

University Hospitals of Morecambe Bay NHS Foundation Trust

Royal Lancaster Infirmary
Furness General Hospital

Investigation follow-up report
September 2013

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Summary

The Care Quality Commission (CQC) carried out an investigation of University Hospitals of Morecambe Bay NHS Foundation Trust in January 2012, using our powers under s48(1)(2)(a) of the Health and Social Care Act 2008.

Our investigation focused on the emergency care pathway and also looked at the trust's governance and management systems at a number of levels. It assessed the systems and procedures that the trust had in place to make sure that people were protected against the risk of unacceptable standards of care and treatment.

We published our report in July 2012 and made 40 recommendations for action by the trust. When we published the report we told the trust that, in addition to any other regulatory activity, we would conduct a formal follow-up review to assess its progress in addressing the recommendations.

Our follow-up visit was conducted in April this year with a team of eight CQC inspectors, two external specialist advisors and an expert by experience (a person who has experience of using hospital services) visiting the trust on 8-10 April and 13-14 April 2013.

We spoke to patients about their experiences and observed the care that was being delivered in the emergency departments and wards. We interviewed a range of people including executive and non-executive board members; nursing staff; doctors; social workers; administrative staff and hotel services staff. In total, we spoke to more than 150 patients and relatives. We also collected information from a number of local organisations that provide and commission care in Cumbria and the North West.

We found evidence of an improvement in the safety and quality of care across the emergency care pathway. Governance systems and leadership have been strengthened with a new Chief Executive and Chairman and a number of new executive and non-executive members of the trust board. We believe changes in the management of the clinical departments across the trust, with the introduction of clinical directors supported by senior nurses and general managers, have the potential to promote local decision-making and improve patient care.

However, these changes are still very much in their infancy and are not yet fully embedded across the organisation. It is a concern that we had to take immediate regulatory action at the time of our follow-up visit, in response to poor infection control practices at Furness General Hospital.

Of the 40 recommendations in our original report, we judge seven to have been met in full; 30 to have been partly met; and three not met.

In respect of the three recommendations not met, there is a need for the trust to take the following urgent action:

- A cultural change programme needs to be 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.
- Suitably qualified and experienced paediatric staff need to be available at all times within the A&E department, particularly around the management of paediatric cardiac arrests, ensuring that, on all shifts in A&E, there is a group of nurses and doctors who are able to manage a paediatric arrest without relying on the input of the paediatric team from the ward areas.
- Complaints handling systems need to be improved to make sure that complaints are responded to fully and in a timely manner, demonstrating that changes to practice have been introduced as a result.

The trust must also ensure action is taken to address the 30 recommendations that were only partly met.

The trust continues to face significant challenges and although we are pleased to report evidence of an improvement in the emergency care pathway, we remain concerned about the sustainability of this improvement in the future. With only seven of 40 recommendations met in full, there is still a great deal of work to be done to deliver the further improvements in the safety and effectiveness of services that are required.

Although publication of this report marks the end of our Section 48 investigative activity, we will continue to monitor the trust closely over the coming months until we are assured that the required service improvements are fully embedded and patients are receiving safe and effective services on a sustainable basis.

We will also be sharing the findings of our report with Monitor and NHS England and it will be used by our Chief Inspector of Hospitals to inform the future inspection of the trust under our new intensive hospital inspection programme.

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1. Introduction

The trust

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 clinical commissioning groups based in Lancashire and Cumbria.

The trust provides services from three principal sites to a population of 365,000, covering South Cumbria, North Lancashire and surrounding geographical areas. The sites are: Furness General Hospital in Barrow; Royal Lancaster Infirmary in Lancaster and Westmorland General Hospital in Kendal. The trust also provides outpatient services at Queen Victoria Hospital in Morecambe, at Ulverston Health Centre and in a range of community-based facilities. The trust has approximately 5,000 staff. In 2012/13 the trust had an income of £280 million.

Furness General and the Royal Lancaster Infirmary have a range of general hospital services, with full A&E departments, critical/coronary care units and consultant-led beds. Westmorland General Hospital provides a range of general hospital services, together with a Primary Care Assessment Service (PCAS) with GP-led inpatient beds, operated by the Cumbria Partnership NHS Foundation Trust.

All three sites provide a range of planned care, including outpatients, diagnostics, therapies, day-case and inpatient surgery. In addition a range of local outreach services and diagnostic services are provided from a number of community facilities across the community.

