

Investigation report

University Hospitals of Morecambe Bay NHS Foundation Trust

Royal Lancaster Infirmary
Furness General Hospital

About this report

The Care Quality Commission (CQC) is the independent regulator of health and adult social care services in England. The main objective of the Commission in performing its functions is to protect and promote the health, safety and welfare of people who use health and social care services. The Commission has the power to conduct an investigation into the provision of NHS care under s48(1)(2)(a) of the Health and Social Care Act 2008. It does so where there is evidence of a significant problem that affects a whole care economy.

Investigations can look specifically or generally at any issue to do with different kinds of health or adult social care, including the commissioning of that care, how particular functions are carried out or provision by particular people or bodies.

An investigation differs from a responsive compliance review in that it normally necessitates a much wider and deeper look at a range of concerns, potentially across all locations within a single provider or a major location, such as an NHS hospital, or even a local care economy. Section 48(1)(2)(a) of the Health and Social Care Act 2008 enables CQC to look at the provision and commissioning of health and social care more widely, that is beyond the 16 outcomes within the essential standards of quality and safety in order to develop a full understanding of the issues and the barriers to improvement.

An investigation is also normally characterised by the need for:

- A degree of independence from any prior regulatory activity
- Specialised external expertise
- Resources outside of the assigned compliance team
- More extensive involvement of people who use the services concerned
- A greater in-depth focus on systems and processes.

Following an investigation, CQC must publish a report, which can make recommendations. These recommendations cannot be enforced. However, the organisations concerned will be expected to produce and deliver an action plan to address the recommendations. Progress will be followed up by the local compliance team.

CQC must also consider whether its report raises matters which make it appropriate for the Commission to exercise its powers under section 53 of the Act to advise the Secretary of State.

Our investigation and enforcement powers will be discharged independently. However, investigations may also uncover evidence that leads us to take subsequent enforcement action relating to the essential standards of quality and safety against individual registered persons or providers, or to refer issues to other regulatory or enforcement bodies, for example the Health and Safety Executive, Safeguarding Authorities, the police or professional regulators. These issues will be referred to the local compliance team for review and followed up as appropriate, using routine compliance review and enforcement methods or joint working protocols, outside of the investigation itself.

The terms of reference outline the need for the investigation to provide further assurance on University Hospitals of Morecambe Bay NHS Foundation Trust systems for protecting people against the risks of inappropriate or unsafe care or treatment. This report focuses primarily on the quality of care and the safety of people using services at Royal Lancaster Infirmary and Furness General Hospital.

This report should be read in conjunction with the review of compliance report February 2012 and published on the CQC website. These reports provide further details of University Hospitals of Morecambe Bay NHS Foundation Trust's performance in meeting the essential standards of quality and safety detailed in section 20 of the Health and Social Care Act 2008.

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Summary

CQC began an investigation of University Hospitals of Morecambe Bay NHS Foundation Trust on 17 January 2012.

We decided to investigate because our regulatory checks throughout 2011, and information we continued to receive, repeatedly revealed concerns in the delivery of safe, quality care in the immediate and long-term across a number of different clinical settings.

We raised the level of our review and action each time new information came to light, culminating in urgent enforcement action and the issue of a Warning Notice in September 2011.

When we continued to receive information about poor practice and indications that previous concerns had not been addressed, we took the decision that continuing to tackle poor performance at the trust on a case-by-case basis was not going to address deep-seated issues around the quality of care.

We considered escalating the enforcement action to suspend or restrict key services. However, the wide geographical spread of the trust's services means that it is very difficult to switch capacity between sites and such action would have a significant impact on the local population. We therefore decided that an investigation was the most appropriate course of action.

Although the original concerns arose in maternity services, the most recent information related to the trust's accident and emergency department and emergency care pathway. Our investigation team therefore focused on emergency care and the trust's governance and management systems. We concentrated on two of the trust's three main sites: the Royal Lancaster Infirmary and Furness General Hospital

Throughout the investigation, we worked closely with Monitor, the regulator of NHS foundation trusts. Monitor has found that the trust was in significant breach of its foundation trust authorisation, due to governance failings in maternity and paediatric services, and has commissioned and published a number of its own reviews.

Concerns and regulatory action leading up to the investigation

In January 2009, NHS North West (the strategic health authority, SHA) and the Healthcare Commission held a risk summit with other regulatory bodies to discuss a number of concerns about the trust, relating to radiology, healthcare-associated infections, and historical governance and cultural

issues. It was agreed that all organisations would continue with their regulatory/performance functions.

The SHA was identified as the lead organisation for follow up with the trust, and the trust notified in March 2009.

In May 2009, CQC (having replaced the Healthcare Commission) became aware of 12 serious untoward incidents (SUIs) having been reported by the trust. SUIs were reported to the SHA and since April 2009 were investigated and monitored by the relevant primary care trusts (NHS North Lancashire and NHS Cumbria). Five of the 12 SUIs related to maternity services.

At this time, we also received correspondence from the father of a baby who had died in November 2008. The father had raised a formal complaint with the trust and, dissatisfied with the outcome, had referred it to the Parliamentary Health Service Ombudsman.

In June 2009, we held discussions with the SHA to gain an understanding of the trust's handling of the incidents and its progress in relation to the scrutiny it faced. The outcome of these discussions was that the SHA were satisfied that the serious untoward incident concerning the death of this baby had been reported and investigated appropriately, and were satisfied with the trust's action plan and progress, although there were still two reports awaiting sign off (a maternity management service review and Birthrate Plus staffing review).

We were provided with a briefing paper, dated 26 June 2009, which confirmed the view that the serious untoward incident concerning the death of the baby had been reported and investigated appropriately, and also contained a summary of the other SUIs. However, no reference was made to whether any commonalities between the incidents had been identified in the five reported SUIs within the maternity units.

In early 2010, the trust applied to register with CQC under the Health and Social Care Act 2008 and declared compliance with the relevant regulations. Having reviewed all the information we held at the time, we issued an improvement letter about minor staffing concerns and registered the trust with effect from April 2010.

We conducted our first unannounced inspection of the trust in June 2010. We looked at the maternity service at Furness General Hospital and found it was meeting the six essential standards of quality and safety that we assessed.

The trust was authorised as an NHS foundation trust on 1 October 2010.

During the course of 2011, we identified a number of concerns that had not previously been highlighted to us, either through statutory notifications or as part of progress reports provided to the SHA or the commissioning bodies.

We reviewed all 16 essential standards at the Royal Lancaster Infirmary in April 2011 and found non-compliance with three of them; improvements were needed to maintain compliance with another five.

We then asked the trust to send us all its review and investigation reports concerning maternity services. Within these was the 'Fielding report', a review commissioned by the trust of all SUIs in maternity services in 2008. The report had been finalised in August 2010 and had not previously been shared with CQC or Monitor. It identified many areas for improvement along with issues about the 'culture of team working'.

While the Fielding report contained some information that we already knew, it also included a number of significant concerns that we were not aware of and hence had not included in any reviews in 2010. They included staff working together co-operatively; management and staff developing a greater degree of trust; and leadership and arrangements for clinical governance.

More concerns about maternity care were brought to our attention in June 2011, resulting in a joint review with the Nursing and Midwifery Council and further unannounced inspections. This time, we found non-compliance in seven out of 10 essential standards. Major concerns were identified regarding the safety and suitability of premises, the suitability of staffing arrangements and monitoring the quality of services within maternity services.

In September 2011, we took enforcement action against the trust and issued a Warning Notice. This required the trust to take urgent action to address the major concerns that had been identified within maternity.

In October 2011, we received further information about poor practice in maternity services, indicating that concerns previously identified and brought to the attention of the trust had not been addressed. The trust also recorded an SUI about a patient who had not been followed up in outpatients.

At this point, Monitor found the trust to be in significant breach of its terms of foundation trust authorisation and used its statutory powers to commission a number of reviews.

In December 2011, we received new information that highlighted potential concerns in the A&E department and the emergency care pathway. We launched the investigation and straightaway issued a Warning Notice requiring urgent action to be taken to address these new areas of major concern.

What we found

Despite action taken by the trust in response to earlier concerns raised, and recommendations made in earlier reviews, our investigation found that patients remained at risk of poor care, particularly those patients in accident

and emergency and other parts of the hospital that provided urgent care. Further action and improvement was required.

And although the focus of this investigation was on the emergency care pathway, it was clear that the concerns were symptomatic of wider and longstanding problems at the trust.

Despite the trust being formed in 1998, it had failed to develop an effective trust-wide clinical strategy. The result of this was a lack in uniformity of care across the organisation and a lack of corporate identity among staff.

In particular, as found by other reviews, there was an apparent dislocation between senior managers and senior clinicians at the trust and a lack of leadership to address practices that directly impacted upon the quality of care patients received at the trust. There had been little impetus to ensure that individual divisions, clinicians and managers worked together to deliver the changes to the emergency care pathway identified by previous external reviews.

There was also little evidence of the whole trust working together to drive change and improvement in the care that was delivered to patients. Underpinning this, as found by other reviews, had been a lack of focus and clarity around governance systems and processes across the trust.

The problems are compounded by the trust's wide geographical spread. As a result, the two main hospitals – Royal Lancaster Infirmary and Furness General Hospital – had retained their own identities and distinct cultures since they merged into one trust. Any plans for cross-site working and standardisation of practices have been limited, with past plans now described by one member of senior management as “aspirational”.

Where areas for improvement had been identified, the trust had been slow to respond. Delays in the development of services had been compounded by their difficult relationship with NHS partners, including commissioners. This had direct impact on the quality of care some patients had experienced.

This was demonstrated by: long waits in accident and emergency; frequent internal transfers of patients to wards outside of the speciality to which they had been admitted; lack of monitoring of patients; inconsistency in the medical review of patients; unnecessary delays to the discharge of patients; lack of regard to the privacy and dignity of patients through the accommodation of both male and female patients together in one ward.

Until new systems and processes for identifying, assessing and managing risk have been embedded, concerns remain regarding inconsistent incident reporting practices; lack of learning from incidents and poor use of performance information to drive change

More specific findings include:

- The trust's awareness of long-standing concerns in the care and management of patients admitted through the emergency pathway had failed to be addressed and had progressively worsened. Following our identification of these concerns in the first few weeks of the investigation, we took immediate enforcement action in February 2012.
- The most significant problems were identified at the Royal Lancaster Infirmary, although during the course of this investigation concerns were present at both sites. These included poor clinical care, a lack of learning from incidents, poor discharge planning, ineffective bed management and a lack of leadership from senior management.
- We also identified an apparent 'shared helplessness' among staff with little ownership by emergency department staff of the current system of patient management. It was also evident that key decisions related to patient care within the emergency care pathway had been made without consultation with the emergency department senior management team.
- Accident and emergency services at the Royal Lancaster Infirmary and Furness General Hospital continued to fail to meet the four-hour access target (the national target is to admit, discharge or transfer 95% of patients within four hours of arrival to the emergency department). There was no reliable way of electronically capturing the time taken from a patient arriving to when they began to receive a full assessment.
- There is an absence of a board approved workforce strategy and a full training needs analysis. As such, the requirements and specialist staffing skills for each ward or department had not been identified. This basis for building clear, cohesive approaches to identify the right staff and ensure contingency plans are in place had not been properly formulated.
- We identified concerns in other clinical delivery areas, including the clinical decision units at both hospitals. We found that there was no coherent operational policy to guide staff for either facility. Both male and female patients were accommodated within these facilities and in the case of the Royal Lancaster Infirmary, included patients that were accommodated for periods longer than 24 hours and patients that required a high level of nursing care. There was little evidence of performance management by senior managers to ensure that the privacy and dignity needs of patients were met. Following our identification of these concerns at the early stages of the investigation, we took immediate enforcement action and conducted a follow-up visit to the clinical decision unit at the Royal Lancaster Infirmary to ensure that the practice of accommodating patients for periods longer than 24 hours and patients that required a high level of nursing care had ceased.

- The trust took measures to address the complaints backlog, dating back to May 2011, through the recruitment of additional staff. Prior to this, the trust's response to complaints had been poor for some time, with a high number of complaints received each year and frequent breaches in the timeliness and quality of responses. The poor response by the trust following receipt of complaints was raised by stakeholders (particularly MPs) as a concern.
- Staffing levels across some parts of the trust were inadequate. The trust was aware of inadequate staffing establishments within medicine following review by the audit commission in August 2010. While temporary funds have been agreed to increase staffing levels, these staff have yet to be recruited.
- A training needs analysis, to ensure that appropriately skilled and experienced staff are available at all times, was not in place. We found that in some areas, staff were not being properly trained and supervised to conduct their roles. Some wards had used security staff to manage patient safety with a resulting impact on the privacy and dignity of patients.
- The trust's management arrangements also highlighted concerns in the ability to monitor the quality of service delivery and an ability to effectively manage the balance of operational delivery and professional standards. For example, during the course of the investigation the Director of Nursing, other than when interviewed, was not visible in clinical areas or as a clinical leader as highlighted by nursing staff interviewed during the course of this investigation. The Director of Nursing's portfolio had increased as result of the loss of the deputy director of nursing post and as a result her time had been focussed on areas of concern highlighted following earlier reviews of compliance, for example maternity services. Since November 2011, the trust had not had a Director of Operations or a Chief Operating Officer. While the role of Chief Operating Officer was vacant, it was covered by members of the Executive Team including the Director of Nursing. A Chief Operating Officer was appointed in April 2012.

Progress reported by the trust

During the course of the investigation, the trust reported that action had been taken to address the areas of concern raised within this report and to concerns identified following previous reviews. These include:

- Stopping the use of the Clinical Decision Unit at the Royal Lancaster Infirmary for the overflow from the medical and surgical assessment units.
- Introduction of spot checks in respect of observations and record keeping.

- All staff have been reminded of their responsibility in respect of privacy and dignity.
- A programme of work to review and improve the emergency care pathway as a whole has been established.

There have also been significant changes to the membership of the trust Board, as an interim Chair, interim Chief Executive, interim Medical Director and Chief Operating Officer were all appointed during the course of this investigation. In addition, the trust also announced appointments to clinical leadership and senior management positions to help drive improvement. Although at the time of writing this report, this recruitment had not been completed.

We have yet to test the impact of these changes. A formal review of the recommendations included within this report will be carried out in six months' time.

Next steps

Following this investigation, the trust needs to assure CQC that it understands the problems it faces and that it knows what it needs to do to tackle them.

The significant changes that are needed are likely to challenge both clinical flows and trust finances. Improvements must be made in the short-term to ensure the immediate safety of people using the service, while medium and long-term answers must be found to the delivery of services and the quality of care.

To do this, the trust needs the support of organisations in the local health economy and commissioners.

The trust must ensure that the recommendations from this investigation are incorporated into the existing improvement programme. Any action should include how they will show evidence of positive impact on the quality of service and outcomes for people, and provide quality assurance for commissioners. Details of the action taken and changes in practice should be submitted to CQC, Monitor, stakeholders and partner agencies, and made available to people who use its services.

We will follow-up progress against these recommendations in six months' time. In the meantime, we will keep the trust under active review, carry out further inspections and follow-up the Warning Notices already issued to the trust.

We have noted where recommendations were also part of other reviews and where they have already been addressed.

