99.48% of case notes were available.
- In clinics which had not transferred to electronic notes, they still used paper records. Staff and managers confirmed during the inspection that access to records had improved and there were no current concerns with access to records. Administration staff had been trained to scan documents onto the electronic system, thus reducing more paper records.
- Mandatory training compliance for information governance for main outpatients was 100%.

Outpatients and diagnostic imaging

- A notes and stationery room was situated in the main outpatient department. We saw this room was kept locked to secure confidentiality of records. There were no notes left in patient areas. The electronic record system meant that there was no patient information on display and, where recording sheets were used, they were kept face down and away from public view. Patients from A&E carried a small card with their details on and they handed it to staff when they were seen.
- Records contained patient-specific information relating to the patient's previous medical history, presenting condition, demographic information and medical, nursing and allied healthcare professional interventions. Dermatology staff had carried out a note taking audit of 69 phototherapy patient files and all had been found to be meeting the required standards. We reviewed three patient consent forms and WHO surgical safety checklists for patients undergoing biopsy procedures and all were completed correctly.
- We reviewed three paper based and six electronic patient records which were completed with no obvious omissions. Nursing assessments of blood pressure, weight, height and pulse were routinely completed. We observed staff undertaking these checks during our inspection.

Diagnostic imaging:

- Diagnostic imaging records and reports were digitised, stored electronically and available to clinicians across the trust via CRIS (Computerised Radiology Information Sustem) and PACS (Picture Archiving and Communications System).
- Senior staff had undertaken a documentation audit to show radiographer compliance in completion of checks. There was good compliance of ID checks. However, the way this was done by individuals varied so some staff were completing written checks and others were completing electronic checks. It was agreed that all staff must complete an electronic check and staff were found to be 100% compliant. Other points audited were patient pregnancy status, which showed 100% compliance, and image markers which also varied according to the method used but staff were 100% compliant across all methods.

Safeguarding

- Staff could describe the standard procedure they would follow if patients 'Did not attend' on a number of occasions.
- All staff we spoke to were aware of safeguarding policies and procedures and knew how to report a concern. They knew that support was available if they needed it or they had a query.
- Staff we spoke with were able to describe how they would report a safeguarding concern. Staff would report online, contact the safeguarding team and discuss with their manager. Audiology staff told us they had raised a safeguarding concern when a parent was aggressive towards their child in the clinic. They reported the incident on the electronic reporting system and also informed the health visitor of the family. The information was shared amongst the audiology team to ensure all staff were aware of the incident because the child was a regular attender.
- Staff in outpatients were required to have safeguarding level 2 training. In Ophthalmology, staff were required to have safeguarding level 2 training and the safeguarding link nurse for the department had safeguarding level 3 training for adults and children.
- Main outpatient safeguarding adults core skills level 2 compliance rates were 97%. Safeguarding children and young people core skills level 2 compliance was 100%. Safeguarding adults and children core skills level 1 compliance was 100%.

Diagnostic imaging:

- In diagnostic imaging; trust records showed that 96% of staff had completed level 1 safeguarding adults and children training, 98% had completed level 2 and 100% had completed level 3.

Mandatory training

- The trust provided information on mandatory training compliance rates and the mandatory training target was 95%.
- Some compliance rates fell below the trust target; Departmental fire safety awareness compliance was 90.3%. Compliance for resuscitation and basic life support was 90% and conflict resolution compliance was 88%. However, equality and diversity, health, safety and welfare, and information governance training all met or exceeded the trust target:

Outpatients and diagnostic imaging

- Staff we spoke with confirmed they had attended mandatory training. Managers had access to an online system to identify staff mandatory training completion rates and would use this system to ensure staff had completed or were booked on mandatory training.
- At our last inspection some staff told us accessing e-learning had practical difficulties as it was located on the intranet. Staff needed to access it through computers in the department, which was not always possible. We also found that staff in the orthopaedic clinic had not completed any recent updates due to pressure of workload and staffing levels. However, at this inspection staff reported no difficulties in accessing computers for e-learning or the time to complete modules at this inspection.

Diagnostic imaging:

- Compliance with mandatory training in radiology ranged from 88% to 99% except for resuscitation and basic life support training which was 80%. Staff told us that there was currently no booking facility for this course and staff were waiting for a course to be made available.
- Infection control mandatory training compliance was 91% compliant and information governance was 94% compliant.

Assessing and responding to patient risk

- Staff were able to describe the action they would take if a patient deteriorated in their care in the department. Dependant on the deteriorating patient situation, staff would carry out clinical observations, contact the doctor and call the crash team for an urgent response if required.
- Audiologists told us they had completed BLS (basic life support) and PLS (paediatric life support).
- Staff told us they would debrief after a patient had deteriorated in the department and complete an incident form. This would then be sent to the patient safety summit. Feedback was provided by senior managers when this occurred.
- The Ophthalmology clinics completed triage for casualty patients. The clinic received a referral and a registered nurse would triage the referral using a grading system to assess and determine the risk. The referral grading guidelines were emergency, urgent and routine. Slots were kept available daily for casualty patients who required urgent treatment. Casualty clinics ran daily in the afternoon.
- Staff incorporated assessment tools into patient pathways, following protocols, standards and NICE guidance. Examples of these were for the assessment and management of psoriasis, and audiological assessment and calibration.
- At previous inspections we found that the trust had experienced issues with appointment bookings. At our last inspection we found that patients' safety was being monitored on a regular basis in relation to delays in accessing appointments. An outpatient improvement group had been convened to monitor and implement improvements in the management of patient appointments.
- Data we collected at this inspection showed there were no delays in providing appointments for patients using the booking system. Staff and patients we spoke to had experienced no delays.

Diagnostic imaging ;

- Diagnostic imaging policies and procedures in the diagnostic imaging department were written in line with the Ionising Radiation (Medical Exposure) 2000 regulations. IR(ME)R to ensure that the risks to patients from exposure to harmful substances were managed and minimised.
- The Radiation Protection Advisor (RPA) and medical physics expert (MPE) were contracted from an NHS Trust in Manchester to support all trust sites. The RPA visited twice a year and the medical physics expert visited each site once every two weeks.
- There were named certified Radiation Protection Supervisors (RPS) on each site to give advice when needed and to ensure patient safety at all times.
- Two senior consultant radiologists were Administration of Radioactive Substances Advisory Committee **(**ARSAC) certificate holders for diagnostic imaging. One was based at Royal Lancaster Infirmary and the other at Furness General Hospital.
- Arrangements were in place for radiation risks and incidents defined within the comprehensive local rules. Local rules are the way diagnostics and diagnostic imaging work to national guidance and vary depending on the setting. Policies and processes were in place to

identify and deal with risks. This was in accordance with (IR(ME)R 2000). Local rules for each piece of radiological equipment were held within the immediate vicinity of the equipment.

- Staff asked patients if they were, or may be, pregnant in the privacy of the x-ray room. Therefore preserving the privacy and dignity of the patient. This was in accordance with the radiation protection requirements and identified risks to an unborn foetus. We saw different procedures were in place for patients who were pregnant and for those who were not. For example patients who were pregnant underwent extra checks.
- Diagnostic imaging used the WHO safer surgical checklist for all interventional procedures.

Allied Health Professionals Staffing

- At previous inspections we had told the trust that it should review its staffing investment to ensure that the allied health professional workforce was developed to meet the growing demand for services. The trust had been successful in recruiting occupational therapists. This ensured that patients had access to specialist occupational therapy staff on the acute and short stay wards.
- Physiotherapy outpatients had a planned staffing establishment of 4whole time equivalent (WTE) staff (three qualified and one non-qualified), and an actual staffing establishment of 24.3 WTE (16 qualified and 7.3 non-qualified, plus one admin) staff.
- Occupational therapy outpatients had a planned staffing establishment of 0.9 WTE staff and an actual staffing establishment of 0.9 WTE staff.
- Dietetics outpatients had a planned staffing establishment of 1.0 WTE and an actual staffing establishment of 4.5 WTE staff.
- There were no current vacancies for audiologists.

Diagnostic imaging :

- At the time of our inspection, within the diagnostic imaging departments, there were sufficient radiographers, clinical support workers, and nursing staff to ensure that patients were treated safely. There were current vacancies and these were being recruited to. However, some staff told us they felt stretched in terms of increases in shifts allocated and on-call requirements but they were meeting the needs of the service. Staff from some teams told us they felt they did not know how much longer they could continue to work at this rate.
- Managers told us they were supportive of staff and planned to recruit more qualified radiographers to support a new shift system. Staff we spoke with were able to corroborate this.
- There had been difficulties in recruitment of qualified radiographers in the past and managers told us these were improving slowly. This was in line with the national picture regarding radiographer recruitment.
- Managers were carrying out succession planning whereby current junior and general radiology staff were undergoing training to specialise in modalities including CT and ultrasound.
- The trust had trained four radiographer advanced practitioners and a consultant radiographer who all reported general radiology images. There were two more advanced practitioners in training and another who was extending their current remit. Managers were aware that radiographer training was helping to reduce the burden on radiologists but it affected the radiographer numbers and further staff were required to backfill as staff qualified in advanced roles.
- Sonographers provided on call cover 24 hours a day and worked at the opposite main site to the on call radiologist. Sonographers reported their own ultrasound scans at the time of each procedure. The trust had recently appointed a lead sonographer and refreshed ultrasound kit across all sites.
- Due to the shortage of sonographers the trust had looked at development of knowledge and experience of existing staff and had appointed a scanning midwife into a sonographer role.
- Advanced practitioners undertook fluoroscopy including hysterosalpingograms, barium swallows and video fluoroscopy in corroboration with speech and language therapists (SALT) to identify swallowing problems for stroke patients. CT radiographers undertook CT colon imaging.
- Radiology managers told us they outsourced some radiographer reporting. An external company provided a radiographer who worked on a sessional basis on site to

report a wider range of examinations. As with outsourced radiologist reporting, there was a service level agreement and contract including quality assurance measures.
- Recruitment of new graduates had resulted in offering posts to four previous students but only one had accepted a radiographer post.
- Data provided by the trust showed the radiology staff absence rate at RLI was 1.72%.