Our January 2012 investigation

In January 2012, we conducted an investigation, using our powers under s48(1)(2)(a) of the Health and Social Care Act 2008, into the quality of care provided by the trust at both the Royal Lancaster Infirmary and Furness General.

Our investigation was designed to assess the systems and procedures the trust had in place to ensure that people were protected against the risk of unacceptable standards of care and treatment. It focused on the emergency care pathway and also examined the trust's governance and management systems at a number of levels within the organisation.

We published [our investigation report](#) on 13 July 2012. It contained 40 recommendations for action by the trust.

When we published the report, we told the trust that, in addition to any other regulatory activity, we would conduct a formal follow-up visit to assess its progress in addressing the recommendations.

2. Findings

We carried out our follow-up visit in April this year.

A team of eight CQC inspectors, two external advisors (specialising in A&E practice and governance) and an expert by experience (a person who has experience of using hospital services) visited the trust on 8-10 April and 13-14 April 2013. The inspection team was supported by a CQC regional intelligence and evidence officer (an analyst), the North West business services staff (administrative staff) and staff from our National Customer Service Centre.

We visited both the Royal Lancaster Infirmary and Furness General. We spoke to patients about their experiences and observed the care that was being delivered in the emergency departments and wards. We interviewed a range of people working at the hospitals including executive and non-executive board members; nursing staff; doctors; social workers; administrative staff and hotel services staff. In total, we spoke to more than 150 patients and relatives.

In planning the review, we collected information from other organisations including North West Ambulance Service NHS Trust; NHS Cumbria Clinical Commissioning Group and Lancashire North Clinical Commissioning Group; Cumbria Partnership NHS Foundation Trust (a mental health trust), the Cumbria Health and Wellbeing Committee (the County Council health scrutiny committee), Cumbria Local Authority and local patient groups. We also received written feedback from individual patients who had received care from the hospital in the months leading up to our visit.

Immediate action taken during the visit

While visiting Furness General on 16 April 2013 we saw poor infection control practices in the resuscitation bay that included dust and debris; inefficient housekeeping practices; and health and safety issues related to electrical wiring and general clutter. We were also concerned that operational problems arising in A&E were not always communicated upwards through appropriate channels.

We raised these matters immediately with the senior management team, who dealt with all the issues promptly. We were able to see the action taken to address all the issues that same day. However as we had found the trust to be non-compliant with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (Outcome 8 of the essential standards: cleanliness and infection control), we issued a separate [inspection report](#) on the specific issue. This was published on 9 May 2013 on our website.

Our findings

The recommendations made in the original investigation report related to the following areas:

- Respecting and involving people
- Care and welfare of people
- Co-operating with other providers
- Safeguarding people from abuse
- Safety, availability, and suitability of equipment
- Staffing
- Supporting workers
- Assessing and monitoring the quality of service provision
- Complaints
- Records
- Leadership.

The findings of this follow-up review are grouped under the same headings. For each area we set out our assessment of the progress made against each of the recommendations, followed by our detailed findings.

2.1 Respecting and involving people

<p>Recommendation 1</p> <p>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.</p>	<p>Met</p>
<p>Recommendation 2</p> <p>Put in place operational standards for the appropriate use of security staff in the care and management of patients.</p>	<p>Met</p>
<p>Recommendation 3</p> <p>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 is made.</p>	<p>Partly met</p>
<p>Recommendation 4</p> <p>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.</p>	<p>Not met</p>

Privacy and dignity

The trust has implemented a number of measures and processes to improve the care environment so that care can be provided in a private, dignified and respectful way.

Improvements included the provision of a new acute medical unit at Royal Lancaster Infirmary with separate female and male medical assessment units and single sex short stay areas.

In addition, we noted that since September 2012 the trust had not recorded any breaches against the Department of Health's mixed sex accommodation

target. This meant that patients of different genders had not routinely shared hospital bays or washing and toilet facilities. The trust provided information leaflets about single sex accommodation to patients using the A&E departments in advance of admission. We observed throughout both Furness General and the Royal Lancaster Infirmary that male and female patients were accommodated in separate areas, with the exception of the medical admissions unit at Furness General.