Background to the investigation

University Hospitals of Morecambe Bay NHS Foundation Trust is a large acute hospital provider serving the population of South Cumbria and North Lancashire. The trust was established in 1998 and gained teaching status in January 2006. Services provided at the trust are commissioned by two primary care trusts (PCTs): NHS North Lancashire and NHS Cumbria.

Services are provided to a population of 365,000 covering South Cumbria, North Lancashire and surrounding areas from three principal sites: Furness General Hospital, Barrow; Royal Lancaster Infirmary, Lancaster and Westmorland General Hospital, Kendal. In addition, the trust also provides outpatient services at Queen Victoria Hospital in Morecambe, at Ulverston Health Centre and in a range of community facilities.

In January 2009, NHS North West (the strategic health authority, SHA) and the Healthcare Commission held a risk summit with other regulatory bodies. At this meeting, concerns were identified in the following areas of service provision at University Hospitals of Morecambe Bay NHS Trust:

- Radiology - specifically lack of process for reading and interpreting test results such as CT and ultrasound scans, poor portering facilities which resulted in a CT scan being delayed, lack of investigation of concerns by the trust and failure to adhere to the trust's own whistleblowing policy.
- Breaches in compliance with the Code of Practice on healthcare-associated infection (HCAI) and related guidance.
- Methicillin-resistant *Staphylococcus aureus* (MRSA) trajectory.
- Historical governance and cultural issues.

At this meeting it was agreed that all organisations would continue with their regulatory/performance functions.

The SHA was identified as the lead organisation for follow up with the trust, and the trust notified in March 2009.

On 19 May 2009, Monitor and the Department of Health sought clarification with regards to the 'low levels of concern' identified within the trust's Organisational Risk Profile (ORP) held by the Healthcare Commission. It was at the time of this contact that CQC (having replaced the Healthcare Commission) became aware of the 12 Serious Untoward Incidents (SUIs) concerning the trust that had been reported by the SHA. SUIs reported to the SHA and since April 2009 were investigated and monitored by the PCT. Of the 12 SUIs reported to the SHA, five of these related to maternity services.

At this time, we also received initial correspondence from the father of a baby who had died in November 2008. The father had raised a formal complaint with the trust and dissatisfied with the outcome and response he had received, had referred the matter to the Parliamentary Health Service Ombudsman (PHSO).

The trust advised us on progress with regards to this complaint, which included plans to undertake an external review, an action plan for supervision of midwives (May 2008) and the Clinical Negligence Scheme for Trusts (CNST) level 2 report (April 2008). We were also advised that further reports would be generated to build on learning and improvement. These included the Local Supervisory Authority (LSA) June 2009, Maternity Management Service Review (Charles Flynn) June 2009 and staffing review – Birthrate Plus commencing summer 2009.

In June 2009, we held discussions with the SHA to get an understanding of the trust's handling of the incidents, any trends, and the trust's progress in relation to the external reviews and investigations. The outcome of these discussions was that they were satisfied with the trust's action plan and progress, although there were still two reports awaiting sign off (Flynn and Birthrate Plus). Our risk rating remained a concern while awaiting the SHA to follow-up on the Flynn report and Birthrate Plus. The SHA advised us that they did not have any comparative data to confirm whether the trust were over or under-reporting SUIs.

We received a briefing from the SHA, dated 26 June 2009. The briefing concluded that the incident concerning the baby who had died had been appropriately reported and investigated, and that action had been taken to address the urgent issues that had been identified. However, the trust was required to produce an action plan with regards to the longer-term issues of team/multidisciplinary working. The briefing also provided a summary of the other SUIs. However, no reference was made to whether any commonalities between the incidents had been identified in the five reported SUIs within the maternity units.

In January/February 2010, we received an application to register the trust under the Health and Social Care Act 2008. The trust declared within their application that they were fully compliant with regulations 9 to 24 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Following review of the information we held, minor concerns regarding staffing were identified and an improvement letter was sent to the trust. A trust board paper, submitted to us as evidence of ongoing compliance work, indicated that the trust intended to commission external experts to complete a review of governance arrangements (now known as the Fielding report). This report was not shared in draft or final presentation with us during 2010

In April 2010, we registered University Hospitals of Morecambe Bay NHS Foundation Trust under the Health and Social Care Act 2008. Conditions were not applied to the registration of the trust.

On 29 June 2010, we conducted an unannounced inspection of the maternity service at Furness General Hospital. The purpose of this inspection was to assess compliance with the action plan that NHS North West had asked the trust produce. Six essential standards of quality and safety were assessed, and the trust was found to be compliant with all of the standards that were assessed.

University Hospitals of Morecambe Bay NHS Foundation Trust was authorised as a NHS foundation trust on 1 October 2010.

We identified a number of concerns relating to the provision of care at University Hospitals Morecambe Bay NHS Foundation Trust during the course of 2011. These concerns had previously not been highlighted to us either through notifications or as part of progress reports provided to NHS North West or the Commissioners.

In April 2011 we conducted a review of compliance at the Royal Lancaster Infirmary. This review looked at compliance with 16 essential standards of quality and safety and found non-compliance with three of the standards and that improvements were needed to maintain compliance with five of the standards.

During April 2011, we requested that the trust provide all review and investigation reports concerning maternity services. Within the documents provided was the Fielding report, with a note stating that the trust may not have previously shared the report with CQC. The Fielding report (finalised August 2010 and not shared with CQC or Monitor) was a review of all serious untoward incidences that occurred in maternity services in 2008 and had been commissioned by the trust. This review was undertaken by three external maternity professional experts and was called the Fielding Review. The review identified many areas for improvement and change along with issues relating to the 'culture of team working'.

While the Fielding report contained some information that was already known to us, such as the serious untoward incidents that had taken place in the maternity service at Furness General Hospital, it also identified a number of significant concerns that we were not aware of and hence had not included in any reviews in 2010. These included: staff of all disciplines working together co-operatively; management and staff developing a greater degree of trust; leadership and arrangements for clinical governance.

Recommendations were included within the Fielding report regarding maternity service provision throughout the trust and the premises at Furness General Hospital.

Additional concerns regarding the provision of maternity care at the trust were brought to our attention in June 2011. This resulted in a responsive review of maternity service provision in July 2011. In planning this review, we met with the Strategic Health Authority (SHA), Nursing and Midwifery Council (NMC) and Local Supervision Advisory Midwifery Officer (LSAMO). This was to share information and agree that the inspection would be conducted jointly with the NMC. The responsive review included unannounced inspections of Furness General Hospital, The Helme Chase unit (at Westmorland General Hospital) and Royal Lancaster Infirmary. It assessed compliance with 10 essential standards of quality and safety with a specific focus on the areas of concern identified within the Fielding report and other information that we had received.

The outcome of this review was that non-compliance was identified in seven of the 10 essential standards where compliance had been assessed. Major concerns were identified regarding the safety and suitability of premises; the suitability of staffing arrangements and the assessment and monitoring of the quality of service provision within maternity services.

In September 2011, we took enforcement action and issued a Warning Notice to the trust. This required urgent action to be taken by the trust to address the areas of major concern that had been identified within maternity services.

In October 2011, we received further information regarding poor practice in maternity services, indicating that concerns previously identified and brought to the attention of the trust, had not been addressed.

In October 2011, the trust recorded a serious untoward incident report about a patient who had not been followed up in outpatients. An investigation conducted by the trust identified that 37,000 patient access plans, for patients with a guaranteed access date, had been missed off the electronic outpatient booking system. While the 37,000 access plans did not relate to 37,000 patients who had missed an appointment, the trust had known for some time that they had a backlog of access plans with guaranteed access dates. Up to this point the trust had only recognised this backlog as an administrative issue and had not considered it as a patient safety concern, nor had the possibility of harm to patients been formally considered.

Monitor, the regulator of NHS foundation trusts, found University Hospitals Morecambe Bay NHS Foundation Trust in significant breach of its terms of Authorisation in October 2011. This was due to governance failings in maternity and paediatric services provided by the trust. Monitor used its statutory powers of intervention under s52 of the National Health Service Act to commission a review of maternity service and to require the trust to commission a review of governance. In addition the trust commissioned a review of outpatients in response to the follow-up outpatients backlog.

Concerns were identified as a result of each of these reviews and the following reports were published by Monitor on 7 February 2012:

- Report of the Diagnostic Review undertaken at University Hospitals Morecambe Bay NHS Foundation Trust
- Report of the Investigation into Follow-up Outpatients Backlog at University Hospitals Morecambe Bay NHS Foundation Trust
- University Hospitals Morecambe Bay NHS Foundation Trust Governance Review.

In December 2011, we were provided with information which highlighted potential concerns in the accident and emergency department and the emergency care pathway. These concerns were confirmed following a responsive review at the trust conducted on 21 December 2011. In February 2012, we issued a Warning Notice to the trust which required urgent action to be taken by the trust to address the areas of major concern that had been identified within the accident and emergency department.

In summary, ongoing engagement through regulatory review throughout 2011 consistently revealed concerns in the delivery of safe, quality care in the immediate and long term across a number of different clinical settings. These reviews have suggested systemic failings in quality implementation and governance, instead of individual gaps in services and models of care.

With information and intelligence suggesting concerns across a number of clinical services, we took the decision that continuing to tackle poor performance at the trust on a case-by-case basis was not going to address deep-seated issues around the quality of care. Consideration was given to the escalation of enforcement action to suspend or restrict key services. While a possible and proportionate course of action, given the concerns that had been identified, such action is serious and the impact on the local population is significant. As a result a decision was taken to launch a full investigation, using powers under s48(1)(2)(a) of the Health and Social Care Act 2008, into the quality of care provided by the trust at the Royal Lancaster Infirmary and Furness General Hospital.

The investigation was designed to assess the systems and procedures the trust has in place to ensure that people are protected against the risk of unacceptable standards of care and treatment. The team focussed on the emergency care pathway and also examined the trust's governance and management systems at different levels of the organisation.

Summary terms of reference

The Care Quality Commission (CQC) has the power to conduct an investigation into the provision of NHS care under s48 (1) (2) (a) of the Health and Social Care Act 2008. The criteria under which CQC will conduct an investigation are at Appendix A of the enforcement policy. The exercise of this power would permit CQC to raise concerns with the Secretary of State for Health under the formal power under c48 (5) of the Act.

In response to the many issues across sites and services at the trust, CQC will carry out an investigation into the systems and procedures that are in place to ensure that people are protected against the risk of inappropriate or unsafe care and treatment, these will include:

- a. Reviewing emergency care pathways by the investigation of the systems for admission (including emergency), internal transfer, discharge and external transfer of patients, including working in conjunction with other stakeholders.
- b. Using the emergency care pathway as a proxy, review the trust's systems and processes for clinical governance including the systems for monitoring the effectiveness of these systems in the provision and delivery of assurance to the Board.

The pathway investigations will identify and assess:

- The systems for ensuring that at all times there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying out the regulated activity.
- The systems for respecting and seeking the views of people using the service and their representatives.
- The systems for seeking the views of staff.
- The systems for assessing and monitoring outcomes for people.
- The systems to support the delivery of safe, quality care in a hospital environment including (but not limited to):
 - Reporting and learning from incidents, near misses
 - Staffing levels, competency and capability
 - Raising concerns and whistleblowing.
- The systems in place to develop the culture of the organisation, in particular individual responsibility and whole trust working.
- Systems and processes for identifying, assessing and managing risk and their effectiveness so not to impact on the quality and safety of care delivered.

- The analysis and learning across the organisation from board level down of incidents that resulted or had the potential to result in harm to people.
- The systems for service improvement by learning from adverse events, incidents, errors and near misses. This should also include using information from safeguarding concerns to identify non-compliance or risk of non-compliance and decisions made to return to compliance.
- Any other matters which CQC and Monitor consider may arise from, or are connected with, the matters above.

The investigation will involve speaking to patients, relatives and frontline staff and observing care delivered at the Royal Lancaster Hospital and Furness Hospital. It will also involve gathering evidence through examination of records, speaking with internal and external stakeholders and requesting written statements. When appropriate CQC may require the support of other agencies to gather or provide evidence, this may include the SHA and the PCT.

The evidence gathering period including preliminary site visits, of the investigation is planned to run over a period of not more than eight weeks, with the investigation running for a period of up to 14 weeks including the drafting of a report.

Approach

The investigation was announced on 17 January 2012. Commissioners, NHS North West and the Department of Health were aware of our concerns, and proposed regulatory response, prior to the investigation being announced. A team of CQC inspectors and external advisors in emergency care began the investigation on 13 January 2012.

Evidence gathering took place from January to March 2012. Both hospital sites were inspected, during which we spoke to patients about their experiences and observed care being delivered. We interviewed more than 200 hospital staff in private and spoke to staff from eight different external stakeholders. We received further information from more than 100 people who had used the trust's services, through interviews and written submissions. MPs and local councillors submitted their views and the views of the constituents they represent.

The investigation team was led by a compliance manager who was independent of the compliance team who usually led on the trust. The investigation team comprised of compliance inspectors; specialist advisors from emergency care; a former chief executive; analysts; regional intelligence and evidence officers and business support staff including staff from our National customer service centre.

Main findings

Respecting and involving people (Outcome 1)

The 2011 National outpatient department survey data highlighted concerns in some aspects of care patients had received before their appointment and when leaving the outpatient department. The trust scored in the worst 20% of organisations in England for three (out of 51) questions. The main areas of concern highlighted were in communication with patients.

Outpatient appointment systems in the trust were subject to further independent review in November 2011. This independent review was triggered after a serious untoward incident review about a patient who had not been followed up in outpatients as required. The result of this serious untoward incident review was that the trust established that some 37,000 outpatient access plans, on the new electronic outpatient booking system (Lorenzo) had been missed.

The external review report, conducted by H&HBellairs Consulting Ltd, and published by Monitor in February 2012, highlighted concerns of a similar theme to those identified following other external reviews conducted within other areas of the trust. These included: failure to recognise the problem; shortage of staff and capability; the arrangements and organisational culture; clinical disengagement; change to booking arrangements without a full risk and impact assessment; no systematic capacity and demand work; delayed or protracted solutions; no real system of holding people to account and poor governance and risk management.

The information we have received from patients, relatives and MPs have confirmed that management of outpatient bookings remained as an area of concern. In particular, efficiency in outpatient appointment bookings and missed outpatient appointment bookings.

The trust has a head of patient and service experience, who also leads the complaints team. There was very little additional resource for the work on patient experience. As a result, developmental work around patient experience had been limited and the trust has missed opportunities to proactively improve patient experience and outcomes based on feedback. For example, the trust Quality Report for 2011 identified that limited progress had been made with regards to the development of patient information, an area identified as in need of improvement in national in patient survey conducted in 2010. Information provided by the trust identified that the main reason for contact with PALS during July to September 2011 related to concerns with regards to communication/information, accounting for 65 enquiries or 19% of the total of 339 PALS enquiries received by the trust.

Despite the lack of resource, some work around patient experience had been conducted. This included the national patient survey, matron's interviews with

patients and the use of 15 hand held devices that are used to collect patient stories. These hand held devices are circulated across the trust. Information provided by the trust indicated that 100 patient stories were being captured during the course of our investigation. In addition, a patient survey of users of the trust's maternity services had commenced and was due to report May 2012.

From discussions with staff and a review of information provided by the trust, we saw evidence that it has a number of committees that examine patient experience. Complaints that are received by the trust are analysed and a quarterly report is produced. There is a patient experience subcommittee who consider this report. It then goes to the integrated risk subcommittee and is fed to the board. However, senior staff commented that the process needs to be more robust as following changes to the report format last year the detail previously provided within these reports was lost.