Breast screening:

- Radiographers undertook mammography and advanced practitioners reported mammograms.
- Data provided by the trust showed the mammography staff absence rate at RLI for national screening programme staff was 2.87% for screening staff in Sept 16, and 3.19% for all mammography staff.

Nursing staffing

- At previous inspections we told the provider that they must ensure staffing levels and skill mix in all clinical areas were appropriate for the level of care provided. At this inspection department managers told us they regularly reviewed staffing and used an electronic tool to manage staffing throughout the clinics and services. There was no fixed staffing establishment for each day in main outpatients. However we were told staffing was flexible in order to meet the clinic needs.
- Data provided by the trust showed that, in May 2015, the sickness rate for outpatient staff at RLI was 6.5% and at this inspection the absence rate for main outpatients at RLI and Queen Victoria Hospital had reduced to 4.52%.
- The trust provided a staffing report from August 2016 showing that the establishment was 29.04 whole time equivalent staff and there were actually 28.99 whole time equivalent staff in main outpatients at the Royal Lancaster Infirmary and Queen Victoria Hospital.
- Managers told us there were no staff vacancies in main outpatients at the Royal Lancaster Infirmary and there were currently no concerns regarding staffing levels.
- Dermatology had 17 nurses in post with two new part time vacancies where staff had reduced hours and moved internally into another role.
- Ophthalmology clinic staffing was described as 'ok at the moment'. Managers told us there were no staffing concerns. There were no nurse vacancies and only a few part time hours in other staffing groups vacant.
- Outpatients did not use agency staff and rarely used bank staff to fulfil staffing requirements.

Diagnostic imaging:

- There were two specialist nurses to support interventional radiology procedures. One nurse sometimes travelled to Furness General Hospital to support staff with clinical skills training, as opposed to supporting clinical sessions.
- Clinical support workers moved between modalities to provide help and support to staff and patients where required.

Medical staffing

- Medical staffing was provided to the outpatient department by the various specialties that ran clinics. Medical staff undertaking clinics were of all grades; however we saw that there were consultants available to support lower grade staff when clinics were running.
- Outpatients did not use locum staff.

Diagnostic imaging:

- At our last inspection we told the trust they should consider its investment into the diagnostic and imaging services to respond to increased demand. Radiologist vacancies were identified on the divisional risk register as a high risk and there were ongoing vacancies within the radiology service. There was a continuing national shortage of radiologists and managers told us by the time of this inspection the trust had an establishment target of 19 WTE consultant radiologists. The trust had been able to fill three consultant vacancies so there were now 13 consultants in substantive posts. However, another 5.5 WTE vacancies remained. The trust had appointed an associate specialist and there were four part time locums.
- At the time of this inspection there were sufficient staff to provide a safe and effective service. Managers stressed that the establishment figure had been set some years ago and did not account for increased capacity and demand for radiology services so they estimated that the service would require more consultants now and in future.
- Data provided by the trust showed the radiologist absence rate at RLI was 1.18%.

Outpatients and diagnostic imaging

- There were no specialist radiology trainees. The trust had lost accreditation with the North West Deanery in recent years but radiologists told us they had won this back in the last year.
- A trust-wide duty radiologist role had been introduced with radiologists covering one 24-hour shift in every 16. All clinicians across the trust were encouraged to contact the person identified on the rota by telephone or email for advice and guidance rather than approaching individuals in person. This was a relatively new initiative and not all trust clinicians were compliant. However, staff told us it was reducing interruptions and improving the service to trust clinicians and patients.
- Radiology managers told us they used consultants with honorary contracts to provide reporting cover for nuclear medicine, head and neck and general radiology images. They also described a 'stable locum radiologist cohort' who supported the departments on a regular basis.
- Diagnostic imaging reporting out-of-hours was outsourced from 22:00 to 08:00. It was provided by one supllier. The trust sent elective work to four companies on the NHS Framework for elective/routine/outsourcing. There were service level agreements and contracts including quality assurance measures in place for these. Around 26% of plain film, 15% of CT, and 26% of MR work was outsourced, and 51% of nuclear medicine was reported by an external radiologist, who provided reporting sessions to the trust.

Breast screening:

- Breast services were managed in a self-contained unit. Staff here told us staffing issues had continued after our last inspection but most were now resolved. Staff we spoke with all told us that they felt supported.
- There were 11.65 WTE substantive radiologists and two vacant posts. Locums were used to fill the vacant sessions. Most consultant radiologists for the breast services worked across all sites. Some cross-sectional image reporting and out of hours work was outsourced. Radiographer advanced practitioners reported the first viewing of non-symptomatic mammograms and second reporting of mammograms was completed by radiologists.
- Staff told us they felt there were sufficient breast screening radiologists to meet the needs of the service.

Major incident awareness and training

- Managers in main outpatients told us the action they would take if there was a major incident.
- Staff told us during a major incident they would report to the major incident room and await further instruction.
- Serious flooding had occurred in recent years and staff told us the major incident plan had been thoroughly tested. Generators had worked well and when mobile phone masts came down the trust used social media and local radio to convey messages about the availability of services. Staff told us they had learned from previous incidents and had confidence in the plans.
- Staff told us they had access, and we saw links, to the Trust wide Business Continuity Management Policy, code of practice and specification. Business continuity plans detailed interdependencies between departments and other services on site.

Diagnostic imaging:

- At a previous inspection we reported that staff did not know their role in the event of a major incident. Staff had taken part in a practice evacuation in the days before this inspection. Managers and staff told us they understood their roles and responsibilities and the exercise had been successful.
- Managers told us if the PACS system was unavailable images could be saved to CD to be transported with the patient or clinicians could visit the department to view x-rays directly on the imaging equipment.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

CQC does not currently rate effectiveness for hospital outpatient and diagnostic imaging services. We found that:

- Clinics in main outpatients were well managed and organised and staff were able to plan resources effectively.
- Staff understood about consent and followed trust procedures and practice.

Outpatients and diagnostic imaging

- Outpatient clinics ran every weekday and some specialist clinics were held each Saturday. Care and treatment was evidence-based and staff followed national guidelines to provide best practice for patient care. Staff were competent and multidisciplinary teams met regularly across a range of services, local networks and specialties, and included both medical and non-medical staff.
- Staff felt supported by their line managers, who encouraged them to develop and improve their practice. The departments supported staff who wanted to work more efficiently, be innovative, and try new services and treatments.
- At a previous inspection staff had raised concerns about their competencies in CT scanning, due to their rotation into this area being stopped by staff shortages. We noted managers had developed a new rota to ensure CT was staffed safely and effectively and staff training opportunities had been developed.
- Staff undertook regular departmental and clinical audits to check practice against national standards and to improve working practices.
- Staff worked well together as a productive team and had a positive and motivated attitude.

Evidence-based care and treatment

- A clinical audit 2016/2017 programme was in place and documented diagnostic imaging planned audits and other speciality audit plans such as pathology and audiology.
- Outpatients could describe examples of protocols they had access to, for example venepuncture protocols.
- Clinicians used multidisciplinary team (MDT) meetings to share experiences and bring specialty teams' attention to themes arising within the trust, regionally and nationally, national audit projects and best practice guidelines.
- Staff told us and we observed protocols, standards, best practice and NICE guidance was available to staff via the trust's intranet.
- Clinicians and nurses we spoke with told us they followed NICE guidelines and described examples in audiology, dermatology and ophthalmology.
- Dermatology staff carrying out minor operations and biopsies completed w WHO surgical checklist for every procedure.

Diagnostic imaging:

- We saw reviews against IR(ME)R regulations and learning disseminated to staff through team meetings and training.
- The trust had a radiation safety policy in accordance with national guidance and legislation. The purpose of the policy was to set down the responsibilities and duties of designated committees and individuals. This was to ensure the work with Ionising Radiation undertaken in the Trust was safe as reasonably practicable.
- The trust had radiation protection supervisors for each modality to Lead on the development, implementation, monitoring and review of the policy and procedures to comply with Ionising Radiation (Medical Exposure) 2000 regulations. IR(ME)R.
- National Institute for Health and Care Excellence (NICE) guidance was disseminated to departments. Staff we spoke with were aware of NICE and other specialist guidance that affected their practice.
- Procedures were in place to ensure the diagnostic imaging department were following appropriate NICE guidance regarding the prevention of contrast induced acute kidney injury.
- Consultant radiologists told us and management staff confirmed they used a WHO checklist for every interventional radiology procedure. Staff had carried out an audit to check compliance with the checklist and found that all procedures underwent a check. However not all checklists were fully completed. A re-audit was planned to be carried out in the following months.
- The departments were adhering to local policies and procedures. Staff we spoke with were aware of the impact they had on patient care.
- The diagnostic imaging department carried out quality control checks on images to ensure that the service met expected standards.