We spoke with and observed a male patient and a female patient being cared for in the same area of this unit, although they did have separate washing and toilet areas. Both of them told us they had no concerns around sharing the same bay. Government guidance on delivering single sex accommodation allows for exceptions in emergencies. In this case, both the male and female patient had taken the last two beds in the unit and required care for only a short period of time. However accurate records of the consultation with the patients involved had not been kept and we asked the trust to ensure that this did not happen again in future.

We had been made aware, through complaints and comments, that patients felt that there was a poor attitude among staff. Patients felt that they had been spoken to in a rude and inappropriate manner and had not been provided with explanations or apologies when the care had been of a poor standard.

Senior managers acknowledged that in the past there had been complaints about the attitude of staff members.

To support staff in managing the privacy and dignity of patients and treating patients with respect, we saw that job descriptions made clear the trust's expectations and supported ward managers in discussing concerns about staff attitudes and behaviours with individual staff members. Staff were given a 'confidence in caring' document that also made clear expectations about what the trust expected from their employees, in terms of their behaviour and actions towards patients

Operational and front line managers told us that they felt that there had been a problem with staff attitudes in the past; however, more recently, there had been improvements. They told us that they were now able to challenge and report poor behaviours to senior staff and the concerns would be appropriately dealt with. We were told that staff were being supported through performance management processes to ensure that they did not adopt a poor attitude or deliver a poor standard of care in the future.

We visited the majority of the wards and departments at both Furness General and Royal Lancaster Infirmary. We did not observe anyone being spoken to rudely or anyone experiencing poor care. We spoke with patients who told us that staff had treated them with dignity and respect.

We saw staff working well to ensure the dignity of patients was maintained within all the wards and departments visited. In the A&E departments, curtains were in use around all patients in cubicles. We did not see any patients waiting in corridors to be treated.

Patient experience

The trust had a number of internal processes in place to measure patient experience. These included matrons' questionnaires, patient experience measures (PEMs) and departmental surveys. Outcomes of these were reported via Divisional Governance Teams and Divisional Management Boards.

According to the national patient survey for A&E departments that was undertaken in early 2012, the trust was rated in the banding 'about the same as other trusts' in all categories. The survey looked at privacy and dignity, communication between the ambulance service, GPs and the trust, waiting times, patient information, explanations, and staff communication to the patient and relatives, pain control, cleanliness, general treatment and the availability of complaints information.

To capture patient experience, the trust had in place a comments card system in the A&E departments at both sites. These comment cards were also in use when we visited last year. Each patient that attended A&E was given a card to complete that included a score for communication; respect and dignity; cleanliness and experience. There was also a section entitled 'how can we improve?' The information gathered was displayed in the department along with a selection of comments. We asked if any improvements had been made as a result of the comment cards. Staff told us that patients had asked for newspapers; better cups and vending machines and these had been provided. We were also informed by staff that the comments cards were about to be used more widely. Senior managers at the trust confirmed this intention.

At Furness General there was a television used to provide patients with information including current waiting times and what to expect during their stay in A&E. There was also a notice board with locally produced information. While the TV could be updated easily, it was a struggle to read the information as the screen was split into three areas. Waiting times were displayed across the bottom of a split screen. The print size and colours used to indicate waiting times were very difficult to read unless sitting immediately in front of the screen.

In addition, the comment cards in A&E, although a good way to receive feedback, were not particularly customer friendly as they were written in small font that may prove difficult for people with visual impairments.

Records about the numbers of cards issued and the numbers returned were not maintained. The trust was therefore not able to determine or measure response rates.

Information gained from the questionnaires did not seem to be shared anywhere else except in the local A&E department. If the feedback was shared, collected, analysed and reported in a systematic way and was shared across both sites, this could enhance patient experiences in both A&E settings. However as there is no such action taken, then the value of the current system in terms of its contribution to improving patient care and experience is highly questionable.

At Royal Lancaster Infirmary there was a good sized notice detailing the colour coding of nurse uniforms, to help with the identification of staff. This was not present at Furness General.

We asked staff on the hospital wards how they ensured that patients were satisfied with the service they received. Staff told us that they carried out regular 'matrons' in-patient' surveys that were undertaken at both Royal Lancaster Infirmary and Furness General using a sample of patients each month. The "matrons' in-patient' survey contained questions about dignity, privacy, nutrition and medication. Staff told us that feedback from these surveys was discussed with them so that they could make any improvements required. This information was reported to senior managers to be included in quality reports.