The trust produces quarterly integrated patient experience reports, which include complaints, concerns, compliments, NHS choices, real time feedback based on the improvement areas from inpatient surveys, patient advice liaison feedback and patient stories. However, there was little evidence to suggest that the information collected by each of these individual methods had been collated and analysed for identification of any specific themes by department or speciality. We were told that the challenge for the trust is "*in sharing learning across the organisation*" and although a "lessons learnt" group had recently been re-established to progress this, this was an area that required further development.

The trust, in conjunction with the Lancashire Local Involvement Network (LINK), conducted an audit of patient experience for those patients that attended the accident and emergency department at the Royal Lancaster Infirmary in June and December 2011. Comment cards were completed by patients and required them to rate the following as either excellent, very good, good, average or poor: Communication and information; Respect and dignity; Cleanliness and Overall experience. A slightly higher proportion (59%) of people rated their overall experience as excellent in December, compared to June (54%).

Patients experienced long waits in accident and emergency for treatment or admission to hospital, especially at the Royal Lancaster Infirmary. For many following admission, this experience was compounded by movement between wards. There was evidence that this sometimes occurred at night and that patients were moved to wards outside of the speciality to which they should have been accommodated. This was to make beds available for other patients. The trust told us that they tried to place those who required less clinical intervention in these 'outlier' beds. However, we found evidence during our visits that patients that were moved did not receive regular medical review, appropriate care and that on occasion their discharge had been delayed.

Some staff also raised concerns about the suitability of the environment of the ward to which 'outlier' patients were placed and the adequacy of staffing arrangements to meet the needs of these patients. One member of staff told us that the observation of 'medical outliers' was compromised as "*staff cannot easily observe these patients because of the ward set up*". Another told us of an elderly, confused patient that had multiple falls following her transfer to the gynaecology ward and had to be transferred back to the medical ward.

Information provided by the trust confirmed that they were not achieving same sex hospital accommodation at each stage of the patient's care. According to the Department of Health's mixed sex accommodation breach statistics for February 2012, the trust reported 24 breaches at the Royal Lancaster Infirmary and three at Furness General Hospital. During our site visits we found examples of a lack of privacy and dignity being afforded to patients in the Clinical Decisions Unit at the Royal Lancaster Infirmary, as a consequence of mixed sex accommodation breaches.

We found that both male and female patients were accommodated together, sometimes for over 24 hours, without the provision of dedicated toilet facilities. The toilets are located within the open plan unit and women, dressed in night attire, were required to walk in the full view of the male patients to use these toilet facilities. While we did not observe such practice at the Clinical Decision Unit at Furness General Hospital, information provided by the trust confirmed that male and female patients are accommodated on the medical assessment unit at Furness General Hospital at times when accessibility to inpatients beds is problematic.

A further example where the privacy and dignity of patients admitted to the trust is compromised was through the use of security personnel to assist in the care and management of some patients. During one of our site visits to the Royal Lancaster Infirmary we observed a security guard sitting outside an open door to the room of female patient. This member of staff told us that the patient had been identified as being at risk of falling and that his role was:

"To make sure she doesn't fall, I wouldn't physically restrain or stop her from getting up, but would call for the nurse."

We looked at the records for this patient and found that they were a 'medical outlier'. A falls risk assessment had been completed prior to the transfer that did not indicate that they were at risk of falls. However, following transfer the patient fell eight times. The next recorded falls risk assessment was conducted following the seventh fall, when the patient was identified to be at high risk. Instruction on the form was that "*if high risk move to observable place and consider 1 to 1 nursing*". We found that the patient had not been moved to a more observable bed until eight days after this risk assessment indicated a need to do so. The additional '1 to 1' nursing did not commence until, the day after they had been moved to a more observable bed and was provided by a security guard and not a nurse during the hours of 12:00 to 20:00. When we

asked a member of staff they told us that they “*had used security guards twice in the last month, both times for medical outliers*”.

In this case, there was a fundamental clear lack of understanding among staff in how to manage basic aspects of care in relation to a patient at risk of falling. One of the staff we interviewed, from another ward where the trust are aware of staffing shortfalls, told us that security guards were often used where additional nursing staff cannot be provided.

We found evidence of poor attitude by some staff towards patients and their care. We received information from over 100 people who had experienced what they considered to be poor quality care. The theme of these concerns included:

- People experiencing long waiting times in accident and emergency.
- People feeling that there was inadequate staffing at the time of their visit.
- People being left alone for long periods of time in accident and emergency; lack of explanation about care and treatment.
- Being spoken to rudely by staff.

One relative told us that when her mother had complained about her care, staff had laughed and taunted her. Another patient told us that she had required assistance to use the commode; had been given limited assistance and fallen. She had then been sent for a CT scan and left alone with no blanket and “*feeling exposed*”. On telling a nurse this when she returned to the ward, the nurse told her “*don’t know what’s the matter with you, there are plenty of people worse off than you*”.

It is not only people who use services who articulated problems with the attitude of staff; several of the staff we interviewed also raised concerns about the poor attitude and behaviour displayed by some colleagues. The theme of these concerns ranged from verbally aggressive phone calls between staff to staff being shouted at by managers in public areas. In addition, the trust confirmed that the attitude of staff was also one of the most common causes of complaints.

Recommendations

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|---|---|
| 1 | Develop and promote a culture where the privacy and dignity of all patients is respected at all times. To ensure that any practice that is contrary to this are reported and action is taken. As part of this make sure that proactive and mandatory education regarding dignity and respect is delivered to all staff. |
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2	Put in place operational standards for the appropriate use of security staff in the care and management of patients.
3	Ensure that the trust acts on the outcomes of its own and national patient surveys and demonstrate that improvements to the quality of the patient experience across the trust are made.
4	Put a cultural change programme in place across the organisation that promotes an identity of a fully merged trust. The programme of change needs to engage all staff and articulate what the expectations are of individual staff.

Care and welfare of people (Outcome 4)

We received over 100 submissions from patients and relatives outlining examples of poor care. The majority of these were patients who had experienced care at the Royal Lancaster Infirmary, while other examples identified from Furness General Hospital and other sites. We did receive some positive feedback from patients who had experienced care at both hospitals. The terms of reference for this investigation identified one pathway of care to follow to explore the quality of care. We decided to examine in detail, the systems and processes in place for the provision of emergency care (referred to as a pathway). The remainder of this section examines the quality of care given to people within this pathway, as well as other issues that were identified.

Emergency care

Concerns about the quality of care in the emergency department, especially at the Royal Lancaster infirmary, were raised by staff, patients, relatives and stakeholders both prior to and during this investigation. In addition, the findings of external reviews, commissioned by the trust and conducted in 2009 and 2012, also identified concerns with regards to the quality of care patients received in the emergency department.

The SHA and commissioners were aware of the findings of each of these reviews and the SHA advised us that a health economy plan was developed and managed by the commissioners. However, we were not aware of the outcomes of these reviews until these documents were requested during the course of this investigation.

Concerns raised by patients and relatives mostly related to waiting times and the quality of care provided. Patients and relatives told us that they had extremely long waits in the emergency department and often experienced poor care. One patient told us that they had passed out at one stage due to extreme pain; was given no pain killers and had told staff that he “*wanted to die*” because of the pain.

Information provided by the trust shows that they have had difficulty in achieving three of the Clinical Quality Indicators set by the Department of Health for accident and emergency. While these indicators were published in December 2010, the trust has only been required to report on these indicators from April 2011. Furness General Hospital has had difficulty in achieving the four-hour access target (the national target is to admit, discharge or transfer 95% of patients within four hours of arrival to the emergency department) and the Royal Lancaster Infirmary had consistently encountered difficulties in achieving this target, with particularly poor performance in October 2011. In October 2011, at the Royal Lancaster Infirmary patients experienced an

average wait of just over seven hours, compared to an average of around six hours for this site. Concerns were initially raised with regard to the poor flow of patients (that is patients are not being transferred to wards or discharged from the emergency department quickly) and long waiting times following an external review conducted in January 2009.

Four recommendations were made to improve patient management in accident and emergency and ensure consistent delivery of the emergency waiting time standard. In September 2009 the trust reported progress that had been made in respect of these recommendations. However, the external review carried out in October 2009, by an emergency care intensive support team, reported a lack of tangible action against the recommendations made following the January 2009 review. The most recent review conducted in January 2012 at the Royal Lancaster Infirmary continued to identify similar areas for improvement to those identified in the reviews conducted in 2009.

The October 2009 report noted that:

“There is a need to put in place a more robust operational policy for the ED with performance management against expected timelines to initial assessment, formulation of clinical decision and dispersal from the ED, with the latter being no longer than 3 hours.”

The deterioration of performance in achieving the four-hour maximum waiting time for patient admission reflects the limited extent to which the trust had been able to implement the recommendations of the reviews conducted in 2009.

The systems and processes adopted within the emergency departments at the Royal Lancaster Infirmary and Furness General Hospital reflected an out-dated model of care delivery, where the patient’s journey and experience of a service can appear uncoordinated with waits and delays inherent in the system. Capacity issues elsewhere in the urgent care pathway have been shown to affect this experience, leading to variable care and unsafe working practices. This creates within the emergency departments the cycle of shortages of cubicles, delays to review of existing patients, capacity bottlenecks, spiralling treatment delays, decreasing patient safety and variable compliance with the Department of Health clinical quality indicators.

The GP urgent care service has been developed by local commissioners. This is a system whereby experienced local general practitioners work alongside the emergency department practitioners in the ambulatory care area of the department, to advise and support emergency care staff on ambulatory patients who could be cared for in the community and avoid the number of unnecessary admissions to the trust.

However, we found that because of capacity issues elsewhere in the emergency department, patients referred to this service often experienced

long waits as stable non-ambulatory patients awaiting a bed were often occupying all available space within the emergency department. Staff told us that other clinical areas (outside of the main emergency department footprint) were frequently used to see patients because of a lack of physical space. They raised concerns regarding the safety of patients and staff when such facilities were used due to lack of visibility of patients and staff by other emergency department staff. The extension and refurbishment of the emergency department at the Royal Lancaster Infirmary, including the development of a new minor injuries unit, commenced in February 2012 and has a scheduled completion date of October 2012.

At the time of our site visits to the Royal Lancaster Infirmary, policy within the trust was to admit all stable GP admissions to the emergency department. We were told that this action had been taken after patient safety concerns, directly attributable to lack of availability of beds, had been raised by GPs. This action resulted in an ever increasing volume of patients attending the emergency department and longer waits for patients within the emergency department.

During the course of this investigation, and following enforcement activity we took after our inspection of the trust in December 2011, action was taken by the trust to stop this practice.

The Department of Health clinical quality indicators for accident and emergency (2010), states that an initial assessment (triage) should be conducted for all people who arrive at the emergency department within 15 minutes of their arrival. Information submitted by the trust, for July to December 2011, indicates that this target was being achieved at Furness General Hospital, but not at the Royal Lancaster Infirmary, where this target was consistently not achieved and an average wait for initial assessment at the Royal Lancaster Infirmary was 22 minutes.

However, observations we made at both sites found the timing and recording of this information to be extremely variable as there was no reliable way of capturing this information electronically. Indeed, information submitted by the trust showed that between 1 April 2011 to 31 January 2012 there were 2,233 recorded delays which lasted more than 15 minutes at the Royal Lancaster Infirmary. At Furness General Hospital there had been 36 delays during the same reporting period. While the average delay at Furness General Hospital was 29:47 minutes at the Royal Lancaster Infirmary it was 34:44 minutes.

The external review report conducted in October 2009 identified concerns regarding the triage process that was in place at the Royal Lancaster Infirmary and stated that:

“During our visit I observed in excess of five ambulance arrivals within the department. Without exception none were greeted by nursing or medical

staff, instead ambulance crews stood and waited in the corridor until approached by nursing staff some time later. I would suggest that this needs urgent attention; a process needs to be implemented with immediate effect to address these gaps in the reception of both ambulance and ambulatory patients. This needs a robust performance management framework around it to ensure that patients are quickly and safely assessed on arrival within A&E."

In 2011, action was taken to address these concerns through the provision of a role, described to us as a "triage corridor co-ordinator". As a member of the clinical emergency department team, the post holder was to conduct initial clinical assessments. The aim was to limit the time a patient waited in the corridor. While some improvement to patient waits was evident as a result of this initiative, the post holder was only present between 11:00 to 19:00. The remaining time was not backfilled by the trust when the nurse was off duty. The privacy and dignity concerns associated with conducting patient assessment in a corridor were not addressed.

We visited the emergency department at the Royal Lancaster Infirmary on a number of occasions, over the course of five days and at different times of the day, the majority of which we observed patients waiting in a corridor within the accident and emergency department attended by ambulance crews. During the course of our observations additional patients joined the end of the line and it was the ambulance crew who took responsibility for ensuring patients with the greatest need, and highest clinical priority, were moved to the front of the queue. These patients did not have their clinical dependency assessed and little or no interaction took place between the patient and a member of the emergency department team until the time of the handover from ambulance crew to emergency department staff.

Staff also told us that the nurse allocated to triage was the first to be re-deployed to the dedicated resuscitation area within the department, when shortages of staff were experienced. Our observations at the time of our site visits to the Royal Lancaster Infirmary confirmed this to be the case.

Standards within the emergency department, related to the need for, or frequency of physiological observations, were not enforced. We were told that a Physiological Observation Track and Trigger System (POTTS) and Early Warning Score (EWS) were used as a means of monitoring a patient's condition and directing action in accordance with the EWS. However, when we visited both sites we observed inconsistent practice by staff with regards to the frequency of observations as directed by the trust POTTS protocol. For example, we looked at the records of a patient who had a EWS score of 5 recorded at 02:35 and the next record EWS score was made at 05:30. As such all of the observations that the patient required were not recorded. The EWS action algorithm states that for a EWS score of four or more "*Increase frequency of OBS to at least hourly*". This is of concern and a clinical risk, as lack of surveillance increases the risk of failure to detect deterioration in a patient's condition.

A further example is that during our site visit to Furness General Hospital we observed that a patient had been assessed to be at significant risk of harm, yet was allowed to go outside the emergency department unsupervised. No further reassessment of risk was done on this patient from the time the patient was seen by the emergency department clinician to the time they were reviewed by the oncoming psychiatric liaison team over five hours later. This despite the recommendations of a recent serious untoward incident and Ombudsman enquiry that mental health patients deemed to be 'high risk' should be reviewed and not be left unsupervised within the emergency department.

We found little evidence that there had been development of evidence based integrated care pathways for the provision of care in the emergency department and other clinical specialities. Where pathways had been developed we observed, and staff we interviewed told us, that they were not consistently used to record care that had commenced in the emergency department. The trust policy was to commence this document while the patient was in the accident and emergency department. For example, when we looked at one patient's records, at Furness General Hospital, we found that the integrated care pathway document for fractured neck of femur (broken hip) had not been commenced until they had been admitted to the ward. This patient had not had an electrocardiograph (heart tracing) while in the accident and emergency department. When this test was conducted prior to surgery, abnormalities were found. In addition, we observed two versions of a generic care pathway used in the two medical assessment units.