Pain relief

- Simple pain relief medication was administered by staff in the outpatients department if required for minor operations such as removal of skin lesions in dermatology. Records were maintained to show medication given to each patient.
- Patients we spoke with had not needed pain relief during their attendance at the outpatient departments.

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

Nutrition and hydration

- Water fountains were provided for patients' use and there was a café staffed by volunteers where people could purchase drinks and snacks.
- We observed staff offering and providing patients with drinks and snacks when they waited for extended times within the department.

Patient outcomes

- Between April 2015 and March 2016, the follow up to new rate for the Royal Lancaster Infirmary was similar to the England average.
- The trust measured the percentage of patients waiting over 30 minutes to see a clinician as 12% and the average length of time patients waited in the department was measured by the trust as 37 minutes.
- After receiving care and treatment, patients were either given another appointment or provided with information about the follow-up appointment process.
- The outpatient departments participated in audits such as hand hygiene, cleanliness and record keeping. Results were collated on departmental dashboards.
- On the day of our inspection a trust wide audit day was in action when staff from the three trust locations met together to take part in clinical audit presentations and learning. We were told and records showed that this was a regular diary commitment to ensure that opportunities for audit were in place across all the trust locations.

Diagnostic imaging:

- All diagnostic images were quality checked by radiographers before the patient left the department. National quality standards were followed in relation to radiology activity and compliance levels were consistently high.
- Diagnostic reference levels (DRLs) audits took place to ensure patients were being exposed to the correct amount of radiation for an effective, but safe scan for each body part and these showed appropriate exposure levels. We saw reports to show radiation protection supervisors collated results and reported them to all staff through team meetings.

Breast screening:

- Radiographer advanced practitioners had devised a 'film reading to consensus' form to help highlight the need for further assessment or patient recall following reporting of mammograms. The team held consensus meetings every weekday and had developed Plan, Do, Study, Act (PDSA) review cycles to ensure patient recalls took place when necessary.

Competent staff

- There were systems within departments to make sure that staff received an annual appraisal. Staff had regular appraisals each year and these were used to identify the learning needs of staff. Appraisal rates at the Royal Lancaster Infirmary were low with 71% of outpatients staff having had an appraisal, however managers confirmed these were booked in.
- Clinical supervision of staff in the past was not formally completed and managers had confirmed they were aware of this and could describe the future plans of embedding the proposed trust clinical supervision policy into the outpatient department. At this inspection dermatology staff provided evidence of minutes and notes taken at weekly teaching sessions and formal group clinical supervision. Each group session took four cases and discussed these in line with national guidelines, journal publications and research.
- Audiology staff we spoke with told us they took part in six-monthly appraisal and supervision activities. Audiologists told us they had completed a BSC degree in audiology accredited by the Royal College of Clinical Physiologists. They completed a CPD portfolio and renewed competencies annually. Staff told us that hearing aid manufacturers provided additional staff training.
- Staff we spoke with had undertaken additional training where required and felt managers would be supportive if training was requested. An example of further training undertaken in the outpatient department was for clinical support workers to carry out phlebotomy; a competency pack was completed and signed off when complete. Managers told us staff would receive re-training if a number of incidents had occurred.

Outpatients and diagnostic imaging

- Staff in ophthalmology had received additional training at a local university in theory and practice of ophthalmic nursing care. Staff told us they were offered training and courses were available in the Ophthalmology department.
- The trust were supporting staff in their revalidation using an electronic system which allowed registered nurses to document what training they had completed. This system allowed staff to see what they had completed and included a 'what you learnt' section.
- Outpatient managers considered the skill mix of staff in main outpatients. Different staff grades would work in different clinics depending on the clinic type. Clinical support workers assisted in the role of patient flow coordinator in the department. Support staff in main outpatients completed competencies as part of their assistant practitioners' course. Outpatients senior nurses told us support staff carried out responsibilities within their areas of competency.
- There were link roles available in the department, for example there was a link nurse for safeguarding, aseptic non touch technique and a dementia champion in the outpatients department.
- Nursing staff were invited to attend chief nurse development days twice a year. Topics for the latest sessions included patient speakers on their experiences and key speakers on specialist subjects eg sepsis.

Diagnostic imaging:

- Managers told us new staff were timetabled as supernumerary for their first two weeks to allow for a full local induction. No new staff undertook out of hours working until they had completed a preceptorship programme.
- The majority of staff we spoke with confirmed that they received one-to-one meetings with their managers on a monthly basis, which they found beneficial. Appraisal rates provided by the trust for diagnostic imaging were 67%. However, at RLI they were only 58%. Managers told us staff not yet completing an appraisal had been identified and this would be completed before the end of the financial year. The use of appraisals is important to ensure staff have the opportunity to discuss their work load and any development needs or support required to help them carry out their role.
- Newly qualified radiology staff were assessed against radiology preceptorship competencies and medical devices training was provided for new and existing staff. Staff were supported to complete mandatory training, appraisal and specific modality training.
- Students were welcomed in all departments. Radiography students came for elective placements and managers told us they regularly recruited new graduates from their student cohorts.
- The department provided local rules and MRI safety training trust-wide for medical and non-medical referrers.
- Radiographers were trained to use each piece of new equipment by applications specialists from suppliers.
- At a previous inspection staff had raised concerns about their competencies in CT scanning, due to their rotation into this area being stopped by staff shortages. Staff shortages across the department had been identified on the trust's risk register. We noted managers had developed a new rota to ensure CT was staffed safely and effectively and staff training opportunities had been developed. Recruitment of new staff and specialty training of existing staff was helping to make gradual improvements in this service.

Multidisciplinary working

- A range of clinical and non-clinical staff worked within the outpatients and diagnostic imaging departments. Staff were observed working in partnership with a range of staff from other teams and disciplines, including volunteers, radiographers, therapists, nurses, booking staff, and consultant surgeons. Examples of this included:
  - a one stop breast clinic at the breast screening service included nurse specialists who could work with a consultant, outpatient registered nurses and diagnostic imaging staff.
  - A one stop prostate clinic included nuclear medicine procedures and urology and head and neck clinics were run with ultrasound support.Ophthalmology outpatients offered nurse led clinics in some areas, for example there were nurse led clinics for visual fields.
- Outpatients offered a number of minor surgery clinics across specialities and managers told us that they could refer to external services such as electronic district nursing notes as necessary.

Outpatients and diagnostic imaging

- We saw that the departments had links with other departments and organisations involved in patient journeys such as GPs, support services and therapies.
- Staff were seen to be working across specialties, directorates and trust sites towards common goals. They asked questions and supported each other to provide the best care and experience for the patient.
- Letters were sent out by the outpatients department to people's GPs to provide a summary of the consultation and any relevant treatment management plans.
- Dermatology outpatients held weekly teaching sessions that included doctors and nurses with support from administrative staff to keep minutes records of outcomes for cases discussed by the team.
- Specialty multidisciplinary team (MDT) meetings were attended by staff from the specialist clinical areas and outpatients department including nurses, consultant leads and radiologists. These meetings were held weekly and the teams discussed management plans as well as case reviews and sharing of best practice. Consultants told us these were well attended and had an educational value for everyone.

Diagnostic imaging:

- Staff told us that non-medical referrers included community MSK (musculoskeletal service) physiotherapists and community specialist nurses.
- Staff told us that an overnight on-call radiographer provided good support to staff referring patients for procedures.

Breast screening:

- Breast screening MDT working included internal daily consensus meetings with radiographers. The team had developed PDSA (plan, do, study, act) mini cycles to embed agreed protocols such as a new vacuum assisted biopsy (VAB) procedure.
- Consultant breast radiologists carried out two-weekly and monthly MDT meetings with breast surgeons. These included joint audit, communications, governance and operational meetings.

Seven-day services

- General outpatient clinics were offered between 08:30 and 17:30 Monday to Friday . Specialist clinics provided additional sessions. Examples of these included:
  - Dermatology drop in clinics were provided on weekdays from 7 am to 7 pm.
  - The Ophthalmology clinic opened 7 days a week. 8am to 8pm on Monday, Tuesday and Wednesday. On Thursday and Friday the clinics were open 8am to 6pm.
  - Casualty appointments were also provided between 9:30am and 3pm on Saturday and Sunday.
- Managers displayed volunteer sheets for extra capacity clinic staffing with skill mix requirements noted. Staff could volunteer for extra shifts and were paid bank staff rates.

Diagnostic imaging:

- Diagnostic imaging services including plain film, CT, MRI and ultrasound were available 24 hours seven days a week for trauma and inpatients with an on call radiographer and radiographer helper on site providing overnight cover and a second on-call available if necessary.
- Outpatients and GP patients could attend for x- rays 5 days a week and some additional lists were added on Saturdays when demand increased.

Access to information

- All staff had access to the trust intranet to gain information relating to policies, procedures, NICE guidance and e-learning.
- Staff told us they could access easy to follow equality and diversity links, guidance and tools to support patient care through the trust intranet.
- Diagnostic results were available through the electronic system used in main outpatients and staff with login access could view results as required.
- Staff told us the audiology department had invested in new audiometers that uploaded the results of hearing tests direct to the electronic records system. Staff said they scanned tympanometry results to the same system.