The trust was in the process of implementing a mobile telephone text based system to gather information about patient experience called 'friends and family'. This system sends patients a text message asking them about their hospital stay following discharge.

The message asks patients if they would recommend the hospital to their friends and family. We noted that patients' replies were anonymised and displayed for staff to see. Staff were unable to give us examples of improvements that had been made following patients' comments from the text service but explained that the system had only been in place a few weeks.

The use of hand-held electronic feedback devices was now embedded in the trust, with these being used to gather and respond to patient feedback in a timely way. The patient stories and recommendations from these were fed back at Governance and trust Board meetings.

Patients spoken with during our visit had been kept up dated during the triage process with waiting times to see a doctor or other health care professional. Three patients that had attended A&E at Royal Lancaster Infirmary more than once in the last six months commented on long waiting times during previous visits.

We saw one elderly patient who was brought in to A&E at Royal Lancaster Infirmary by ambulance. . Staff in A&E stayed with the patient until they had been appropriately transferred. We saw staff communicate with the patient in a reassuring and comforting way.

All the patients we spoke with at both hospitals about being treated with dignity and respect felt they had been treated properly. At Furness General we observed drawn cubicle curtains around beds and we saw a nurse go into a cubicle of an elderly lady who was agitated and cover her legs; rearrange her clothing and reassure her.

All the patients we spoke with in A&E expressed satisfaction with the care they had received. A mother of a child needing treatment told us, “My daughter is nervous of males and everything was handled extremely well.” A male patient told us, “At no time have staff not treated me with dignity and respect.” He also confirmed that he had not observed staff treating other patients with any lack of dignity or respect either.

The use of security staff

We asked staff about the use of security guards to ‘keep an eye’ on vulnerable patients when there were not enough nursing staff to undertake one-to-one observations. This was something that had been used on a regular basis when we visited last year. We were told that security guards were no longer used in this way and that the practice no longer happened. Staff told us that the only time security guards were now utilised by nursing staff was when there was a concern that staff may be physically threatened by a member of the public.

The trust now only used security staff to provide staff with support to manage violent or aggressive patients. Guidance and a Standard Operating procedure to support the appropriate deployment of security staff was in place.

2.2 Care and welfare of people

<p>Recommendation 5</p> <p>Develop and implement a trust strategy for improving the flow of emergency / urgent patients. This strategy needs to have the engagement of all clinicians and managers as a key component.</p>	Partly met
<p>Recommendation 6</p> <p>Put in place operational standards for the routine clinical surveillance of patients attending the emergency department.</p>	Met
<p>Recommendation 7</p> <p>Develop 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.</p>	Partly met
<p>Recommendation 8</p> <p>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.</p>	Partly met
<p>Recommendation 9</p> <p>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'.</p>	Partly met
<p>Recommendation 10</p> <p>Review current guidance regarding referrals for review by social services to support improvement in discharge planning and discharge of patients.</p>	Partly met

<p>Recommendation 11</p> <p>Review access to rehabilitation facilities at WGH to ensure equitable access on the basis of clinical need.</p>	<p>Partly met</p>
<p>Recommendation 12</p> <p>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.</p>	<p>Partly met</p>

Patient flow through the hospital

The trust had clearly recognised the need to improve in this area and had developed and implemented an emergency recovery plan to improve performance. This plan was being monitored formally on a weekly basis. Part of this improvement plan was the ‘Transforming Unscheduled Care’ project that aimed to provide assurance that current changes were improving the quality and effectiveness of the care delivered to patients in the A&E departments across Royal Lancaster Infirmary and Furness General. Significant work had been undertaken to improve unscheduled care at both sites through the Programme Management Office (PMO) projects. The progress of these projects was reported in monthly Board Reports.

One key national outcome is that time spent in A&E should be less than 4 hours for 95% of patients. In January 2013, the trust met the 95% target but in April 2013 it did not, achieving 90.52% overall (Furness General - 92.2%; Royal Lancaster Infirmary - 89.35%). The trust advised us that the reasons for not being able to meet the target were:

- An increase in emergency admissions of 11.3% over the same time as last year.
- The unavailability of beds due to the impact of the winter vomiting bug Norovirus.
- Staffing shortages due to higher levels of sickness and absence that meant contingency beds could not be opened. There was also a shortage of bank staff available to cover.
- The inability to divert to other trusts due to pressures experienced across the country.
- The inability to discharge well patients because they had been in contact with patients with symptoms of diarrhoea and vomiting.
- A lack of community resource at Royal Lancaster Infirmary and Furness General that resulted in patients experiencing extended stays that impacted on the patient flow through the healthcare system.