When we asked staff about this we were told that both documents had been developed in isolation. Staff also told us that while the integrated care pathway documents for fractured neck of femur had been in place for some time at Furness General Hospital, it had only been introduced at the Royal Lancaster Infirmary on 6 February 2012, the first day of our site visit inspection to the Royal Lancaster Infirmary.

We found evidence that there were delays in the admission of patients to an in-patient bed following their discharge from the emergency department. These delays were in part due to waits for transport to medical unit 2 at the Royal Lancaster Infirmary but the majority were due to beds not being available. Data provided by the trust identified that at the Royal Lancaster Infirmary, 40% of the 2,233 recorded delays in handover of patients to emergency department staff from 1 April 2011 to 31 January 2012 were caused as a result of no hospital beds being available. While at Furness General Hospital 27.78% of the 36 recorded delays for the same time period were caused as a result no hospital beds being available.

Staff told us when bed capacity becomes problematic senior staff initiate the transfer of some patients to other wards. The care and management of patients who have been placed on wards outside of the speciality to which

they should have been admitted (referred to as medical outliers), was raised as a concern by some of the staff we interviewed. One member of staff told us:

'Risk management doesn't understand the risks of outliers. We were not asked about what the solutions would be, get invited to meetings but they don't listen.'

There did not appear to be any systematic approach to ensure this group of patients are reviewed consistently and regularly by medical staff. Some of the staff we interviewed told us that they spent a significant amount of time attempting to contact medical staff to review their patients. In addition, we found examples of two patients who had not been reviewed following transfer from a medical ward. One patient, at the Royal Lancaster Infirmary, waited over 24 hours for a review of blood tests that had been completed. Another patient, at Furness General Hospital, waited five days for review and when this happened they were found to have a fracture of the spine. From the notes, it was not clear how serious the fracture was, how and when it occurred, when the x-ray was done, and whether there had been any indication of the injury prior to it being identified.

Some of the patients and relatives we spoke with told us that transfer of their relative had taken place during the night and that medication had not been transferred with them. One relative told us that her husband's medication had been lost and that he didn't get them for two days as the hospital pharmacy had been unable to supply them.

Discharge

There were concerns raised about the discharge process within the trust, with a reported lack of consistency in applying discharge processes, especially for those patients who are 'outliers'. A discharge planning team was introduced at the Royal Lancaster Infirmary in 2011, but not at Furness General Hospital, where there is a lead discharge nurse and nurse discharge co-ordinators on three wards. No rationale was articulated with regards to the differences in approach at the two sites.

Site based 'complex discharge' meetings to manage and monitor individual complex cases were held weekly on both sites. These were multidisciplinary and involved external partner agencies. In addition, there were bed managers at both sites and the bed manager at the Royal Lancaster Infirmary had additional support from a deputy matron.

We were told that the trust was reviewing its discharge strategy and that all relevant specialities were involved in a project to review the length of stay of patients and was considering how it could reliably adopt the principles of the department of health guidance "*Discharge from hospital pathway, process and practice*".

Information provided by the trust indicated a higher than average length of stay in medicine at the Royal Lancaster Infirmary (6.7 days) when compared to the national average (5.4 days) and many staff attributed this to a lack of rehabilitation service provision both within the trust and in the community. While the trust has rehabilitation beds, staff told us that the 'step down' facility at Westmorland General Hospital was only available to patients who live in Kendal. During our site visit we observed patients who were awaiting rehabilitation; beds were available at Westmorland General Hospital but the patients were not transferred as they did not live in the Kendal area.

A senior manager described the capacity problems at the Royal Lancaster Infirmary as being due to the "*culture of actually not doing particularly medical ward rounds early in the day*". Early ward rounds were conducted on the medical admissions unit at the Royal Lancaster Infirmary. We were told that this had made a difference to the availability of beds within this facility. Other staff raised concerns that medical review of patients were not conducted daily by all consultants and that some patients were not reviewed at all at weekends.

The majority of staff told us that another of the main reasons for delays in patient discharge is lack of 'to take out' medication (TTO). Patients should be sent home with all of their medication. The electronic patient management system (Lorenzo) is used to order TTO medication and to write the discharge summary. We were told that delays with producing a prescription have been experienced following the introduction of Lorenzo. However, senior staff told us that there were also delays when prescriptions had to be hand written. A concern with regards to the timeliness and content of discharge summaries was also noted by one of the statutory stakeholders in the trust quality account published in June 2011.

Staff told us that where the discharge of a patient can be predicted doctors are requested to order the TTO medication in advance. However, we were told that there were dedicated times when medication that has been ordered will be returned to the ward. The outcome of this was a high number of patient discharges in the afternoon/evening or an additional, unnecessary overnight stay in hospital for some patients. Staff told us that the admissions lounge was often used to accommodate patients who were waiting for TTO medication. One patient told us that the doctor had discharged them at 10:00 and did not leave hospital until 15:30 as they had to wait for a discharge letter. Concerns were also raised that delays in completion of both TTO prescriptions and discharge summaries were significantly worse for the 'medical outlier' patients.

The trust did not have an electronic, real time, bed management system in place at either site. Bed meetings were held three times a day and were used to discuss the beds that are available and to predict any that may become available later. There is good evidence that the bed management that was in place was not effective. We observed bed meetings at the Royal Lancaster

Infirmery and found that little discussion took place at these meetings, nor did any agreed actions to maintain flow within the hospital emanate from them. However, this was not our observations of the bed meetings at Furness General Hospital, where we found that actions were agreed and progress monitored.

A senior member of staff described the bed meetings as “*pointless with no output*”. Another senior member of staff told us that the information they received from wards was often inaccurate as staff did not declare all beds that were available and that more accurate information was achieved through “*walking around*” the wards.

The outcome of this inaccurate bed availability recording was that patients who were admitted to hospital for surgery were sometimes admitted on the basis of a bed being available or may be available after surgery. Staff told us that there had been occasions when predicted bed availability had not been realised and the patient had had to remain in the theatre recovery area until such time that a bed did become available. The trust’s integrated performance report for January 2012 identified that 10 operations had been cancelled “*at the last minute*” at the Royal Lancaster Infirmery due to beds not being available. Several staff we spoke to identified specific wards that were known to mis-declare their bed state or that simply did not declare empty beds as soon as they became available. Despite this being reported to senior managers, little action had been taken to address this.

The trust had some initiatives and staff in place to try and improve the discharge process. This included community discharge teams who worked to support patients being discharged from the trust. There was also a Short Term Intervention Team (STINT) within Furness General Hospital who worked within the emergency department and inpatient wards. At the Royal Lancaster Infirmery the Rapid Emergency Access Co-ordinator Team (REACT) worked predominantly within the emergency department, but had recently begun to review patients who were able to be discharged within 24 hours of admission.

Staff told us that they had seen improvements in the delay to patient discharge previously experienced as result of these initiatives. A review of their effectiveness to determine future service provision had been scheduled. We were told that the local authorities differed in the level of community service that they provided, which impacted on the ability for patients to be discharged, with a lack of community rehabilitation and nursing/residential care facilities a concern for many of the staff we interviewed.

Delay to the discharge of patients that required additional support at home was further compounded by a delay in their referral for assessment of social care needs. The majority of staff we interviewed told us that patients could not be referred for assessment until the patient had been assessed to be medically fit for discharge. However, when we spoke with one of the local authorities they told us that while this had been the case 12 months ago,

following initial discussions with senior managers at the trust regarding the remodelling of discharge services, they had agreed to take earlier referrals. The local authority also expressed concern at the lack of knowledge among trust staff of the transitional care services that are available.

Recommendations	
5	Develop and implement a trust strategy for improving flow of emergency/urgent patients. This strategy needs to have the engagement of all clinicians and managers as a key component.
6	Put in place operational standards for the routine clinical surveillance of patients attending the emergency department.
7	Develop its discharge and bed management teams and processes to ensure that they are interlinked and that patient flow is managed effectively from the point of admission to the point of discharge.
8	Review current guidance regarding 'to take out' medication so that patient discharges are not delayed. The trust needs to ensure that it monitors adherence with the guidance and takes appropriate action to ensure the delivery of a timely and effective service.
9	Develop and utilise a more effective and accurate means of collection and use of bed management and discharge information. To facilitate more effective bed management and significantly reduce the number of 'medical outliers'.
10	Review current guidance regarding referrals for review by social services to support improvement in discharge planning and discharge of patients.
11	Review access to rehabilitation facilities at Westmorland General Hospital to ensure equitable access on the basis of clinical need.
12	Develop a culture where everyone feels empowered to challenge unacceptable standards of care. This may be regular monitoring of practice and feedback and learning opportunities for staff.

Co-operating with other providers (Outcome 6)

Both the trust and NHS partners, including commissioners, reported that historically there have been difficult relationships between them.

NHS partners and commissioners have been aware of concerns with regards to the quality of services provided by the trust for some time. In May 2010, one of the commissioners raised concerns with the trust about a number of issues relating to the trust services, including urgent/emergency care, and identified a need for more effective trust engagement with primary care. The importance of seeking clarity on the concerns raised and identification of the remedial action required was also stated, as was the concern as to the damage that could be caused to the joint work that was needed in the medium and long term, should the concerns remain unresolved.

While the trust provided a response to each of the concerns that had been identified, they also expressed disappointment that the commissioner seemed to regard the failure to meet accident and emergency 4 hour waiting time targets and ambulance turnaround times, as an acute trust issue rather than a symptom of the performance of the whole health economy.

Senior staff at the trust stated that dialogue with commissioners in the past had not been constructive, but there had been recent improvement. This view was supported by one stakeholder who described more effective working relationships regarding complex discharge arrangements.

There was evidence of integrated working across the trust to support the discharge of patients. Some staff are employed by other stakeholders but work within University Hospitals of Morecambe Bay NHS Foundation Trust to facilitate discharge either to social care or to community hospital beds or to prevent admission. However, absence of effective partnership working in the past has impacted upon the speed in which proposed service developments have been implemented, with delays in service development to deliver the delivery of unscheduled care (acute medical services), identified in 2007 following the review of acute medical services provision conducted in 2006, being one such example.

In 2006, the trust conducted a review of acute medical services provision and following consultation with Cumbria PCT, a new model for the delivery of acute medical services was agreed. The aim of which was to provide “*a more integrated service across hospital and community settings*”. The target for an implementation of the new model was agreed as April 2008, although it was also stated that implementation would be incremental. One of the changes that was identified was the closure of the emergency treatment service at Westmorland General Hospital, and the development of this service into a Primary Care Assessment Service. It was anticipated that this move would lead

to additional numbers of patients attending the emergency departments at the Royal Lancaster Infirmary and Furness General Hospital.

The trust recognised that additional work was required to determine the means by which this additional number of patients could be accommodated. However, the speed in which the alternative means of service provision were developed and introduced did not keep pace with the target for implementation of the new model. This has resulted in an ever increasing number of patients attending the emergency department at the Royal Lancaster Infirmary and patients experiencing long waits to receive care and/or to be admitted.

While development of an integrated rehabilitation service provision between hospital, community and social care was seen as fundamental to this new model, it is clear that implementation has been different across the trust, with services in Cumbria being more advanced than those in Lancaster. For example, measures to prevent admissions into hospital through provision of community lead service within the emergency department have been in place for some time at Furness General Hospital but have only recently been implemented at the Royal Lancaster Infirmary.

There was clear pressure to deliver improved services due to the increasing numbers of patients attending the emergency department, an increase in numbers of patient complaints and the struggle the trust were experiencing in meeting four-hour maximum wait in accident and emergency before admission, transfer or discharge. Senior managers at the trust and stakeholders described poor relationships between them as contributing to delays in the development of these services.

The trust has reported that there is a paediatric special interest group within accident and emergency. However, concern with regards to the adequacy of arrangements for the care of patients with mental health needs was raised as a particular problem by senior staff in accident and emergency. Staff indicated that patients experienced long delays waiting for the crisis assessment team to attend the department and this was confirmed by the observation we made at the time of our site visit to Furness General Hospital.

Another area of concern raised by staff was the accessibility to community services, particularly nursing/residential and rehabilitation services. Staff indicated that a lack of such service provision had resulted in patients experiencing delays in their discharge.

External stakeholders described a culture within the organisation that was both affable and approachable, but was either unwilling or unable to respond in a timely way to concerns raised. Indeed commissioners we spoke with told us that the trust had been heavily focussed on achieving foundation trust status and suggested that the trust's focus on this process potentially detracted from the concerns being raised about the quality of patient care.

The lack of engagement of clinicians at the trust was cited as a major concern by all of the commissioners, as well as the trust management's lack of action to resolve this. In addition, commissioners also raised concerns that the trust failed to deal with 'difficult' senior clinicians, variations in practice, insularity and resistance among senior clinicians to move to cross-bay working. These were issues that were also identified by staff at the trust that we spoke with and this is detailed elsewhere within this report.

Recommendations

13	Engage and develop robust working practices with external providers and partners to facilitate adequate provision of rehabilitation and mental health services.
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Safeguarding people from abuse (Outcome 7)

The trust's safeguarding arrangements at the Royal Lancaster Infirmary have recently been assessed as part of the joint regulatory assessment of children's safeguarding services and services for looked after children as part of the Ofsted/CQC inspection of Lancashire Local Authority. Additional information can be found in those recently published reports.

The trust had a group for safeguarding adults and safeguarding children, which discussed a range of issues regarding its safeguarding arrangements, including education of staff. Minutes from the meetings indicated that a range of relevant issues were discussed. However, while the minutes showed that individual safeguarding incidents were discussed there was little evidence of any discussion having taken place regarding trend analysis from safeguarding referrals and the minutes provided little detail of any topics that had been discussed at the meetings.

Membership of the group was reviewed in September 2011 when the group membership was extended. However, there had not been full attendance by all members of this group between April 2010 to November 2011 and some members of the group had attended less than 50% of the meetings. The Lancashire Ofsted/CQC report of safeguarding and looked after children services published in March 2012, identified poor safeguarding practices; ineffective governance arrangements; insufficiently robust arrangements for the treatment and safeguarding of children and young people and significant gaps in full compliance with requirements with regards to safeguarding audits and the commissioning of safeguarding training.

Following the publication of this report, action has been taken to strengthen divisional governance and risk management arrangements. This includes the establishment of an accident and emergency special interest group to share learning and assist in embedding new safeguarding standards and guidance.

While the trust have named doctors, nurses and midwives for safeguarding children and safeguarding reporting structures including escalation of concerns are in place, the recent Ofsted/CQC inspection raised concerns regarding the robustness of the safeguarding arrangements for children and young people that are in place at the Royal Lancaster Infirmary. As a result of the Ofsted/CQC inspection action has been taken to strengthen named nursing and midwifery staff capacity and to strengthen lead safeguarding roles within teams. This includes ensuring protected time to enable midwives working with vulnerable women to fulfil their safeguarding and partnership working responsibilities. Information provided by the trust indicated that they have also recruited an additional named nurse for safeguarding to ensure that one named nurse is located at both the Royal Lancaster Infirmary and Furness General Hospital.

Some stakeholders told us that there were effective working relationships between the trust and safeguarding boards. However, they also told us that oversight of their performance by Cumbria LSCB (Local Safeguarding Children's Board) was relatively recent and limited in scope. They also stated that there was an appropriate level of representation on the Cumbria Executive Safeguarding Board, (although the trust had only been invited to attend the Board from December 2011, and trust attendance at the board was from a middle manager rather than senior manager level) and the Lancashire area leadership group which is a sub group of the Lancashire safeguarding board.