Diagnostic imaging:

- Diagnostic imaging departments used picture archive communication system (PACS) and computerised radiology information system(CRIS) to store and share images, radiation dose information and patient reports. Staff were trained to use these systems and were able to access patient information quickly and easily. Systems

were used to check outstanding reports and staff were able to prioritise reporting so that internal and regulator standards were met. There were no breaches of standards for reporting times.

- The diagnostic imaging department kept an electronic list of approved referrers and practitioners. This ensured that all staff, both internal and external, could be vetted against the protocol for the type of requests they were authorised to make. During our inspection a radiographer raised a query about an unknown referrer and the manager worked with them to establish that the referral could be accepted. They added the doctor to the list of referrers.
- Orthopaedic surgeons used image intensifiers in theatres with protocol in place to support and monitor these. Radiologists advised surgeons on safe practices regarding IR(ME)R regulations.
- There were systems in place to flag up urgent unexpected findings to GPs and consultants. This was in accordance with the Royal College of Radiologist guidelines.
- Diagnostic results were available through the electronic system used in the department. These could be accessed through the system available in clinics.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us they had an understanding of the mental capacity act from the safeguarding course they were required to attend. Staff in Ophthalmology could describe when they use verbal consent and staff would contact the safeguarding lead for advice on MCA and DoLS. Staff told us there was MCA 2005 guidance on the ward.
- Staff were able to describe when they would use verbal consent and told us consent forms completed would be uploaded to their electronic system.
- Mental capacity act training and deprivation of liberty safeguards training was covered in the trust safeguarding training.
- Nursing, diagnostic imaging, therapy and Medical staff understood their roles and responsibility regarding consent and were aware of how to obtain consent from patients. They were able to describe to us the various ways they would do so. Staff told us that, consent was usually obtained verbally although consent for any interventional radiology was obtained in writing prior to attending the diagnostic imaging department.
- Consent forms were in use in main outpatients, for example for dermatology minor procedures or tonsillectomies. Written consent forms were scanned onto the electronic system.
- At a previous inspection, staff had reported that they had received training in the Mental Capacity Act 2005. However, at that time we found during our discussions with them that their knowledge was variable and some staff could not demonstrate a sound knowledge of the principles inherent within the legislation. During this inspection, staff in outpatients and diagnostic imaging services, including administrative staff, told us they had undertaken Mental Capacity Act and Deprivation of Liberty Safeguards training. Staff we spoke with told us they had a good understanding, including the implications of their role and responsibilities that would result from a patient's lack of mental capacity and the support that may be indicated as a result. Staff were able to provide examples of how they had identified mental capacity problems and actions they had taken to mitigate risks to such patients. They told us if any queries or problems arose in the outpatient setting they would contact the named leads within the trust for advice.
- Patients told us that staff were very good at explaining what was happening to them prior to asking for consent to carry out procedures or examinations.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring as 'good' because:

- During the inspection, we saw and were told by patients, that the staff working in the outpatient and diagnostic imaging departments were kind, caring and compassionate at every stage of their journey and patients were given sufficient time for explanations about their care and were encouraged to ask questions.

Outpatients and diagnostic imaging

- People were treated respectfully and their privacy was maintained in person and through actions of staff to maintain confidentiality and dignity.
- Patients we spoke with were overwhelmingly positive about the way staff looked after them. Care was planned and delivered in a way that took account of patients' needs and wishes.
- There were services to emotionally support patients and their families. Staff were trained to identify when people needed emotional support with their care. Staff reacted compassionately to patient discomfort or distress and to suit individual needs. Staff involved patients by discussing and planning their treatment and were able to make informed decisions about the treatment they received.
- The trust had a number of clinical nurse specialists and lead nurses available for patients to talk to about their condition. There was access to volunteers and local advisory groups to offer practical advice and emotional support to patients and carers..

Compassionate care

- Staff in outpatients and diagnostic imaging were caring and compassionate to patients. We observed positive interactions with patients. Staff approached patients and introduced themselves, smiling and putting patients at ease. Staff from all departments we visited gave examples of how they had gone out of their way to provide for care for patients. One example was from the administration team who had hand delivered letters and preparation for urgent diagnostic imaging appointments.
- An intermittent fire alarm sounded throughout the departments during our inspection. We observed staff talking to patients and putting them at ease, explaining what the alarm meant. The lead nurse left us for a few moments to help a patient in a wheelchair find somewhere to wait away from the main thoroughfare.
- Clinic names were not displayed in order to maintain privacy and confidentiality.
- Patients' privacy and dignity was respected by staff. Consultation and treatment rooms had solid doors and patients could get changed before seeing a clinician. Staff were observed to knock on doors before entering and doors closed when patients were in treatment areas.
- We spoke with 10 patients and three people close to them and all said that staff were friendly with a caring attitude. There were no negative aspects highlighted to us.
- We observed staff behaving in a caring manner towards patients they were treating and communicating with and respecting patients' privacy and dignity throughout their visit to the department. However, diagnostic imaging had no dedicated porters and staff could not influence the transport of inpatients to and from wards and we saw patients waiting on beds and trolleys in public areas and corridors during our inspection.
- Comments from the friends and family test survey were shared with staff at staff meetings and results showed 86.4% of patients were likely to recommend friends and family to the outpatient service in September 2016. This was worse than the England average of 92%)
- Friends and family test data for the physiotherapy departments were positive. Medical unit 1 achieved 91.7% of patients that would recommend the service and medical unit 2 achieved 94.7% of patients that would recommend the service.
- Staff told us they would check that patients understood what had been said in the clinics and would support patients, families and carers during clinics.
- On a previous inspection we had observed and the trust data confirmed that some patients were told to expect results by telephone. Staff described examples of how they had given difficult messages to patients and those close to them both sensitively and privately. The departments had set aside quiet rooms where staff, including specialist nurses, could discuss results or share bad news face to face. This ensured patients could access emotional support in a timely manner.
- Managers told us a hearing loop was available in the main outpatient department and could be used if required. Staff had access to interpreter services and staff would usually organise a deaf interpreter before an appointment if possible. Chaperones were available to patients in all departments we inspected.

Understanding and involvement of patients and those close to them

- Patients told us that they were involved in their treatment and care. Those close to patients said that they were kept informed and involved by nursing and

medical staff. All those we spoke with told us that they knew why they were attending an appointment and had been kept up to date with their care and plans for future treatment.

- Outpatients and diagnostic imaging staff involved patients in their treatment and care. We saw staff explaining treatment. We observed examples in outpatients and diagnostic imaging where staff gave patients and families time and opportunities to ask questions.
- Clinical support workers frequently checked the entrance areas of clinics and radiology reception to greet people and assist them where required. Staff we spoke with described examples where they would provide further support to patients if required.
- If clinics were running late, the trust provided patients with a voucher which they could take to the canteen and get a packed lunch and drink. Staff would also offer drinks and incident report the occurrence if it related to transport delays.
- Outpatient services had developed 'next step' cards and these were provided to patients in clinics and provided further contact information on who to contact if they had further questions or enquiries.

Emotional support

- We observed volunteers greeting patients and visitors to the department to ask if they needed help or directions.
- Patients told us that they felt supported by the staff in the departments. They reported that, if they had any concerns, staff offered explanations or signposted them to services for advice and information.
- Staff made sure that people understood any information given to them before they left the departments. Emotional support for patients was available. For example, specialist nurses worked with the clinical teams in the breast services department and were present for extra support when patients received bad news.

Are outpatient and diagnostic imaging services responsive?

Good

We rated responsive as 'good' because:

- The trust provided a range of specialist clinics and cancer screening services for patients in the North West including Lancashire and Cumbria.
- We found that outpatient and diagnostic services were responsive to the needs of patients who used the services. Extra clinics and imaging sessions were added to meet demand and waiting times for diagnostic imaging appointments were within acceptable timescales. Patients were able to be seen quickly for urgent appointments if required.
- Clinics and related services were organised for some specialties so that patients were only required to make one visit for investigations and their consultation. Clinic and imaging appointments were rarely cancelled .
- The Trust met most referral to treatment targets (RTT) in most specialties.
- Reporting times for urgent and non-urgent procedures consistently met national and trust targets for all scans and x-rays for inpatients and outpatients.
- There were also systems to record concerns and complaints raised within the department, review these and take action to improve patients' experience.
- During our last inspection we noted that there was no information available in the departments for patients who have a learning disability. At this inspection staff told us, and gave examples of how they made sure services could meet patients' individual needs, such as for people living with dementia, a learning disability or physical disability, or those whose first language was not English.
- The outpatient and diagnostic imaging departments were able to access telephone translation services, interpreters via the booking service in the contact centre and sign language specialists for patients.
- The departments recorded concerns and complaints, which they reviewed and acted on to improve patient experience.

However:

- There were some specialties where the 18 week referral to treatment targets (RTT) were not always achieved and some backlogs for follow up waiting times.
- The diagnostic imaging service had breached six week wait targets for outpatients in specialist MRI services.

Outpatients and diagnostic imaging

- Portering services at Royal Lancaster Infirmary were managed centrally and did not suit patient needs in diagnostic imaging. Staff had difficulty ensuring patients were in the right place at the right time for their procedure. Staff could not influence the transport of inpatients to and from wards and we saw patients waiting on beds and trolleys in public areas and corridors during our inspection.
- During our last inspection we noted that the trust needed to improve the waiting times for patients once they arrived in the department. At the time of this inspection information provided by the trust showed that 12% of patients waited longer than 30 minutes to see a clinician once in clinic and 19.6% of clinics started later than planned.

Service planning and delivery to meet the needs of local people

- The trust served a mixed rural and urban geographical area of 1000 square miles. The trust's outpatient and diagnostic imaging services were located throughout the geographical area to facilitate access to clinics and reduce travel times for people using the services.
- Clinics were booked 52 weeks a year and the outpatient department had access to a room booking service which allowed them to monitor which rooms were available and book extra rooms for extra clinics if required.
- Outpatients offered some clinics via video conferencing and were proposing to introduce this further.
- Between April 2015 and March 2016, the 'did not attend rate' for the Royal Lancaster Infirmary was similar to the England average.
- Information leaflets were available in Ophthalmology, there were several information leaflets designed for the visually impaired and staff confirmed they could request larger print if required.
- Telephone assessments were in place in the Ophthalmology clinic for some conditions. However, staff would request patients came to clinic for their consultation if the condition was complex.
- There were two bariatric waiting room chairs in main outpatients.
- Text reminders were not in place for appointments at the trust, however staff told us the trust were looking into introducing text reminders to patients.
- Services were planned in line with regional commissioning plans and the service senior managers produced an annual business plan from the trust 5 year plan.
- The outpatients department flexed capacity and staffing to meet demand. Extra clinics were added to ensure provision met demand.
- Clinical nurse specialists were available and led a range of clinics.
- Clinics were organised to meet patients' needs. Some specialist one-stop clinics were organised so that all investigations and consultations happened on the same day. Clinicians, nurses and therapists carried out joint assessments and treatment and regular Saturday morning clinics were scheduled to reduce waiting times for new and follow up appointments.
- Staff meetings were held first thing in the morning to plan for the day ahead. Teams discussed each clinic taking place and highlighted concerns such as patient numbers or cancellations.
- Managers told us that the trust were exploring moving more outpatient sessions from the hospital to community to bring care closer to the patient's home. Staff were aware that this system would involve working with a wider range of commissioners and community services because it would involve treating patients from across trust borders.
- Outpatients and diagnostic imaging departments were responsive to requests from clinicians to accommodate patients on 2 week waits and short notice additional clinics.
- Patients told us that parking was an issue at the Lancaster site and signage to certain departments such as 'medical one 'physiotherapy was limited with difficult access for disabled or less mobile patients.

Diagnostic imaging:

- The diagnostic imaging department had good processes in place and the capacity to deal with urgent referrals and additional scanning sessions were arranged to meet patient and service needs.
- The radiology department had no dedicated porters. Portering services at Royal Lancaster Infirmary were managed centrally and staff in the department told us they had difficulty ensuring patients were in the right place at the right time for their procedure.
- Digital dictation was used in diagnostic imaging to enable a swift turnaround for reports and letters. Urgent

reports were flagged for prioritisation. Diagnostic imaging reporting and record-keeping was electronic and paperless methods were used to reduce time and administration requirements.

- Consultant radiologists worked across divisions to identify examinations that did not require radiologist reporting such as routine orthopaedic films an chest x-rays for respiratory clinics. Specialty teams had agreed that when they did require specific images to be reported they would request them specifically.
- Royal Lancaster Infirmary had four bedded interventional radiology day case unit. This reduced the need for radiology patients taking up acute ward beds and allowed them to be nursed and observed close to the team who were treating them. Two nurses and a clinical support worker staffed the unit while radiologists and radiographers carried out the procedures. The service provided procedures including nephrostomy, biliary and ascitic drainage, CT biopsies and urinary stents. Vascular work including angiograms was no longer carried out at the trust and had been transferred to another north west acute NHS trust.

Access and flow

- Between August 2015 and July 2016, the trusts referral to treatment time (RTT) for non-admitted pathways for outpatient services was better than the England overall performance. The latest figures for July 2016 showed 92% of this group of patients were treated within 18 weeks.
- Between August 2015 and July 2016 the trusts referral to treatment (RTT) time for incomplete pathways for outpatient services achieved the operational standard of 92%. It had been below the national standard since January 2016.
- Between January 2016 and July 2016 there were 64299 appointments from referral to first attended appointment in outpatients. 71.10% of patients were seen within 5 weeks of referral, 18.52% of patients were seen between 6 and 11 weeks, 5.92% were seen between 12 and 17 weeks and 4.45% were seen over 18 weeks.
- The 2 week wait from GP urgent referral to first consultant appointment figures varied between quarter 2 2015/2016 and quarter 1 2016/2017. 90.7% of patients were seen within 2 weeks in quarter 2 2015/2016 and 92.5% of patients were seen within 2 weeks in quarter 3 2015/2016. The trust achieved the 2 week standard in quarter 4 2015/2016 with 95.1% of patients seen within 2 weeks and the trust achieved the 2 week standard in quarter 1 2016/2017 with 96.5% of patients seen within 2 weeks.
- Managers told us they received reports when patients were close to breaching the referral to treat targets. The trust did not always achieve the 18 week RTT targets. The department was addressing this by holding extra clinics on Mondays, Tuesdays and Wednesdays.
- The trust provided information which detailed the reason for the failure to meet RTT targets which was vacancies and capacity and demand and some of the action being taken to address the RTT position such as a business case for more staff.
- Managers in physiotherapy told us referral to treatment 18 week targets were mostly met.
- The trust achieved the standard of 96% for the percentage of people waiting less than 31 days from diagnosis to first definitive treatment between quarter 2 2015/2016 and quarter 1 2016/2016. The trust were at 98.6% or above between these periods.
- The trust achieved the operational standard of 85% of percentage of people waiting 62 days from urgent GP referral to first definitive treatment between quarter 2 2015/2016 and quarter 1 2016/2017. The trust were at 86.3% or above during these periods.
- The average percentage of clinics cancelled from January to April 2015 was 0.6%. The most commons reasons for clinic cancellations were annual leave, clinic slot cancellations and care provider unavailable. Patients we spoke with had never experienced cancelled clinics.
- Staff in audiology told us they triaged all referrals to prioritise urgent appointments. They had a departmental target for new referrals of 16 days and staff reported this target was running on time. Staff telephoned patients to agree a suitable appointment time within the 16-days from referral. Referrals received from the ENT department were all seen within six weeks and staff said that RTTs were never breached.
- Staff described clinic access to appointments and capacity in ophthalmology as ‘a challenge’. Follow up appointments were particularly difficult to achieve, however staff told us they ensured urgent appointments were booked in by trying to fit an appointment in where possible and over booking if necessary. Trust wide data showed they were not always achieving the required

review appointment times. For example, there were 1579 patients waiting 1 to 3 months past their review date and there were 229 waiting 4 to 7 months past their review date.

- There were other services within outpatients not meeting follow up waiting times. For example, in rheumatology there were 1260 patients waiting 1 to 3 months past their review date and there were 730 patients waiting 4 to 10 months past their review date.
- Next day or same day appointments were not generally offered in main outpatients. However staff told us if a consultant required the patient to attend urgently they would ensure the patient had an appointment as soon as possible.
- Patients were sent a letter confirming an appointment date, the letter had contact details for the trust and the patient could call back and change appointments if required.
- During our last inspection we noted that the trust needed to improve the waiting times for patients once they arrived in the department At the time of this inspection information provided by the trust showed that 12% of patients waited longer than 30 minutes to see a clinician once in clinic and 19.6% of clinics started later than planned. At this inspection patients told us waiting times varied and we observed a patient being called for their appointment within five minutes of their arrival.
- Managers confirmed a trust 'Did not attend' (DNA) policy was in place and included in the joint access policy. Staff we spoke with in all departments gave examples of how they followed the DNA policy for adults and for children, ensuring good sharing of information with referrers and community staff as well as reporting safeguarding concerns.

Diagnostic imaging:

- Senior radiographers and the department manager attended patient flow meetings twice daily to assess capacity and demand and make adjustments to staffing where necessary.
- Radiology managers told us diagnostic imaging waiting times, measured over all sites, from all urgent and non-urgent referrals met national targets except for some CT and MRI scan appointments. We spoke to the administration team in radiology who told us request lists were vetted by the senior radiographer and radiologist Average wait times across all modalities for 2 week wait patients ranged between 3.9 days and 12 days. For inpatients, the average wait for a scan ranged between 0.2 days for general radiology to 1.5 days for MRI. Average wait times for emergency patients ranged between 0 days for general radiology, CT, fluoroscopy, and obstetrics, and 8 days for nuclear medicine. Within nuclear medicine, emergency patients waited no more than one day for lung scans, and the average wait was two days for all other scans. Requests made on a Friday usually resulted in a wait of more than two days for a request, but the service aimed to carry out the request on the following Monday, depending upon the availability of the isotope.
- Staff carried out a continuous review of planned diagnostic imaging sessions in relation to demand and 7-day working arrangements. They monitored waiting times through an electronic system that would identify any possible breach dates. This enabled the team to take action such as adding an extra MRI list for the mobile unit or adding an extra cologram list on a Saturday. They organised additional CT sessions to accommodate urgent diagnostic imaging requests. A high proportion (90%) of urgent referrals for CT and MRI scanning were carried out on the same day.
- Turnaround times for radiology reports were not all monitored. Most of those recorded were in line with Keogh national standards and for some categories the trust had devised local standards. Of all images reported:
  - 90% of critical and urgent inpatient scans were reported within 12 hours
  - 90% of non-urgent inpatient scans were reported within 24 hours
  - 99% of six week target scans were completed on time and
  - 93% of two week urgent cancer referral scans were completed on time.
- A snapshot survey on unreported radiology studies carried out in September 2016 showed that no images were left unreported for more than 30 days. Reporting times for urgent and non-urgent procedures consistently met national and trust targets for all scans and x-rays for inpatients and outpatients. However, staff told us some MRI scans were not completed within target.