However, concerns were expressed that while the nominated trust representative was of an appropriate level, their attendance has been poor at these meetings and the trust representative that did attend the meetings had not always been someone with the authority to make decisions at a strategic level. Stakeholders told us that while they received safeguarding alerts from trust that the majority of these had been for those patients admitted to the trust where concerns of abuse or neglect were identified at the time of admission, with very few alerts having been raised where abuse or neglect may have occurred while in the care of the trust. The trust indicated that they were using cross district safeguarding policies and procedures; this was confirmed by stakeholders.

The trust did not have a safeguarding adults training strategy despite having identified the need for one in February 2011. However, safeguarding adults and safeguarding children training (level 1 basic awareness) is included as a component of the trust's corporate induction training and the mandatory training workbook. Staff are required to complete an on line questionnaire to demonstrate that they have understood what they have been taught. Data supplied by the trust showed some variation in the number of staff who had completed level 1 basic awareness safeguarding training with medical staff reported as the lowest percentage of staff to have completed the training. In addition, staff who work with children are required to complete level 2 child protection training within the first six months of commencement in post, followed by updates every three years. We have been unable to determine whether this trust standard has been met as a central record of all staff that had completed level 2 child protection training has not been maintained.

There was variation in response from the staff we interviewed when we asked if they had received safeguarding training, and some staff did not appear to understand the term 'safeguarding' until prompted by inspectors. A proportion of staff told us that they had received training in children's safeguarding and safeguarding adults; others told us that they had received training in children's safeguarding but not safeguarding adults and others told us that they had not received any training at all despite their having worked at the trust for a considerable period. An area of concern raised by some staff was that the time afforded on the corporate induction programme for

safeguarding training was inadequate to ensure that staff would be able to recognise safeguarding concerns.

Recommendations	
14	Develop a safeguarding adults training strategy and ensure that all staff complete the appropriate level of safeguarding adults and safeguarding children training.
15	Ensure appropriate representation and attendance at internal and external safeguarding meetings.

Safety, availability and suitability of equipment (Outcome 11)

The trust maintained a register of all equipment and their expected lifespan. Information provided by the trust regarding equipment that needs to be replaced (as at October 2011) indicated a range of critical items of equipment that were in need of replacement (nearing end of lifespan, obsolete, broken, not fit for purpose etc.). While replacement of these items of equipment had been approved, timescales for replacement had not been identified. The trust's monthly integrated performance report for January 2012 identified that nine operations had been cancelled "*at the last minute*" due to equipment problems.

Access to equipment was articulated as an area of concern, by a number of staff, at both emergency departments. One member of staff told us that:

"Equipment on A&E is old, unreliable and there is not enough of it."

In May 2010, North Lancashire PCT presented a paper to the trust board regarding patient safety and clinical quality issues at the trust. One of the service failings reported within the document was that:

"GPs working on the Urgent Care Floor in UHMB report a lack of basic equipment such as auroscopes and blood pressure cuffs."

We observed that there was a lack of availability of blood pressure cuffs, of the various sizes that are required, at the accident and emergency department at Furness General Hospital.

Staff in the emergency departments told us that they often had problems accessing equipment such as fluid pumps. This was because patients were transferred from the emergency department to the ward, equipment wasn't returned and staff spent time searching for equipment.

Another issue raised by staff related to the trolleys that were in use at both emergency departments. We were told that senior management had been aware for some time that several of the trolleys that were in use were unsuitable, but funds had only just been made available to purchase new trolleys.

Concerns regarding the withdrawal of a trust ambulance that had been used to transport patients from the main hospital site to medical unit 2 were raised by staff at the Royal Lancaster Infirmary. The distance between the two sites is relatively short, but is not under cover and ambulance transportation was required following withdrawal of the trust ambulance. Staff told us that re-instating the ambulance would improve the current internal transfer

arrangements as patients would not be unduly delayed through waiting for an ambulance. Several patients we spoke with raised concerns about the lack of availability of on-site transport between medical unit 2 and the main hospital site.

The trust has systems in place to audit the quality of bed mattresses. Mattresses are audited every three months and records are retained in the Infection Prevention and Control office. However, staff told us that ‘condemned’ mattresses were still in use at the trust and replacements were the responsibility of each individual ward. We were told that the trust would only know if all condemned mattresses had been replaced when the next audit was conducted and that there was no annual funding programme for the replacement of mattresses.

Some staff raised concerns about the availability of paediatric resuscitation equipment in the emergency department at Furness General Hospital. We were told that equipment had not been available at the time an ill child was admitted to the department and equipment had needed to be accessed from another clinical area. Staff told us that paediatric resuscitation equipment was routinely checked to ensure that all required items are available for use at all times. However, when we looked at these records we found that there were omissions in the records of weekly checks at Furness General Hospital and unlike the document used at the Royal Lancaster Infirmary, the document did not itemise each piece of equipment that was required.

Recommendations

16	Review the availability of medical devices in clinical areas and ensure that appropriate levels of equipment are available at all times. Ensure that staff are appropriately training in the use of medical devices and introduce a programme of regular review to ensure proactive response to changes in service provision.
17	Develop a strategy for the proactive replacement of equipment to ensure that all items of equipment remain fit for purpose and that sufficient equipment is available at all times.
18	Ensure that systems are in place in accident and emergency departments so that sufficient resuscitation equipment is available.

Staffing (Outcome 13)

From the data supplied by the trust, an accurate figure for the number of vacancies per staff group per department could not be established. Despite repeated requests to the trust, we could not reconcile the vacancy totals, funded establishments and staff turnover data that had been supplied. This meant that it was not possible to conclusively determine the number of vacancies at the trust or whether vacancies were more evident within an individual staff group per department. However, the information provided by the trust for the reporting period April 2011 to 30 March 2012, indicated a higher percentage vacancy factor, for medical and dental staff and registered nurses and midwives, within emergency care when compared with the whole trust.

What was clear from the documents was that the trust had a smaller number of permanent staff compared to its funded establishments, and of the 486 vacancies that were advertised from April 2011 to January 2012, 34% were temporary posts. However, it has not been possible to determine specific services or departments where vacancies exist as vacancy information is not reported in this way.

There was regular use of bank staff in the period from September 2011 to February 2012, where the trust used an average of 4.3 whole time equivalent (wte) bank nurses each day. Information provided by the trust indicated that a total of 28 substantive, non-medical staff, were rostered to work across the two emergency departments. The maximum number of bank staff used across the emergency departments on a single day was reported as 7 wte on 9 February 2012 and that 5 agency staff were also on duty. This was at a time of high patient activity due to particularly inclement weather.

The second highest number of bank staff used across the emergency departments on a single day was reported as 7 wte on 5 February 2012 and that two agency nurses were also on duty. This means that on 5 February 2012, 24% of the staff that were working within accident and emergency were not substantive members of staff.

Our inspection of the Royal Lancaster Infirmary emergency department, conducted in December 2011, identified significant concerns regarding the adequacy of staffing arrangements. We found that the number of staff that had been on duty at the time of our inspection, and the number of staff routinely rostered to be on duty at night, was insufficient to meet the needs of the people using the service. The trust have since provided an additional nurse at night, however, we were told that this increase in staffing was a temporary measure and a permanent increase to the staffing establishment had to be agreed.

We were told that medical staff vacancies within the emergency department was of particular concern, especially at the Royal Lancaster Infirmary. The sustainability of clinical staff recruitment at the emergency department at the Royal Lancaster Infirmary was added to the trust's strategic risk register in 2011, prior to our inspection of the Royal Lancaster Infirmary in December 2011. Despite the long standing difficulty in recruiting medical staff, when we spoke with senior staff in the emergency department, little thought had been given to the use of non-medical clinicians and there was little evidence of significant extended role development for professions allied to medicine.

There were a very small number of emergency nurse practitioners (ENP) at the Royal Lancaster Infirmary and none at all at Furness General Hospital. ENPs work for those patients attending with minor injuries and illnesses. However, ENPs have historically been pulled from this work to undertake traditional nursing roles when there is insufficient flow (that is patients who are not being transferred to wards or discharged from the emergency department quickly). This reduces the clinical exposure of the ENP group, who may never gain the confidence in treating a wider range of clinical presentations. We were told that ENPs had left their posts at Furness General Hospital because they were dissatisfied with their roles.

Another area of concern raised by staff was the absence of a suitably trained paediatric nurse. While the trust has a paediatric nurse within the staffing establishment for the emergency department this post had been vacant for some time, and when an ill child was admitted to the emergency department support was provided from the medical and nursing team from the Paediatric Department. While staff we spoke with had no concerns with regards to the adequacy of these arrangements when prior notice of such admissions was received, they did raise concerns about the care and management of ill children on those occasions where no prior notification had been received.

While the nursing establishment and skill mix have recently been reviewed at the Royal Lancaster Infirmary, this had yet to be started at Furness General Hospital, although we were told that additional support workers were required. However, a meaningful workforce or staffing plan cannot be undertaken until an overall emergency department strategy has been developed as some of the perceived need for extra staff may not be required once more structured pathways through the department have been improved and working practices changed.

Lack of staff was not just a problem in the emergency department. Information provided by the trust indicated that there were concerns with regards to the adequacy of nurse staffing within the division of medicine. In August 2010 a nurse staffing benchmarking exercise was conducted at the trust by the Audit Commission. The outcome of this review was that when compared with 69 other hospitals, while the average nurse to bed ratio for the trust was 1.26 wte, for the division it was 0.9 wte, giving a shortfall of 33 wte below the national peer group. Six wards were identified as having a

significant shortfall, four at the Royal Lancaster Infirmary and two at Furness General Hospital. In addition four other wards were marginally below the peer groups, three wards at the Royal Lancaster infirmary and one at Furness General Hospital.

In July 2011 approval was given by the Chief Executive Group to increase the nurse to patient ratio from 0.95 wte per bed to 1.1 wte per bed. However, only temporary funding was agreed and in a paper presented to the Clinical Quality and Safety Committee in October 2011 the limitations of this approach were stated as *“there is generally little uptake for temporary posts.”* Indeed in January 2012 a further paper was presented to the Chief Executives Group which stated that:

“The division remains approximately 29 WTE nurses below our national peers group. It is nationally accepted that appropriate nurse to patient ratios are directly related to safe, timely patient care and outcomes.”

One senior manager told us that the decision to approve the temporary increase to the nurse establishments had been *“protracted”* and that they had experienced *“a lot of sleepless nights”*. They went on to say that until the additional nurses had been brought into post to address the remaining shortfall concerns with regards to the adequacy of staffing arrangements would remain.

Concerns with regards to the adequacy of staffing arrangements raised by staff were not limited to medical and nursing staff. Staff told us that a lack of availability of porters at the Royal Lancaster Infirmary had led to delays in the movement of patients from the emergency department to other departments and that in some instances members of staff other than porters had transferred patients which had resulted in other patients being left unattended.

There had also been changes to the portfolios held by different members of senior staff, including members of the executive team, and concerns were raised by some staff about their ability to effectively manage their extended portfolio. One member of staff told us that they were *“drowning”* and that because of the pressure they were not able to address their strategic priorities.

The trust has a policy to direct staff on the actions to take where there are insufficient staffing levels. The majority of staff that we interviewed told us that they would alert the site co-ordinator or matron and request additional support. One member of staff we interviewed told us that they would report it as a clinical incident. However, during our site visits we observed examples of inadequate staffing arrangements, where the situation had been escalated and additional staffing to manage the risk to patient care had not been provided. The outcome for the patients was that while we observed staff trying very hard to provide care to the patients, they did not have time to do more than tend to basic care needs, documentation had not been completed

and relatives raised concerns about the poor level of communication they had with staff regarding the care and management of the patient.

While the majority of staff we interviewed were aware of the whistleblowing policy, some staff expressed concerns over reporting incidents. Indeed during the course of the investigation we received information of concern from seven whistleblowers who had not felt able to raise concerns with the trust for fear of recrimination.

Recommendations	
19	Review its human resource information systems and ensure that accurate data is available for the entire organisation, so that robust data reporting is ensured.
20	Establish a workforce strategy and plan that looks at: the current staffing establishments and skill mix; recruitment and retention; contingency and succession planning.
21	Undertake systematic skill mix and staffing needs analysis in accident and emergency at Furness General Hospital to ensure that they have the right numbers of staff, with the right skills, available at all times.

Supporting workers (Outcome 14)

The trust is a university hospital and as such has links with a number of education establishments. There is an education and training department, led by the Director of Human Resources, and is an integrated structure between medicine, nursing and allied health professionals. Beneath the Director of Human Resources there is an assistant director of Knowledge Education Learning and Development (KELD) and a Director of Medical Education, and staff from clinical divisions and within other specialist departments that help to deliver education and training across the trust.

The trust has two education centres and a variety of training opportunities are provided to staff internally. Also additional training for staff is provided by external trainers. Documents provided by the trust show that bank staff are required to complete both induction and annual mandatory training. However, while the majority of bank staff that have substantive employment with the trust have completed the mandatory training, information provided by the trust indicates that seven (20%) of the 35 other bank staff used have yet to complete the annual mandatory training. The trust also use agency staff and training for this group of staff is provided by their employer.

The trust's People Strategy was approved in October 2007 and is currently being revised. The revised strategy focuses on a number of areas, including: workforce development and downsizing and succession planning and talent management. The revised strategy has not yet been approved by the trust board.

A training needs analysis aligned to the special needs of a speciality or department had not been conducted at the trust. Information obtained from annual staff appraisal was also not systematically used as the means for determining training and education requirements. As such, the requirements and specialist staffing skills for each individual ward or department had not been identified. One member of the executive team that we interviewed told us that they were concerned that a workforce development strategy, based upon the principles described, had yet to be developed and some of the staff we interviewed raised concerns about the lack of training and development they had received prior to re-deployment following service reconfiguration.

Induction training for new starters is mandatory and includes attendance at the corporate induction training and completion of a local / speciality work place induction. The only exception to this was all those staff employed on temporary contracts where, according to the trust Staff Induction Policy (2011 – 2013), attendance at the corporate induction training was not mandatory. Monthly corporate induction programmes were held at both sites and the trust's target for attendance within two months of a permanent member of staff's commencement in employment had been set at 95%. Data

from the trust indicate that the trust had consistently failed to meet this target from 2010 to 2012. For example during the third quarter of 2011 – 2012, 87% of new starters had attended the corporate induction within the specified time frame, 10% within three to four months and 3% had been with the trust for five months or more before attending the training.

The majority of annual mandatory training was delivered to staff in the form of a mandatory training work book and staff were required to complete and achieve an 80% pass score on an online multiple choice questionnaire to demonstrate their understanding of the training they had received. Data provided by the trust indicated that on 31 December 2011 only 60% of staff had completed this training and mandatory training should be completed by all staff by 31 March 2012.

However, while the trust retained records of all staff that have completed the multiple choice questionnaires, they did not retain central records of all mandatory training that had been completed. This information was held by individual managers and we were told that *“a central system should be up and running by 1 April 2012”*.

The majority of staff we spoke with told us that they had completed mandatory training, while others indicated that they had been unable to access any training in addition to the mandatory training due to staff shortages and/or lack of funding. One member of staff told us that it had taken *“four years to get permission to go on a course”* and that she needed the training for the job she was employed to do.