- Administration staff gave follow up appointments for orthopaedic MRI scans thus reducing waits for radiology requests from clinics.
- Managers told us that they had received very positive comments from other departments and specialties on their performance in providing a good and prompt service to meet targets. These included Accident and Emergency imaging and reporting as well as timely imaging for specialties to support referral to treatment targets.

Breast screening:

- Mammograms for inpatients were linked to their admission dates so their average wait time of 2.9 days was planned around their surgery.
- Staff told us that a Public Health England investigation into service standards had interrupted the service to some extent the previous year but that all minimum standards including 62 day treatment targets were now being met.

Meeting people's individual needs

- Outpatients provided 'one-stop' clinics for Cardiology, Respiratory, Thyroid and Urology.
- The trust provided rapid access clinics for a number of services such as Cardiology, Maxillo-facial and ear, nose and throat.
- Outpatients provided a number of Saturday clinics if required.
- A patient flow co-ordinator was in place in main outpatients and they were in place to assist and welcome patients, carers and families in the main outpatients.
- We saw patients who were required to be at the hospital for long periods of time, for example those with multiple appointments or waiting for ambulances, were offered food or a snack and regular drinks by staff.
- If clinics were running late, staff would inform patients and offer them a drink. There was a guidance document for staff to use on the action to take depending on how late the clinics are running. For example, action to take if the clinic was running 15 to 30 minutes late, 30 to 60 minutes late and later than one hour.
- Appointment times allocated to patients were around 15 to 20 minutes for a new patient and around 10 minutes for a follow up.
- Patients were offered a choice of appointments where possible and could attend a different trust site if requested. Patients we spoke to had chosen the time and site that suited them best.
- The bookings teams organised interpreter services for patients who did not speak or understand English. Staff told us that they experienced no difficulties in accessing interpreters. Staff in Dermatology outpatients told us they had used interpreters in the department several times. However, booking staff had to rely on GPs and hospital referrers ensuring that the trust were aware of a patient's requirements.
- Staff told us that interpreters were preferable to friends and family to ensure that clinical messages were put across correctly and also to maintain patient confidentiality. They were able to access interpreters if referrers informed the hospital, as needed using a telephone service, and the PALS department provided sign language support when requested.
- During our last inspection we noted that there was no information available in the departments for patients who had a learning disability or a visual impairment. During this inspection we noted staff had undertaken projects to improve access to information for people with learning disabilities and those with a visual impairment. Staff we spoke with gave examples of working with patient groups to provide information in 'easy read' format. Most literature was available in large print and staff told us they would enlarge documents on a photocopier when they recognised a patient or carer required large print.
- Staff told us they could provide patient letters in large print if it was identified this would be helpful to a patient.
- Patients told us they had access to a wide range of information. Information was available on notice boards and leaflets. A range of different information leaflets were available in the clinics and outpatient areas visited. Staff told us and we observed leaflets were available in a large font in most areas to ensure they were easy to read.
- Staff told us and we saw the butterfly scheme for dementia patients was in use and the department had a link nurse for dementia. Staff did not always have to rely on referrers or those accompanying patients to inform them if a patient required extra support; the butterfly label was attached to patient notes and nursing homes often sent a dementia passport.

Outpatients and diagnostic imaging

- The department had access to yes and no cards, pain scale cards and body charts for patients' use. There were health education leaflets and dietary leaflets in place. Signs for toilets and x-ray were in dementia-friendly colours (yellow and black).
- Staff could access private areas to hold confidential conversations with patients if necessary and receptionists informed staff quickly if patients had communication difficulties.
- Staff told us they would regularly show anxious patients around the minor operations areas in the department. They told us that a visit and a chat with staff prior to their appointment was usually enough to reduce a great amount of anxiety on the day. This reduced stress for the patient, potential last minute cancellations, and the amount of time taken for the procedure and, therefore, shorter waits for other patients.
- The breast screening service offered a one-stop-shop approach to appointments where all investigations and consultations were carried out on the same day and patients left with a diagnosis and treatment plan. Patients we spoke with at the Royal Lancaster Infirmary liked this approach.
- Departments were able to accommodate patients in wheelchairs or who needed specialist equipment. There was sufficient space to manoeuvre and position a person using a wheelchair in a safe and sociable manner.
- Bariatric and high rise furniture and equipment was available and accessible.

Diagnostic imaging:

- Patients with complex individual needs such as those with learning difficulties were given the opportunity to look around the department prior to their appointment. Staff could provide a longer appointment or reschedule an appointment to the beginning or end of the clinic.
- There were separate toilets and waiting areas for patients who had received radioactive injections. This reduced the risk of radioactive exposure to visitors and ensured correct waste procedures were adhered to.
- Staff told us that the communications team could produce information for patients in different languages, and that staff could access sign language interpreters for deaf patients. The trust had a translation policy, which detailed that and any correspondence could translated into any language and Braille within 24 hours. However, appointments staff told us they were not able to produce letters in languages other than English.
- Staff told us they could borrow a trolley suitable for bariatric patients from A&E.

Learning from complaints and concerns

- Between April 2015 and March 2016 there were 12 complaints about outpatient services at the Royal Lancaster infirmary. RLI took an average of 27.58 days to investigate and close complaints. This is in line with the trust policy on complaints, which states that complaints should be signed off within 35 days of receipt, unless a different timescale has been agreed with the complainant.
- The main themes for complaints were patient care and delays to treatment. Managers in main outpatients told us they had made changes to their services and environment in response to complaints.
- Patient advice and liaison information regarding complaints was on display throughout the outpatient departments.
- Staff were aware of the local complaints procedure and were confident in dealing with concerns and complaints as they arose. Managers and staff told us that complaints, comments and concerns were discussed at local team meetings, actions agreed and any learning was shared.
- None of the patients we spoke with had ever wanted or needed to make a formal complaint.
- Patient advice and liaison information regarding complaints was on display throughout the outpatient departments.

Are outpatient and diagnostic imaging services well-led?

Good

We rated well-led as 'good' because:

- The management structure was clear and all outpatient services were managed by one directorate with one common goal. Managers and staff talked of the trust's recent difficulties and their vision for the future of the departments. They were aware of the risks and

challenges. Staff we spoke with felt supported by their local team leaders and managers, who encouraged them to develop and improve their practice. Staff worked well together as a productive team and had a positive and motivated attitude. Teams were involved in planning improvements for departments and services.

- There was good communication between specialties and directorates and staff. Staff felt proud to work for the trust and felt they provided a good service to patients. They were frustrated about past problems and the continuing poor public perception of the trust.
- There was an open and supportive culture where staff discussed incidents and complaints, lessons learned and practice changed. All staff were encouraged to raise concerns. There were effective and comprehensive governance processes to identify, understand, monitor, and address current and future risks. These were proactively reviewed.
- There were systems and processes for gathering and responding to patient experiences and the results were well publicised throughout the departments.
- Local managers were active, available and approachable to staff. Individual departments had good leadership and management and staff told us they were kept informed and involved in strategic working and plans for the future. However, breast screening staff had experienced previous difficulties caused by some long-term staff grievances. There had been an investigation into the Breast Screening Unit by an independent body regarding the quality of clinical practice and recommendations had been addressed. Culture in this service was improving with strong leadership.
- Regular daily meetings took place in all departments where anticipated problems were discussed. There was an open and supportive culture where incidents and complaints were discussed, lessons learned and practice changed. The departments were mainly supportive of staff who wanted to work more efficiently and were able to develop to improve their practice, be innovative and try new services and treatments.
- We found that risks identified during our inspection were on the risk register. At previous inspections we had not seen evidence of clear plans to mitigate the identified risks. However, at this inspection there were clear plans for positive change but due to the changes required by estates, these were moving slowly.

However:

- Some staff told us that because of prolonged shortages in staffing they felt stretched with no room for additional work or stresses to the departments.

Vision and strategy for this service

- The core clinical services division had a vision which was 'providing the best services in the right time and place'. A core clinical services business plan was in place for 2016/2017 and included outpatients and diagnostic imaging. The plan set out service development plans for outpatients and radiology services.
- The outpatient department were working towards 'choose and book' as part of the development.
- Senior managers we spoke with were able to describe the vision for the service and the plans in place to progress work and develop services.
- Staff we spoke with were able to describe the 'better care together' strategy.
- Staff told us that senior managers were approachable to ask questions or discuss their concerns.
- Outpatients staff told us that they had a flexible and effective room utilisation plan and full control to make decisions on how to use the rooms proactively. Clinical specialty staff worked with outpatients department managers to inform them when rooms were not required thus freeing up space for other teams.

Diagnostic imaging:

- The diagnostic imaging department had good leadership and management and staff told us they were kept informed and involved in strategic working and plans for the future.
- The trust had a strategy for the introduction and continued use of more efficient and effective working using information technology such as electronic records and digital dictation systems. A new picture archiving and communication system (PACS) had recently been introduced and training was underway for staff across all trust sites. The system had been upgraded through a regional collaboration with other local trusts. Staff understood that the new system would improve

accessibility and remote reporting in the future, although this depended on suitable broadband access especially in rural areas. There were two PACS managers and an administrator on site to support the system.