Data supplied by the trust indicated that while the majority of staff working in accident and emergency had completed paediatric life support training, the same could not be said for advanced paediatric life support training (APLS). This was raised as a concern by staff who worked in accident and emergency. One member of staff told us of an occasion when an ill child had been admitted to the department and there were *“No staff on duty with APLS”*.

As a university hospital trust, there are a number of medical training posts, ranging from foundation one doctors through to specialist training posts. As part of their information submission, the trust provided US with a copy of their self-assessment 2011, which they are required to undertake to inform their submission to the deanery, and a report that summarised the position regarding postgraduate training in medicine at Royal Lancaster Infirmary as of September 2011.

The report for medicine at Royal Lancaster Infirmary contained information from the deanery visit conducted in October 2010. We did not receive a copy of this deanery report at that time, nor was it provided in the information submitted by the trust as part of this investigation. One of the issues raised by the deanery at that time was that:

“The trust must establish processes to ensure trainees are able to handover the care of their patients safely at the end of their duty period. Handovers should be supervised by a senior member of staff preferably a consultant and should provide opportunity to learn.”

When this issue was reviewed in 2011, the report for medicine at Royal Lancaster Infirmary found that that little progress had been made.

Another area of issue raised by the deanery in 2010 was that:

“Working patterns and intensity of work by day and by night must be appropriate for the learning. Shift and on-call rota patterns must be designed so as to minimise the adverse effects of sleep deprivation.”

The review conducted by the trust in 2011 concluded that:

“There are new consultant staff in acute medicine and respiratory medicine. It is likely this will improve senior review of patients and supervision with opportunity for feedback.”

However, we were told by medical staff that concerns regarding the adequacy of supervision from senior medical staff, especially at the Royal Lancaster Infirmary during the night and out of hours, remained. They also told us that this concern had been raised with senior medical staff and training supervisors as they believed patient care was being compromised as a result of there being inadequate senior medical cover at the Royal Lancaster Infirmary.

The data supplied by the trust indicated that the majority of divisions would meet the trust’s target of 100% of staff having had an appraisal, with the exception of those members of staff who were on long term sick or on maternity leave, and interviews with staff confirmed this to be the case. However, a concern was raised at the quality of the appraisal that they had received. Data from the national staff survey for 2011, although showing an increase in the percentage of staff having well structured appraisal in the last twelve months, would support the concerns raised by some staff with regards to the quality of the appraisal they had received.

While a proportion of staff we asked told us that they felt supported by their manager, a further proportion of staff said that they did not feel supported by their manager, and a further proportion said that while they felt supported by their line manager they did not feel supported above the level of their line manager. These findings were evident across all staff groups and at all levels.

The impact of staff feeling unsupported appeared to be an apparent ‘learned helplessness’ among some staff groups. Observations of staff and interview with them identified some level of acceptance of poor practice, which had direct impact upon the quality of care experienced by some patients. For example staff told us that patient care was being compromised due to: long

waits in the emergency department; inadequate staffing; overnight accommodation of patients and ambulatory care patients on the clinical decision unit and accommodation of male and female patients on the clinical decision unit. Staff told us that they had grown so tired of seeing a lack of management action to tackle these problems that they no longer saw it as their issue.

There were mixed views from staff on access to supervision; a proportion of staff indicated that they did receive supervision, while others said that such opportunities were not available to them. The greatest difficulty cited was a lack of available time.

Recommendations	
22	Support a skills escalation programme in the emergency department that seeks to develop nurses who have already successfully completed an emergency nurse practitioner or advanced clinical practitioner course and reduce reliance on them undertaking traditional nursing duties due to shortages of staff. Continue to recruit appropriate permanent staff to accident and emergency and ensure that it reduces its reliance on agency and locum staff and focuses on improving the quality of care.
23	Explore and develop strategies for delivering services with different staff groups so that reliance on difficult to recruit staff groups is reduced.
24	Explore and develop strategies for joint working and delivery of services across the trust, ensuring effective utilisation of skills, knowledge and experience.
25	Ensure that its whistleblowing systems and processes allow staff a route to raise concerns early and staff feel empowered to raise concerns, without the fear of reprisal.
26	Continue to develop a central training database to record all training attended by staff and monitor and take swift action where non-attendance at mandatory training is identified.
27	Continue to develop and deliver training to staff to support the development of quality services, seeking alternative solutions where staff have difficulty accessing training due to staffing constraints.
28	Ensure that suitably qualified and experienced paediatric staff are available at all times within the accident and emergency department.

29	Ensure that appropriate supervision is provided to junior medical staff at the Royal Lancaster Infirmary, especially out-of-hours and at night.
30	Ensure trust policies and procedures for dealing with poor performance of staff are robustly implemented, and any concerns with regards to poor performance are addressed in a timely manner.

Assessing and monitoring the quality of service provision (Outcome 16)

Governance systems in the trust have been subject to several previous reviews by both CQC and Monitor. The most recent review, conducted by PricewaterhouseCoopers LLP (PwC) and published by Monitor in February 2012, found that;

“The trust’s governance processes, systems and capabilities are inadequate and are well below the standard that we would expect in an NHS Foundation trust.”

While it is acknowledged that the trust have had a relatively short amount of time to enact any real change in response to the findings of this review, it was evident that there had been little change to practice among staff working within wards and departments with regards to the identification and management of risk at the trust. However, it is noted that there had been some progress with regards to the development of risk management systems within the trust.

The trust had a number of key committees for the management of clinical governance, risk and patient safety. The Clinical Quality and Safety Committee (CQSC) was chaired by a non-executive director and reported directly to the board. All of the non-executives sat on the CQSC and all trust directors (except for the chief executive and the chair) attended. The integrated risk subcommittee was a subcommittee of the CQSC and was chaired by the director of nursing.

Each of the divisions had their own governance arrangements and these had evolved differently. The effectiveness of these arrangements was described as “variable” by senior staff and some senior executives. One of the staff we interviewed described the system that was in place at the time of our site visits as “chaotic”.

Senior staff raised a number of concerns about the reporting processes within the trust. One commented that the CQSC had an odd structure in the trust because it “morphed out of the audit committee”. It was seen as a committee that enabled the trust to bring together issues of quality and risk, but was now considered to be “no longer fit for purpose”. A non-executive director stated that the committee was too operational and as it was led by a non-executive director, this pulled them into operational issues. Further issues raised by senior clinicians and managers were the lack of medical representation on the CQSC; that the associate medical directors did not attend this committee and that this had led to a lack of important medical engagement.

The trust had a Head of Clinical Governance that was managed by the medical director and a risk management team that consisted of a team manager, two risk managers, and three other more junior staff.

The governance structure was described to us as being in a state of “*flux*” as the trust had begun to make changes to its governance processes and systems following receipt of the PWC report. This included: revision of the structure and terms of reference of a number of committees and sub-committees and staged implementation of electronic risk reporting (Safeguard) across the organisation. A programme office had also been established to strengthen tracking of the trust’s improvement agenda and to ensure regular audits of frontline practice to promote up to date feedback on service quality and patient safety.

It was clear from our interviews with staff and documents submitted to us by the trust, that a lot of performance information was collected. However, what remained unclear was the extent to which the information that had been collated and used to identify and drive change.

Many senior staff we spoke with acknowledged that information the key committee (CQSC) received had not enabled them to identify key issues and risks. They told us that there had not been a governance expert on the CQSC and the emphasis had been on presentation of graphs and charts, no-one had been there to provide interpretation and identify trends. Senior executives stated that the way that the board had sought to be assured on clinical quality had not been effective and that CQSC had not been effective in providing the board with the right information. That the information that had emanated from CQSC was too detailed and as such the board had not been able to focus on the bigger picture and the right issues. However, they also added that the board had not been clear what it wanted from this, and other subcommittees in terms of information. One non-executive director stated that more work was required around getting proper analysis of incidents and in having assurance that issues had been acted upon.

The quality of clinical outcomes information was seen as problematic by senior clinical staff that we interviewed. They commented that it required proper collection and analysis in order to be used effectively and that this had been lacking. One non-executive director commented that receiving raw data at board level meetings “*was not good enough*”. Another senior clinician told us that there had been a lack of infrastructure within the divisions to ensure that clinical information about outcomes could be collected and collated and reported to the board.

Obtaining information from the trust was described as “*very difficult*” by one of the statutory stakeholders, and they told us that this had resulted in delays to the progress of service improvement initiatives. However, they also told us

that this situation had changed very recently and that compliance with requests for information had improved.

The culture within the trust was described in the January 2012 PwC report as being one of *“trying to ‘manage risks’ informally rather than recording and escalating risks”*. Some of the staff we interviewed confirmed that this position remained unchanged and was particularly evident within the emergency care pathway, especially at times of peak activity.

An escalation plan to support the ‘smooth patient flow, regardless of the level of escalation’ is in place at the trust. However, what is evident, from discussions with staff and stakeholders and from our observations during our site visit to the Royal Lancaster Infirmary, is that any actions taken within the trust when escalation moved from level 2 (significant pressure) to level 3 (acute pressure) had little, if any, impact on the quality of care experienced by patients admitted to accident and emergency at the Royal Lancaster Infirmary.

For example, we observed that the length of time patients waited to be assessed and/or admitted remained unchanged regardless of the level of escalation. On one occasion at 09:00 we observed seven ambulances queuing outside the emergency department and large numbers of patients waiting in the ‘walk in’ area. Staff told us that two members of the medical staff were absent due to sickness and no cover had been provided. The trust escalation moved to level 3 at 10:30, yet at 11:55 the total number of patients had increased, one patient had been in the department for six hours and 39 minutes, five ambulances were queued outside and patients on trolleys were queued in the ambulance corridor. One senior manager told us *“At the Lancaster site, hand on heart I don’t think there is anything different that happens between level one and level three.”*

Staff reported a further example that related to radiographers working alone at night, often with more than one patient. Patients were sometimes intoxicated and patient care was seen as compromised as they were not being observed while the radiographer was taking the x-rays. These incidents were not consistently reported. One member of staff told us that:

‘It’s pretty hideous. I’ve learnt to manage on my own. I feel very vulnerable’

An online risk and reporting system was in place. However, some of the staff that we interviewed told us that they did not always use the online risk and incident reporting tool to report all instances where patient care has been compromised or where there had been near misses. One example was that the clinical decision unit at the Royal Lancaster Infirmary was used as extra bed capacity by the trust at times of bed shortages, accommodating both males and females, from many different specialties. When we interviewed staff they told us that coherent operational policies for this facility were not in place and insufficient staffing levels and mixed sex breaches were not always reported.

Some staff raised concerns regarding the risk to patient safety as a result of insufficient supervision of junior medical staff at the Royal Lancaster Infirmary. We were told that the trust clinical incident reporting system was not used to report such incidents and that alternative means of collecting such information outside the system had been devised. Interviews with medical staff verified that they were not centrally engaged with incident reporting. Some stated that incident reporting does happen, but they were not sure what was fed back. One of the executive directors confirmed that clinical incident reporting among medical staff was poor and that little action had been taken to address this.

As a result of the review of governance conducted by PwC and published by Monitor in February 2012, the trust has worked to create an electronic risk management system, to improve the use of the risk registers and standardise reporting across the trust. We were told that there was a *“huge industry of putting risks on the register”* but the challenge was to get people to see it as a tool for managing risk and that this needed to be rolled out across the whole trust. This view was echoed by other senior executive staff, including the non-executive directors. They outlined the need for a far tighter relationship between risk and reporting through the subcommittees and stated that it was *“still slow to get off the ground”*.

Information supplied by the trust included minutes from a Hospital Management Team meeting that was held on 07/12/2011 and one of the actions agreed at this meeting was *“to look at the process of communicating/disseminating learning points from divisions through the structure”*. While it is accepted that our visit occurred shortly after the publication of the PwC governance review report in February 2012, staff views regarding the communication and dissemination of learning points remained unchanged, that they had not received any feedback after they had reported concerns and several gave this as a reason for their failure to report future incidents. One change that had been made was to the ward and departmental meetings, where some of the meetings had been dedicated to clinical governance. However, the effectiveness of this means of communication is yet to be tested and the majority of staff we interviewed reported that attendance at ward and departmental meetings had been poor.

We were told that more work was required around the analysis of incidents and in having assurance that issues had been acted upon. Our observation would confirm this. For example a review of a serious untoward incident involving the care and management of a patient with mental health needs led to the implementation of a unified risk stratification tool (the ‘SAD’ Scoring system) to assess individual risks of patients attending the emergency department with mental health issues and following episodes of deliberate self-harm.

During our site visit to Furness General Hospital we observed that a patient had been assessed to be at significant risk of harm, yet was allowed to go

outside the emergency department unsupervised. No further reassessment of risk was done on this patient from the time the patient was seen by the emergency department clinician to the time they were reviewed by the oncoming psychiatric liaison team some five hours later. This despite the recommendations of a recent serious untoward incident and Ombudsman enquiry that mental health patients deemed to be ‘high risk’ should be reviewed and not be left unsupervised within the emergency department.

While it is acknowledged that emergency staff have made efforts to try and maintain safe emergency care systems in the midst of the significant re-organisation of services that has occurred in the past few years, there were areas of practice that had not been fully developed that would go some way to mitigate the patient safety concerns that we identified. One example is that senior emergency department team did not enforce standards related to the need for, or frequency of, physiological observations. During our visit to the Royal Lancaster Infirmary we observed patients waiting in the ‘ambulance corridor’ with ambulance staff for considerable periods of time, without being assessed by a member of the emergency department team. Furthermore, several members of staff we interviewed told us that some “*stable*” ambulance patients only received one full set of observations, irrespective of the time they remained in the emergency department.

The trust had a resource for clinical audit, that included a clinical audit manager and two clinical audit facilitators (with one more coming into post) at the Royal Lancaster Infirmary and there were four audit staff at Furness General Hospital. However, while there was a clear process for the prioritisation of clinical audit, we were told that the divisions had only just begun to use risk information to determine audit activity.

Recommendations

Recommendations with regards to the quality assurance mechanisms at the trust were made following the review of governance arrangements conducted by PwC and published by Monitor in February 2012. As reported above, while the trust had taken action to address some of the concerns identified within the PwC report, concerns remained.

31	Ensure that it has adequate systems of governance to promote high quality care for patients and to deal with concerns about poor standards of care in an effective and timely manner.
32	Continue to carry out the review of all corporate and clinical governance systems across the organisation to ensure that effective and streamlined systems and reporting structures are in place to provide robust assurance ward to board.

33	<p>Continue to develop, embed and then maintain a system of governance that provides accurate and real time information that in turn translates into an effective assurance process and acts as a driver for improvement in clinical quality standards. Review the systems and processes for incident reporting to ensure that all incidents are reported and staff receive feedback after reporting incidents. Embed clinical governance reporting arrangements within individual divisions. Implement quality assurance processes to ensure consistency within divisions and to provide accountability for local quality standards.</p>
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Complaints (Outcome 17)

The trust received 555 formal complaints in 2010/11, which represented a 17% increase from the previous year. The majority of complaints concerned the outpatient department, followed by the emergency department and orthopaedics. The trust had a head of patient and service experience, who also leads the complaints team. There was very little resource for the work on patient experience.