Governance, risk management and quality measurement

- At our last inspection we found that the trust's governance and management systems were not fully embedded in all parts of the service and not all services were following trust policies and procedures. At this inspection we found evidence from board level to conversations with support staff that improvements had been made across all areas.
- There were governance arrangements in place for outpatients and diagnostic imaging. Governance was discussed at the division governance assurance group who would then escalate governance concerns to the weekly patient safety summit, the trust quality committee which in turn was escalated to the trust management board. Staff told us that mortality reviews also fed into this group.
- The core services division had a governance lead and deputy governance lead in place. Managers attended monthly executive meetings to discuss targets, risks and achievements.
- Managers we spoke with were able to describe the risks and challenges to their services and the action being taken to mitigate risks. Risks described such as staffing and accommodation of services were documented on the risk register. Risks were discussed at the monthly division governance assurance group meeting which outpatient and diagnostic service managers attended Managers in each department took responsibility for actions. The core clinical services risk register was reviewed monthly.
- Learning from risks was shared across the organisation via newsletters, regular staff team meetings, and staff communication emails.
- The main outpatient department used the 'WESEE' document to record meetings and this included sections to follow such as workforce and staffing, and training issues.
- The service managers led finance and workforce 'check and challenge' meetings and staff voices with staff side representatives. Managers told us the aim was to encourage open dialogue.
- Managers received weekly performance reports that documented mandatory training and other operational reports. These reports were presented and discussed at the monthly divisional governance and assurance group meeting. Information from this meeting would then be feedback by managers to staff in the departments.

Diagnostic imaging:

- Staff told us they understood the management and governance structure and how it reported up to the executive board and back down to staff with lessons learned across the trust.
- Diagnostic imaging had a separate and additional risk management group consisting of modality (specialist diagnostic imaging services for example CT and MRI) leads, radiology risk assessors and radiology protection specialists.
- In diagnostic imaging radiation protection supervisors (RPS), from specialties within the department and across all sites, raised, discussed and actioned risks identified within the department and agreed higher level risks to be forwarded to the divisional manager.
- The organisation had systems to appraise NICE guidance and ensure that any relevant guidance was implemented in practice. In diagnostic imaging these included radiology related stroke thrombolysis and non-thrombolysis imaging times.
- Within the diagnostic imaging department, there were examples of audits taking place to ensure that NICE and other guidance was being adhered to. For example,.CT urograms had replaced IVUs (intravenous urograms) following a national audit on the prevention of contrast induced acute kidney injury.

Breast screening:

- There had been an investigation into the Breast Screening Unit by an independent body. The investigation had been initiated after concerns were raised regarding the quality of clinical practice in the breast screening service provided the trust. The investigation report was completed in 2014 and outlined that the service was meeting national minimal standards; however there were quality issues in the service that needed addressing. At this inspection we observed that the recommendations were followed and maintained. Staff worked cohesively as a team to ensure quality improvements were made and senior staff told us the service met the required standards.

Outpatients and diagnostic imaging

Leadership of service

- Staff gave overwhelmingly positive feedback about leadership of the service and departments and they said there had been major improvements since the last inspection.
- We found no examples of temporary leadership roles.
- Department managers and team leaders told us they felt supported by senior managers. Managers told us they had regular meetings with service managers and assistant managers in the directorate. Department managers told us directors regularly visited the different trust sites and we were told there were no communication challenges between the different hospital sites. There was an open door policy for managers.
- Staff told us that the executive team sent out regular communications to staff. Staff felt that most line managers communicated well with them and kept them informed about the day to day running of the departments. We observed good, positive and friendly interactions between staff and local managers.
- Staff we spoke with felt managers were approachable. Managers were mostly visible and available across the Royal Lancaster site. However, some managers covered more than one hospital so were not always available on site. Staff told us that they knew where managers were and they were always contactable by telephone if required.
- Managers at Royal Lancaster Infirmary told us they encouraged staff to develop and encouraged further training in staff. Staff were also encouraged to develop if they had a particular area of interest.
- Staff told us that they had annual appraisals and were encouraged to manage their own personal development.
- Staff told us they were able to access training and development provided by the trust. However, some staff had not been able to access funding from the trust or time to be released for external courses.
- Many staff we spoke with told us that they had worked at the hospital for many years. Staff enjoyed their role and described good team working in the outpatient department.

Diagnostic imaging:

- Staff told us diagnostic imaging department leadership felt stable and was positive and proactive. Staff told us that they knew what was expected of staff and the department and that every effort was being made to recruit and train more staff.
- Staff told us they saw the divisional management team regularly. The clinical director had a clinical role as well as senior management responsibilities so understood the needs, priorities and pressures on staff within the department.
- Consultant radiologists told us that the communication style of the new clinical director was better than previously and interpersonal relationships had improved.
- A new administration team supervisor had been appointed and the administration team held a formal monthly meeting as well as a daily cross-bay online meeting for secretaries. A member of the administration team attended the departmental team brief to share information with the whole team.
- Managers told us that IR(ME)R incidents were never looked on as a reason to apportion blame but as an opportunity to learn. Staff involved completed a reflection exercise and learning points were disseminated in team meetings and a 'Learning to Improve' bulletin.
- Most of the staff we spoke with told us they were content in their role. However, the department, especially CT, had been short staffed all of the previous year and demand had increased. Managers had implemented a shift system including on-call shifts and CT staff told us they found it increasingly difficult to work additional shifts. CT staff felt that they could approach managers with concerns but did not always feel listened to, or confident that action would be taken when possible.

Breast screening:

- Some staff told us they felt the department had not been well-led in the past. Several clinicians had experienced difficulties when grievances, allegations and challenges had been made against individuals and staff felt little or no resolution was found.
- Staff described a current strong leadership that had improved team cohesion, governance, and

communications mechanisms with standardised operating procedures. Clinicians told us that locums had reported to them they were impressed with the clinical director's leadership.
- Staff told us they felt there was a new determination to succeed amongst teams and that they felt valued. However, some staff told us they felt that some line managers did not have the ability or capacity to make decisions and some displayed undermining behaviour that had been reported to senior managers but remained unresolved.

Culture within the service

- Managers told us they encouraged team work throughout the outpatient departments and that, because of this approach, the culture had improved. Managers felt there was openness and honesty in the teams. They said that in general staff embraced change, could see the overall picture for improvements and contributed to a 'can do' culture. Staff told us they felt empowered to suggest and implement changes.
- Staff we spoke with felt the culture of the departments was open and honest and staff would be happy to report concerns and felt that these would be investigated fairly.
- Staff we spoke with told us their teams were good, supportive and they enjoyed their role. Staff felt respected and valued by managers.
- Staff were proud to work at the hospital. They were passionate about their patients and felt that they worked in highly skilled teams. Staff told us that they would be proud if members of their family were cared for by staff in the department. However, some staff told us they felt frustrated that the trust's reputation was still poor following previous inspections and reviews. They told us this caused additional stress and strain on morale in very busy departments.
- Outpatients department managers told us that there were formal team meetings, however it was difficult to have a set team meeting regularly.

Diagnostic imaging:

- Diagnostic imaging staff told us there was a good working relationship between all levels of staff. We saw that there was a positive, friendly but professional working relationship between consultants, nurses, radiographers and support staff.
- Diagnostic imaging staff told us that they felt there was a culture of staff development and support for each other. Staff were open to ideas, willing to change and were able to question practice within their individual modalities.
- Department managers told us that there were formal team meetings. Teams would have team meetings on trust audit days.

Breast screening:

- Staff and managers told us cultural issues identified and corroborated at previous inspections had been addressed. However, staff we spoke to were of the general opinion that challenging behaviour had been tolerated by management and that disputes had 'consumed energy and emotion' of the team over several years.
- Staff told us that in spite of ongoing personnel issues, managers had improved morale to some extent with greater cohesion and team working. Working in the department felt more comfortable since the appointment of new leadership and staff told us they now felt they had the support and resources to deal with problems.
- Staff told us that MDT working with surgery colleagues helped staff feel more empowered and able to instigate change.

Public engagement

- The trust was proactive in seeking patient feedback within the outpatient services. We found feedback forms available in all the departments we visited with post boxes for patients and visitors to leave the completed forms. Patients told us they were actively encouraged to complete these. We looked at a sample of ten completed cards which were all overwhelmingly positive about the care people had received.
- Information was displayed on message boards throughout the outpatient services to engage the public in messages about the service and to seek feedback.
- A patient assessment group had identified that access to the main entrance was difficult for wheelchair users. The trust had installed a pressure pad operated automatic door in response.

Staff engagement

- Staff in all departments told us team leaders encouraged staff to share ideas and support staff in

implementing new ideas to benefit the service provided. Staff told us they felt more engaged with the trust than in previous years and that there had been some improvements in service delivery.

- Staff were invited to attend or dial in to a staff voices meeting held at Westmorland General Hospital. This was an opportunity for any staff to speak directly with the divisional management team.
- Managers told us they arranged team meetings during trust audit days to ensure all staff were available. Ophthalmology clinics had a daily handover and tried to have a monthly staff meeting, however these were not always regular. Staff told us daily handovers and staff meetings were used to discuss learning from incidents.
- Staff told us main outpatients and diagnostic imaging managers shared new information and news with staff through team meetings. Information was attached to the appendix of meeting minutes and staff signed an attendance document so managers knew information and minutes had been read.
- Staff told us they held staff huddles each morning. We saw evidence of notes from meetings and information for staff on noticeboards.
- The main outpatient department at Royal Lancaster Infirmary had undertaken a staff survey to gather staff views on outpatient improvements. This provided a platform for staff to raise improvement ideas.
- Policies and procedures were available to staff via the trust intranet.
- Managers told us that nursing and clinical support staff were keen to work with consultants to develop new practices, including the extension of roles and the introduction of new procedures.
- Departmental staff liaised with specialists from other hospitals within the trust and neighbouring trusts to keep updated with new practices and developments to ensure that services offered were in line with current practice and effective.

Innovation, improvement and sustainability

- Strategies for service improvements were in place in both diagnostics and outpatients. Staff told us they were involved in projects they had identified or contributed to regarding strategies for improvements across the department.
- The Ophthalmology department had worked with external partners to offer further care in the community, this had been progressed using the better care together strategy. Staff had details of services which were trained to provide some eye care and could refer to these as required. This reduced the need for hospital visits.
- The audiology department had achieved IQUIPS accreditation (Improving quality in physiological services) which is a professionally-led assessment and accreditation programme designed to improve services, care and safety for patients. Staff told us accreditation is renewed annually and tests are carried out every three years.

Outstanding practice and areas for improvement

Outstanding practice

- The service was one of only three trusts which were successful in securing funding to pilot a maternity experience communication project. This was a patient-based, communication-improvement training tool for multi-professional groups in maternity services. The project had the potential to be adopted nationally if learning outcomes and measurable improvements could be made for women using maternity services.
- The bereavement team, Chaplaincy and specialist palliative care team worked together to promote compassionate care at the end of life. A particular innovation relating to this had been the development of death cafes. A death café provided an opportunity for people to talk more openly about death and dying. The trust had held death café's for the public as part of dying matters week and also had used them to support staff to talk more openly about death and to promote better communication with patients and relatives at the end of life.
- There were a number of innovations relating to compassionate care for patients at the end of life. This included the use of canvas property bags with a dragonfly symbol so staff knew that the person had been recently bereaved. In addition bereavement staff sent out forget me not seeds to family members following the death of a loved one. Families were also able to get casts of patient's hands which was a service provided by an external organisation with funding for this provided by the trust.
- The trust had adopted the dragonfly as the dignity in death symbol. This was used as a sign to alert non-clinical staff to the fact that a patient was at the end of life or had died. A card with the symbol could be clipped to the door or curtain where the patient was being cared for. By alerting all staff this meant that patients and family members would not have to face unnecessary interruptions and non-clinical staff knew to speak with clinical staff before entering the room. An information card had been produced for non-clinical staff explaining the difference between the dragonfly symbol (dignity in death) and the butterfly (dementia care).
- The bereavement team, chaplaincy and specialist palliative care team worked together to promote compassionate care at the end of life. A particular innovation relating to this had been the development of death cafes. A death café provided an opportunity for people to talk more openly about death and dying. The trust had held death café's for the public as part of dying matters week and also had used them to support staff to talk more openly about death and to promote better communication with patients and relatives at the end of life.
- A remembrance service was held by the chaplaincy every three months for those bereaved. We were also told that 'shadow' funeral services had been delivered within the trust when patients had been too unwell to attend funerals of loved ones.
- Relatives were sent a condolence letter by the bereavement service a few weeks after the death of a loved one, support was offered at this time.

Areas for improvement

Action the hospital MUST take to improve

In urgent and emergency care services:

- Monitor performance information to ensure 95% of patients are admitted, transferred or discharged within four hours of arrival in the emergency department .
- Ensure patients do not wait longer than the standard for assessment and treatment in the emergency department.

In services for children and young people:

- Ensure there are sufficient nursing staff to ensure compliance with British Association of Perinatal Medicine (BAPM) and Royal College of Nursing (RCN) guidance.

Action the hospital SHOULD take to improve

In urgent and emergency care services:

Outstanding practice and areas for improvement

- Ensure observations are recorded appropriately to allow the assessment and early recognition in the deteriorating patient
- Ensure nursing documentation is completed in accordance with the trust policy.

In medical care:

- Ensure all risk assessments (particular reference to venous thromboembolism and multi-factorial falls risk assessments) are completed for all patients where appropriate and evidence of the same is documented consistently.
- Ensure medicines documentation records patient allergies, venous thromboembolism risk and oxygen prescribing.
- Ensure National Early Warning Score ("NEWS") triggers are followed or in the event of deviation, ensure trigger levels are adjusted with clinical rationale documented to evidence.
- Ensure all nursing and medical clinical documentation is completed in full and in accordance with recognised professional standards;
- Where medicines are stored in fridges, ensure temperature ranges are recorded in accordance with policy to ensure the safety and efficacy of the medicine is not compromised;
- Ensure all staff complete all elements of their mandatory training requirements and ensure accurate compliance figures are maintained;
- Ensure all staff benefit from the appraisal process and these are completed on an annual basis in accordance with local policy;
- Ensure there is a reasonable and proportionate induction process or access to relevant induction information for all locum medical staff attending the hospital on an ad-hoc or short term basis.
- Ensure action plans put in place to address shortfalls in local and national patient outcome audits are monitored and reviewed in a timely manner reasonable timeframe to ensure compliance is measured.
- Ensure there is a review of patient comments and PLACE findings regarding food quality and consider measures which may be implemented to improve nutritional care;
- Ensure staff awareness and knowledge of MCA and DoLS theory is underpinned by consideration of procedural competence in making such applications to avoid potential legislative breaches;
- Ensure where family attendance is required at care meetings sufficient notice is given;
- Ensure the patient and family members are given appropriate time, opportunity and in the right arena to voice opinion on care and treatment plans;
- Ensure where external staff are required to support in 1:1 observation of patients, they are suitably trained to perform the task;
- Ensure the number of patient bed moves after 10pm are kept to a minimum to avoid patient and family anxiety and distress;
- Ensure the effectiveness of the new governance framework is measured and adapted accordingly;
- Ensure the effectiveness of current staff engagement themes and consider other formats which will support divisional strategy; and,
- Ensure reasonable measures are put in place to support staff wellbeing and ensure all staff know what is available to them.

In surgery:

- Ensure that care pathways are reviewed in accordance with the trust policy,
- Ensure that hand hygiene audits take place monthly, and that improvements are made,
- Nursing documentation should include whether a patient has had food and/or drinks whilst in the emergency department.
- Continue to improve Referral to Treatment Times (RTT) for patients and continue to implement trust-wide initiatives to improve response.
- Increase orthogeriatricians input on surgical wards
- Ensure all transfers between locations are performed in line with best practice guidance and policy. Where practice deviates from the guidance, a clear risk assessment should be in place.
- Continue to engage staff and encourage team working to develop and improve the culture within the wards and theatre department.
- Continue with staff recruitment and retention.
- Ensure medicines reconciliation is completed in a timely way.
- Ensure medication fridge temperatures are checked within trust policy timescales.

Outstanding practice and areas for improvement

In critical care:

- In 2015 we reported that the unit had limited space and during this inspection we noted again that the unit was over twenty years old and would not meet current national standards for new buildings and environment. This also had an impact on handwash sink provision. There was however a clear estates strategy which outlined the plans for unit upgrade and expansion. Issues around estates and environment were on the directorate risk register and had been identified as a 'not met' against National D16 commissioning service specifications for critical care services, during an assessment by the LSCCCN. The trust should continue to monitor environmental standards and challenges in critical care and continue with strategic plans for refurbishment and expansion.
- Take action to improve physiotherapy staffing and be clear in how it supports rehabilitation for patients in line with GPICS (2015).

In maternity and gynaecology:

- Ensure that outcome measures are developed to monitor the effectiveness of the strategic partnership with Central Manchester University Hospitals NHS Foundation Trust and Lancashire Teaching Hospitals NHS Foundation Trust.
- Ensure that care records (including cadiotocograph CTG's) are legible, complete, timed, and dated.
- Continue to monitor the cultural assessment survey for obstetrics and gynaecology and improve values around organisational culture.

In services for children and young people:

- Ensure that all children with an acute medical problem are seen by a consultant paediatrician within 14 hours of admission.
- Ensure the environment of the children's unit and neonatal unit are fit for purpose.
- Ensure there is a review of all children and young people's mortality and morbidity.
- Ensure that documentation refers to Gillick competency and should ensure that staff are properly trained and confident to assess Gillick competency properly.
- Continue to ensure that communication takes place with partner agencies about the placement of CAMHS patients.

In outpatients and diagnostic imaging:

- Continue to build relationships and develop closer team working for medical staff in radiology and breast services across all locations to develop a one trust culture.
- Continue to ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed in order to meet the needs of the patients. This is particularly in relation to radiology, dermatology and allied health professionals.
- Continue work started to ensure that all premises used by the service provider are suitable for the purpose for which they are being used, properly used, properly maintained and appropriately located for the purpose for which they are being used. This is particularly in relation to services provided from medical unit one.
- Ensure it meets referral to treat targets in outpatient clinics and should ensure they address backlogs in follow up appointment waiting times.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing How the regulation was not being met: There were insufficient nursing staff to ensure compliance with British Association of Perinatal Medicine (BAPM) and Royal College of Nursing (RCN) guidance.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance: assess, moniotor and improve the quality and safety of the services provided in the carrying on of the regulation activity. How the regulation was not being met: The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the A&E. The trust breached this standard between October 2015 and September 2016. The last month that the Trust delivered the 95% ED 4-hour performance standard was in August 2015.