As a result developmental work around patient experience has been limited and the trust has missed opportunities to proactively improve patient experience and outcomes based on feedback. For example, the trust Quality Report for 2011, identified that limited progress had been made with regards to the development of patient information, an area identified as in need of improvement in national in patient survey conducted in 2010. Information provided by the trust identified that the main reason for contact with PALS during July to September 2011 related to concerns with regards to communication/information, accounting for 65 enquiries or 19% of the total of 339 PALS enquiries received by the trust.

There were a high number being investigated by the Parliamentary Health Service Ombudsman. The complaints analysis report for 2010/2011 identified the largest cause of dissatisfaction was with clinical care and treatment provided by the trust, communication and diagnosis. The Ombudsman also found that twelve of the forty four complaints they received in 2010/11 had been previously returned to the trust for local resolution. Further analysis of these incidents by the Ombudsman found that:

“The most cited reason for complaints returning to PHSO after local resolution by the trust was unnecessary delay in the complaint process. The next most cited reasons were where complainants believed communication by the trust was unhelpful, ineffective or disrespectful and where complainants believed a poor explanation was provided.”

The trust annual complaints report for 2010/11 highlighted a number of recurring themes including: administrative procedures, outpatient appointment delay and waiting time for outpatient appointments; clinical treatment; communication/information to patients; inadequate care/treatment and appointment cancellation for outpatient. The most common complaint was regarding the trust’s administrative procedures. However, despite the trust being aware of these concerns, our discussions with patients and relatives would suggest that these concerns remained.

The trust had a high number of contacts with its patient advice and liaison service (PALs), and had seen a rise in the number of complaints year on year from 2009 – 2010. One member of staff described the increase as being

“massive” for complaints, informal concerns and PALs queries and said that the biggest increase had been the number of informal concerns and PALs queries received by the trust.

While additional resources had been allocated to the complaints management team in July 2011 and January 2012, some of the patients we interviewed raised concerns about the delays in the trust’s response to their complaint. One patient told us that she had yet to receive a response to a complaint she had made in August 2011.

The trust’s ability to deal with and respond to complaints was described as *“not working well at the moment”*. In fact the level of distress it caused to some patients who spoke to us was as bad as the poor care experiences they were complaining about in the first instance.

One patient complained about their frustration in just trying to raise a concern:

“Phoned every day for a week to complaints department before got through.”

While another, in correspondence with their local MP, described the quality of response they had received from the trust as:

“Just another cover up and distressing experience for us.”

Some patients and relatives told us that they had to wait weeks for a response to their complaint. Others told us that they simply hadn’t received a response. The poor timeliness of response was compounded by the response sent to patients, which from the complainant’s perspective did not match their recollection of events, did not answer all of the concerns they have raised and left the complainant with more questions.

Recommendations

34	Develop and improve its complaint handling systems to ensure that complaints are responded to fully and in a timely manner and demonstrate that changes to practice have been introduced.
35	Conduct a review of its current resources allocated to the management of complaints to ensure compliance with complaint response times.

Records (Outcome 21)

During the course of the investigation we spoke to a number of staff about record keeping, as well as reviewing case notes and tracking patients across the trust at both hospital sites.

The quality of records that we looked at was generally satisfactory and in line with established standards. However, there were several examples where staff had not completed all of the required sections. These included discharge information, and the on-going assessment and monitoring of patients in accident and emergency. The potential outcome of incomplete discharge information is delayed discharge, what is of greater concern is the high risk of deterioration of a patient without recognition associated with the absence of on-going monitoring.

The trust was aware of concerns regarding storage of medical records. In a medical records audit report, commissioned by the trust in May 2011, it was found that due to the lack of space within the medical records departments conditions had become unworkable and unsafe and posed a significant risk to staff in terms of Health and Safety law. The adequacy of medical records storage and the quality of medical records was also included in the trust's risk register. While steps had been taken and approval given by the board in November 2011, to move to an electronic document management system, concerns regarding the availability of medical records remained. A paper presented to trust board in November 2011, identified the difficulty the department experienced in locating notes for outpatient appointment when they were not returned to the medical records library following the discharge of a patient. The paper stated that:

"There is a culture within the trust of hoarding notes in small stock piles when clinical teams know that the patient will return to them in a number of weeks."

Missing patient notes was one of the most frequent clinical incidents reported in the trust quarterly incident report for Q3 2011 – 2012. One of the concerns raised by two patients was that their medical records were not available when they attended an outpatient's appointment (for one patient) or had been admitted to hospital (for the second patient). These patients told us that not only was this inconvenient, but also caused anxiety as they had to wait longer for the results of investigations. This also led to delays to the start of any treatment that they required.

A further concern identified during our visit was a back log in patient records being properly filed in the medical admissions unit at the Royal Lancaster Infirmary. Through review of records and staff interviews, we found that records were being retained on the ward despite the patient having been

discharged from hospital for some considerable time. Staff told us that records were retained on the ward so that they were available if the patient was re-admitted, as they had previously experienced difficulties in obtaining notes when patients had been re-admitted shortly after being discharged. However, one member of staff expressed concerns about this and told us that:

“We have a back log of patient filing that goes back 12 months – this could mean vital information about a patient is not married up if they have been discharged home from MAU and then come back to A&E – this really worries me.”

One of the senior managers told us that they were aware of this issue and described it as *“a storage and filing issue”*.

Staff also told us that access to medical records had been problematic for some time and that duplicate files were constantly in use, as they were only allowed to request a maximum of five sets of patient records per day. However, this was disputed by a senior manager who told us that:

“The limit will just be for the back log and not for patients coming in. I don’t know why staff are not getting the notes they request. Notes are missing.”

During our site visit to Furness General Hospital access to medical records was managed more effectively. However, there were two examples where there had been a delay in accessing medical records. For one of these patients an x-ray had been ordered on 6 February 2012 and the request was returned with a note from the radiologist stating *“previously seen # from attendance and x-ray in March 2010”*. Staff told us that this x-ray should not have been requested and that the only reason this happened was because the medical records had been unavailable for some time and medical staff were unaware that this was a long-standing condition.

Recommendations

36	Improve its systems for the management of records to ensure that notes can be retrieved effectively and expediently, and reduce the risks associated with multiple sets of temporary notes.
37	Ensure that all patient information is appropriately and expediently filed so that an accurate record in respect of the care, treatment and support that a patient has received is maintained.
38	Ensure that records about the care, treatment and support are clear, factual and accurately maintained.

Leadership

The trust has experienced recent changes to its board. The Chairman and Director of Operations and Performance left the trust prior to commencement of this investigation. During the course of the investigation the Chief Executive resigned and the Medical Director stepped down from this post. An interim Chair, interim Chief Executive, interim Medical Director and Chief Operating Officer have been appointed. The trust also announced appointments to clinical leadership and senior management positions to help drive improvement, although, it should be noted that at the time of writing this report, this recruitment had not been completed. In addition there are a number of non-executive director vacancies as four non-executive directors stood down from the trust board in March 2012.

The trust does not have a trust-wide clinical strategy. One member of the executive team that we interviewed described the clinical strategy that had been in place as “*aspirational*” and that it had never been realised.

There has been a number of contributing factors to the problems with the emergency care pathway, particularly at the Royal Lancaster Infirmary. We found little evidence of cross bay working, and a lack of cohesion across the trust, with different clinical divisions and staff not working together. Through speaking with staff and observing practice there appeared to be a lack of ownership by some senior clinicians to engage with managers to address the issues of patient flow. Some evidence was found that influential individuals were trying to make a difference by changing practice, for example in the medical assessment unit at the Royal Lancaster Infirmary. However, the fundamental patient flow problems, described within this report, were not being addressed. Staff perceived that they were blamed for breaches of the four-hour target and for non-compliance with the care quality indicators and that there was little proactive management of the problem to ensure it was being addressed.

One senior medical staff member commented that there was a lack of ownership and inertia for ‘sorting things out’ within the organisation and stated: “*the impression is that, by and large, they are a fairly dysfunctional group who do not work well together. There is a lot of talking but not a lot of doing.*”

The poor attitude of some medical consultants was raised as a concern by senior managers, senior clinicians and stakeholders, as was the failure of those responsible for addressing such issues. One senior clinician told us that “*there are 2 or 3 difficult characters to manage and one of them is line managed by me. Conversations have been had with these people but nothing has changed*”. We were told that the attitudes and behaviours of some staff had

inhibited service development and one example was the lack of cross division working to address patient flow through the emergency pathway.

As part of their information submission, the trust provided US with their exit interview guidelines, a process they used to understand the reasons why people left the trust and to identify areas for improvement. Of the twenty five consultants that had left the trust between May 2010 and November 2011, only one exit interview had been returned. This identified inadequate communication between clinicians and line managers as a concern as well as generally with the trust.

One senior clinician described the relationship between the consultant body and the executive as *"distant and untrusting"*. While another told us that they were frustrated at the lack of engagement between senior clinicians, senior managers and trust executives, and the lack of efficiency in *"making things happen"*. Examples given of initiatives that had not been realised, included clinics that had been promised, that never materialised, delays in decisions about improvements at the Royal Lancaster Infirmary, and papers that had been presented to recruit new staff that had not been responded to.

Several senior clinicians and managers described a difference in the level of engagement between senior clinicians and senior managers at the two hospitals. We were told that senior clinicians at Furness General Hospital were more willing to engage than those at the Royal Lancaster Infirmary. One said: *"Divisions (medicine and surgery) are very divided at RLI – it's better here even though some people think it's still like that here."*

Senior managers stated that the hospital management team (HMT) was a way of ensuring engagement of clinicians. However, senior medical staff told us that it had not been a forum for debate and that the agenda had been largely controlled by the executive team who brought in serial papers or speakers. One commented: *"it is more about informing you than resolution of issues"*. It was acknowledged by executive level staff that this forum needed to be reviewed.

Some of the staff we interviewed told us that there were different cultures at the two hospitals. Furness General Hospital was described as being *"more friendly and welcoming"* than the Royal Lancaster Infirmary, with stronger team working between relevant clinical, medical and nursing staff, while some staff at the Royal Lancaster Infirmary told us that there was a *"bullying"* culture within the organisation. They told us that while they felt supported by their immediate manager, they received little support from senior managers. During the course of the investigation we received information of concern from seven whistleblowers who had not felt able to raise concerns with the trust for fear of recrimination.

There was little evidence of corporate identity among the staff that we interviewed. Instead they aligned themselves to the individual hospital in

which they worked. One senior clinician could identify what was happening at Furness General Hospital but appeared to have less insight into issues at the Royal Lancaster Infirmary, this despite them being responsible for both sites.

Absence of visible leadership from the executive team was also raised as a concern by some of the staff we interviewed. While it was acknowledged that there had been an increased visibility over recent months, staff felt that this was reactive, due to the level of scrutiny that the trust was under. One member of staff told us:

"We are not supported by the trust or anyone, staff in A&E support each other. We only see members of the executive team once in a blue moon."

One senior member of staff raised the issue that because the executive team were based at Kendal "you don't see them in the corridor". Their actual physical placement therefore affected the development of effective working relationships.

External stakeholders described a culture within the organisation that was both affable and approachable, but was either unwilling or unable to respond in a timely way to concerns raised. Commissioners we spoke with told us that the trust had been heavily focussed on achieving foundation trust status and suggested that the trust's focus on this process potentially detracted from the concerns being raised about the quality of patient care.

The lack of engagement of clinicians was cited as a major concern by all of the commissioners. They felt that the trust had not effectively dealt with this issue despite being clearly aware of its existence. In addition, commissioners also raised concerns that the trust failed to deal with 'difficult' senior clinicians, variation in practice, insularity and resistance among some senior clinicians to move to cross-bay working.

Poor communication from the senior managers, especially with regards to changes to working practices, was raised as an area of concern by a number of staff that we interviewed. While the trust used a variety of means to communicate with staff, such as email and meetings, a proportion of staff raised concerns that changes were made by senior managers without prior discussion and/or engagement having taken place with clinical staff.

This was raised as a significant concern during interviews with senior clinical staff working in accident and emergency at the Royal Lancaster Infirmary. One example given was the decision the trust had taken to admit all patients, assessed by their general practitioner as requiring admission to hospital, to the accident and emergency department. This was at a time when the emergency department was already failing to meet the four-hour access target (the national target is to admit, discharge or transfer 95% of patients within four hours of arrival to the emergency department). The outcome for patients following this change was that waiting times increased and patient

satisfaction decreased. The outcome for staff was that they were placed under additional pressure to care for these additional numbers of patient. This is reflected in the increase in the number of complaints and concerns that were raised with the trust following this change.

Three senior medical staff who we interviewed specifically held a view that the trust had prioritised financial balance over the quality of patient care. The trust has to deliver a cost reduction plan of £14.5 million in 2011/12 at an average of £1.2 million per month. One non-executive director and a member of the executive team told us that the trust needed to have tight financial control, and that previous cost efficiency measures added to current cost reduction plans meant that *"the business model is very difficult to operate under these circumstances."* Another member of the executive team described the trust as *"a lean organisation"*. However, other members of the executive team told us that financial balance had not been prioritised over the quality of patient care. They told us that any failure to identify the impact of any cost improvement initiatives was a result of the quality and governance arrangements that have now been found to be inadequate.

Another concern that was raised by senior staff was the lack of direction and clarity around what the strategic priorities were for the trust. A member of the executive team told us that *"the new vision is not clear, that the trust did not have a clear story and didn't know what we wanted."* Some senior executives described how they had become too operational in their approach as they had been *"fire fighting"* all the issues that were arising from external reviews.

One consultant criticised their colleagues in the medical division at the Royal Lancaster Infirmary and stated that there was *"diluted responsibility and ownership of issues by consultants"*. An example was given of a patient who required a feeding tube to be replaced. It took four days for the patient to have this procedure done, as they got passed from one service to another and consultants did not visit over the weekend.

Some clinicians also criticised the lack of medical leadership. One stated *"we are meant to meet once a month with divisional leads but he sometimes cancels meetings"*. When they did meet, they would discuss things and agree and then *"nothing would happen"*. A number of senior clinicians directly criticised the medical leadership, stating that it *"hasn't been strong enough"*.

Senior clinical staff we interviewed also gave their personal view that there is a lack of willingness at high levels of the organisation to *"have the courage to make difficult decisions"*. One stated that *"staff at lower levels and middle management muddle through"*.

Recommendations

Recommendations with regards to the culture, cross divisional working and managerial and clinical leadership arrangements at the trust were made following the review of governance arrangements conducted by PwC and published by Monitor in February 2012. As reported above, while the trust has begun to take action to address some of the concerns identified within the PwC report, concerns remained.

39	Develop a trust wide clinical strategy and a culture of whole systems working across all the divisions to avoid 'silo' working.
40	Ensure its board assures itself that it has the right leaders and managers in place to develop the trust and improve the quality of services. Put in place measures to ensure effective and visible managerial and clinical leadership across the organisation.

Conclusions

Through this investigation we have identified a number of key concerns with the provision of patient care at the trust. The focus of this investigation was on the emergency care pathway. However, the concerns identified go beyond this clinical area.

It is clear that the concerns we have identified through our review of the emergency care pathway were symptomatic of a number of wider problems at the trust. In particular, these were the apparent dislocation between senior managers and senior clinicians at the trust and the lack of leadership to address practices that directly impact upon the quality of care patients received at the trust. There had been little impetus to ensure that individual divisions, clinicians and managers work together to deliver the changes to the emergency care pathway identified by previous external reviews. There was also little evidence of whole trust working to drive change and improvement in the care that is delivered to patients.

Underpinning this, as found by other reviews, had been a lack of focus and clarity around governance systems and processes across the trust.

Systems were in place to seek the views of people using the service and their representatives and for seeking the views of staff. However, while the information was reviewed and actions identified, the actions were not always fully implemented.

There had been a lack of strategic service development, reflected by the failure to develop a trust wide clinical strategy. More specifically the absence of a workforce strategy and a full training needs analysis had not been in place. As such, the requirements and specialist staffing skills for each ward or department had not been identified. This basis for building clear, cohesive approaches to identify the right staff and ensure contingency plans are in place had not been properly formulated.

Where areas for improvement had been identified, the trust had been slow to respond. Delays in the development of services had been compounded by their difficult relationship with NHS partners, including commissioners. This has had direct impact on the quality of care some patients experience as demonstrated by: long waits in accident and emergency; frequent internal transfers of patients to wards outside of the speciality to which they had been admitted; lack of monitoring of patients; inconsistency in the medical review of patients; unnecessary delays to the discharge of patients; lack of regard to the privacy and dignity of patients through the accommodation of both male and female patients together in one ward.

The trust's systems and processes for clinical governance, including the systems for monitoring the effectiveness of these systems in the provision and delivery of assurance to the Board, have been subject to recent review and remain under review. However, until new systems and processes for identifying, assessing and managing risk have been embedded, concerns remained regarding inconsistent incident reporting practices; lack of learning from incidents and poor use of performance information to drive change.

During the course of this investigation there have been significant changes to the membership of the trust Board, as an interim Chair, interim Chief Executive, interim Medical Director and Chief Operating Officer were all appointed during the course of this investigation. In addition, the trust also announced appointments to clinical leadership and senior management positions to help drive improvement. Although at the time of writing this report, this recruitment had not been completed.

In addition, the trust reported that action had been taken to address the areas of concern raised within this report and to concerns identified following previous reviews. These include: Stopping the use of the Clinical Decision Unit at the Royal Lancaster Infirmary for the overflow from the medical and surgical assessment units; Introduction of spot checks in respect of observations and record keeping; all staff have been reminded of their responsibility in respect of privacy and dignity and a programme of work to review and improve the emergency care pathway as a whole has been established.

However, we have yet to test the impact of these changes. A formal review of the recommendations included within this report will be carried out in six months' time.

Recommendations

As a result of this investigation, we have a number of recommendations that University Hospitals of Morecambe Bay NHS Foundation Trust should fulfil. These will feed into a further formal review of compliance of the University Hospitals of Morecambe Bay NHS Foundation Trust, which we will carry out in due course.

The University Hospitals of Morecambe Bay NHS Foundation Trust should:

Respecting and involving people who use services

1. Develop and promote a culture where the privacy and dignity of all patients is respected at all times. To ensure that any practice that is contrary to this are reported and action is taken. As part of this make sure that proactive and mandatory education regarding dignity and respect is delivered to all staff.
2. Put in place operational standards for the appropriate use of security staff in the care and management of patients.
3. Ensure that the trust acts on the outcomes of its own and national patient surveys and demonstrate that improvements to the quality of the patient experience across the trust are made.
4. Put a cultural change programme in place across the organisation that promotes an identity of a fully merged trust. The programme of change needs to engage all staff and articulate what the expectations are of individual staff.

Care and welfare of people who use services

5. Develop and implement a trust strategy for improving flow of emergency/urgent patients. This strategy needs to have the engagement of all clinicians and managers as a key component.
6. Put in place operational standards for the routine clinical surveillance of patients attending the emergency department.
7. Develop its discharge and bed management teams and processes to ensure that they are interlinked and that patient flow is managed effectively from the point of admission to the point of discharge.

8. Review current guidance regarding 'to take out' medication so that patient discharges are not delayed. The trust needs to ensure that it monitors adherence with the guidance and takes appropriate action to ensure the delivery of a timely and effective service.
9. Develop and utilise a more effective and accurate means of collection and use of bed management and discharge information. To facilitate more effective bed management and significantly reduce the number of 'medical outliers'.
10. Review current guidance regarding referrals for review by social services to support improvement in discharge planning and discharge of patients.
11. Review access to rehabilitation facilities at Westmorland General Hospital to ensure equitable access on the basis of clinical need.
12. Develop a culture where everyone feels empowered to challenge unacceptable standards of care. This may be regular monitoring of practice and feedback and learning opportunities for staff.

Cooperating with other providers

13. Engage and develop robust working practices with external providers and partners to facilitate adequate provision of rehabilitation and mental health services.

Safeguarding people who use services from abuse

14. Develop a safeguarding adults training strategy and ensure that all staff complete the appropriate level of safeguarding adults and safeguarding children training.
15. Ensure appropriate representation and attendance at internal and external safeguarding meetings.

Safety, availability and suitability of equipment

16. Review the availability of medical devices in clinical areas and ensure that appropriate levels of equipment are available at all times. Ensure that staff are appropriately training in the use of medical devices and introduce a programme of regular review to ensure proactive response to changes in service provision.
17. Develop a strategy for the proactive replacement of equipment to ensure that all items of equipment remain fit for purpose and that sufficient equipment is available at all times.

18. Ensure that systems are in place in accident and emergency departments so that sufficient resuscitation equipment is available.

Staffing

19. Review its human resource information systems and ensure that accurate data is available for the entire organisation, so that robust data reporting is ensured.
20. Establish a workforce strategy and plan that looks at: the current staffing establishments and skill mix; recruitment and retention; contingency and succession planning.
21. Undertake systematic skill mix and staffing needs analysis in accident and emergency at Furness General Hospital to ensure that they have the right numbers of staff, with the right skills, available at all times.

Supporting workers

22. Support a skills escalation programme in the emergency department that seeks to develop nurses who have already successfully completed an emergency nurse practitioner or advanced clinical practitioner course and reduce reliance on them undertaking traditional nursing duties due to shortages of staff. Continue to recruit appropriate permanent staff to accident and emergency and ensure that it reduces its reliance on agency and locum staff and focuses on improving the quality of care.
23. Explore and develop strategies for delivering services with different staff groups so that reliance on difficult to recruit staff groups is reduced.
24. Explore and develop strategies for joint working and delivery of services across the trust, ensuring effective utilisation of skills, knowledge and experience.
25. Ensure that its whistleblowing systems and processes allow staff a route to raise concerns early and staff feel empowered to raise concerns, without the fear of reprisal.
26. Continue to develop a central training database to record all training attended by staff and monitor and take swift action where non-attendance at mandatory training is identified.
27. Continue to develop and deliver training to staff to support the development of quality services, seeking alternative solutions where staff have difficulty accessing training due to staffing constraints.
28. Ensure that suitably qualified and experienced paediatric staff are available at all times within the accident and emergency department.

29. Ensure that appropriate supervision is provided to junior medical staff at the Royal Lancaster Infirmary, especially out-of-hours and at night.
30. Ensure trust policies and procedures for dealing with poor performance of staff are robustly implemented, and any concerns with regards to poor performance are addressed in a timely manner.

Assessing and monitoring the quality of service provision

Recommendations with regards to the quality assurance mechanisms at the trust were made following the review of governance arrangements conducted by PwC and published by Monitor in February 2012. As reported above, while the trust had taken action to address some of the concerns identified within the PwC report, concerns remained.

31. Ensure that it has adequate systems of governance to promote high quality care for patients and to deal with concerns about poor standards of care in an effective and timely manner.
32. Continue to carry out the review of all corporate and clinical governance systems across the organisation to ensure that effective and streamlined systems and reporting structures are in place to provide robust assurance ward to board.
33. Continue to develop, embed and then maintain a system of governance that provides accurate and real time information that in turn translates into an effective assurance process and acts as a driver for improvement in clinical quality standards. Review the systems and processes for incident reporting to ensure that all incidents are reported and staff receive feedback after reporting incidents. Embed clinical governance reporting arrangements within individual divisions. Implement quality assurance processes to ensure consistency within divisions and to provide accountability for local quality standards.

Complaints

34. Develop and improve its complaint handling systems to ensure that complaints are responded to fully and in a timely manner and demonstrate that changes to practice have been introduced.
35. Conduct a review of its current resources allocated to the management of complaints to ensure compliance with complaint response times.

Records

36. Improve its systems for the management of records to ensure that notes can be retrieved effectively and expediently, and reduce the risks associated with multiple sets of temporary notes.

37. Ensure that all patient information is appropriately and expediently filed so that an accurate record in respect of the care, treatment and support that a patient has received is maintained.
38. Ensure that records about the care, treatment and support are clear, factual and accurately maintained.

Leadership

Recommendations with regards to the culture, cross divisional working and managerial and clinical leadership arrangements at the trust were made following the review of governance arrangements conducted by PwC and published by Monitor in February 2012. As reported above, while the trust has begun to take action to address some of the concerns identified within the PwC report, concerns remained.

39. Develop a trust wide clinical strategy and a culture of whole systems working across all the divisions to avoid 'silo' working.
40. Ensure its board assures itself that it has the right leaders and managers in place to develop the trust and improve the quality of services. Put in place measures to ensure effective and visible managerial and clinical leadership across the organisation.

Next steps

We have set out a range of recommendations that the trust must fulfil. We will monitor implementation, but the trust needs the support of organisations in the local health economy and commissioners. The significant changes that are needed are likely to challenge both clinical flows and trust finances.

Many leaders and managers in the trust have been overwhelmed in responding to outcomes of a large number of external reviews that have been conducted within a relatively short time frame. Improvements must be made in the short term to ensure the immediate safety of people using the service, while medium and long term answers must be found to the delivery of services that meet the needs of the whole health economy.

The trust must develop an action plan, which includes outcome evidence of positive impact on the quality of service provided and provides a quality assurance framework for Commissioners. The action plan should be submitted to CQC, Monitor, stakeholders and partner agencies, and made available to people who use the service.

We will continue to monitor progress against the recommendations made within this report and conduct compliance activity in accordance with timeframes identified within the trust action plan.

In addition, we will conduct further compliance reviews in respect of the warning notices that have been issued in 2011 and during the course of this investigation.

Appendix 1: Full terms of reference

1. On 2 September 2011, the Care Quality Commission (CQC) issued a Warning Notice to University Hospitals Morecambe Bay NHS Foundation Trust in respect of failing to comply with Regulation 10.
2. On 11 October 2011, Monitor found University Hospitals Morecambe Bay NHS Foundation Trust in significant breach of its terms of Authorisation due to governance failings in maternity and paediatric services provided by the trust. Monitor used its statutory powers of intervention under s52 of the National Health Service Act 2006 to require the trust to:
 - a. Commission a review of governance (including quality governance); and
 - b. Accept the appointment of external expert clinical advisors to undertake a diagnostic review of maternity services, including their interface with paediatrics.

The review into governance at the trust has been commissioned and the final report will be provided to Monitor in the week commencing 23 January 2012.

The diagnostic review of maternity services has been completed by external experts. The final report including recommendations has been received by Monitor, CQC and the trust.

3. Following Monitor's intervention, other significant issues have arisen which have caused concern as to the strength of governance (including quality governance) at the trust. These issues include:
 - a. Thousands of outpatient follow up appointments not being booked in line with clinically determined access dates;
 - b. High mortality under both the Dr Foster HSMR and the NHS Information Centre for Health and Social Care SHMI measures of mortality; and
 - c. Strength, capacity and effectiveness of the Board of Directors as a result of Board vacancies.

The trust has also stated that it has concerns about medicine, stroke and emergency care services that it provides and commissioners have raised concerns about emergency care in the context of ambulance transfers and performance.

4. The Care Quality Commission (CQC) has the power to conduct an investigation into the provision of NHS care under s48 (1) (2) (a) of the Health and Social Care Act 2008. The criteria under which CQC will

conduct an investigation are at Appendix A of the enforcement policy. The exercise of this power would permit CQC to raise concerns with the Secretary of State for Health under the formal power under s48 (5) of the Act.

5. In response to the many issues across sites and services at the trust, CQC will carry out an investigation into the systems and procedures that are in place to ensure that people are protected against the risk of inappropriate or unsafe care and treatment, these will include:
 - a. Reviewing emergency care pathways by the investigation of the systems for admission (including emergency), internal transfer, discharge and external transfer of patients, including working in conjunction with other stakeholders.
 - b. Using the emergency care pathway as a proxy, review the trust's systems and processes for clinical governance including the systems for monitoring the effectiveness of these systems in the provision and delivery of assurance to the Board.

CQC retains the right to expand the clinical pathways reviewed should concerns or evidence of non-compliance against the Essential Standards be identified.

The pathway investigations will identify and assess:

- The systems for ensuring that at all times there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying out the regulated activity
- The systems for respecting and seeking the views of people using the service and their representatives.
- The systems for seeking the views of staff.
- The systems for assessing and monitoring outcomes for people.
- The systems to support the delivery of safe, quality care in a hospital environment including (but not limited to):
 - Reporting and learning from incidents, near misses
 - Staffing levels, competency and capability
 - Raising concerns and whistleblowing
- The systems in place to develop the culture of the organisation, in particular individual responsibility and whole trust working;
- Systems and processes for identifying, assessing and managing risk and their effectiveness so not to impact on the quality and safety of care delivered.

- The analysis and learning across the organisation from board level down of incidents that resulted or had the potential to result in harm to people.
 - The systems for service improvement by learning from adverse events, incidents, errors and near misses. This should also include using information from safeguarding concerns to identify non-compliance or risk of non-compliance and decisions made to return to compliance.
 - Any other matters which CQC and Monitor consider may arise from, or are connected with, the matters above.
6. The investigation will involve speaking to patients, relatives and frontline staff and observing care delivered at the Royal Lancaster Hospital and Furness Hospital. It will also involve gathering evidence through examination of records, speaking with internal and external stakeholders and requesting written statements. When appropriate CQC may require the support of other agencies to gather or provide evidence, this may include the SHA and the PCT.
 7. While the focus of the investigation will be on UHMBFT an investigation under the Act gives CQC the option to look at the provision of health care across a local system. In order to ensure that recommendations made are deliverable it will be necessary for CQC to review the role and function of the commissioners (and the support provided to commissioners by the SHA) and their capacity to performance manage and support the trust in making and sustaining the necessary improvements.
 8. CQC may take enforcement action at any time during the investigation if there is evidence of major concerns and risks to the health, safety and wellbeing of people, this includes the use of its urgent powers.
 9. Executive leadership will be provided by the Director of Operations on behalf of CQC and the Compliance Director on behalf of Monitor. An Investigation Manager will lead the investigation on behalf of CQC and, in conjunction with Portfolio Director at Monitor, lead the regulatory collaboration.
 10. Findings and recommendations of the investigation will be incorporated into compliance regulatory activity of both Regulators in line with their relevant regulatory requirements.
 11. The investigation will focus on current clinical pathways with the aim of informing future changes and the implementation of a sustainable model of care.

12. The evidence gathering period including preliminary site visits, of the investigation is planned to run over a period of not more than eight weeks, with the investigation running for a period of up to 14 weeks including the drafting of a report.
13. CQC will publish a report on the findings of the investigation, and will make recommendations as appropriate to the trust and other relevant bodies.

Terms of Reference confirmed on 13 January 2012 by Amanda Sherlock – CQC Director of Operations CQC and Adam Cayley – Monitor Compliance Portfolio Director

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