It should be noted that many trusts across the country experienced similar pressures, with the average performance nationally during the beginning of April 2013 being 90.4% for similar reasons as experienced by this trust.

Overall between November 2012 and April 2013, the trust's level of compliance with the A&E waiting time target has generally been between 92 – 94%, apart from March when it fell to 91%. The trust met the A&E target in May 2012, exceeded the target in October 2012 and met the target in January 2013. As a result of strategies put in place an incremental improvement is projected for the summer period and while the trust do not anticipate that they will be able to achieve 95% for the period April – June 2013, they do envisage being able to achieve the 95% target between July – September 2013.

The trust had carried out a substantial amount of work on patient pathways and had reconfigured the layout of the A&E and wards at the Royal Lancaster Infirmary to better facilitate patient flow. Due to the configuration of wards and departments at Furness General, where it was not as easy to change the layout of services, this had not happened to the same degree.

The Royal Lancaster Infirmary A&E department had recently undergone significant refurbishment. Improvements had been made that divided the department into three main areas; major, minor and resuscitation. This meant that staff were able to triage patients more effectively. Alongside more effective triage systems, the trust had developed ambulatory care and Hospital Outpatient Treatment (HOT) clinics (a consultant / associate specialist run clinic where GP referrals are assessed) at the Royal Lancaster Infirmary and a 'see and treat' room at Furness General all of which were GP led. This meant that there was somewhere in both hospitals for non-acute emergency patients to be seen and cared for, speeding up the process within the A&E department and reducing the length of stay.

We spoke with ambulance crews who were attending the A&E departments. They told us that liaison between the trust and the North West Ambulance Service (NWAS) had improved in the last six months. Crews still felt however, that at Royal Lancaster Infirmary there was a longer waiting time to handover the patient to hospital care during particularly busy periods.

We looked at the systems that the trust had in place for monitoring patient waiting times. The trust had developed an electronic system that gave 'live' information displayed on a television screen within the A&E departments (not visible to patients waiting to be seen) at Royal Lancaster Infirmary and Furness General. The information displayed the patient's name and how long they had been waiting. Patients within the four hour time period were highlighted in green, those close to breaching the four hour time period were in amber and those that had breached were red. This meant that the trust had developed more effective systems for monitoring patient waiting times.

In order to improve patient flow through the hospital, at Royal Lancaster Infirmary an early discharge initiative 'Bed before 10' had been implemented which consisted of increased ward rounds focused on ensuring timely discharge of patients, and a short stay unit had been opened for patients with an expected stay of less than 72 hours.

At Furness General a short stay medical area and surgical assessment unit were set up on existing wards to organise the length of stay of patients and daily 'bed meetings' were revamped to take place three times a day. As at Royal Lancaster Infirmary, the 'Bed before 10' plan had also been implemented.

Plans were in place for further improvements which included a 'Length of Stay' project which was to focus on improvements in patient pathways and the appropriateness of ward configurations.

Both hospitals participated with other NHS colleagues in the Urgent Care Network and had implemented complex discharge meetings on a weekly basis.

During our original investigation we noted that patients were often moved from ward to ward in order to free up space for new admissions. This meant that patients who required medical care might be placed on a surgical ward where the staff did not have a depth of knowledge about their condition. These patients were known as 'outliers'.

We asked about how 'outliers' (when due to the lack of beds in a specific speciality, usually a medical ward, patients are placed in other wards to be cared for) were now being managed across Royal Lancaster Infirmary and Furness General. Staff told us that, wherever possible, patients were managed within the correct speciality. If they had to be accommodated on a different ward or department then they were now reviewed more regularly by medical staff and bed managers. Staff told us that keeping patients in the correct speciality was more difficult if the hospital was full or at night time. Staff told us that ward rounds happened on every ward and we saw consultants and staff undertaking these at Furness General.

We looked at a selection of patient records for those patients who had been an outlier in another speciality. We found that their treatment or discharge did not appear to have been delayed or inappropriate and they had been regularly assessed by the correct specialist doctors and the bed managers.

Staff confirmed that outliers (usually medical patients) were seen by the relevant specialist junior doctors daily. Consultants saw their patients at least twice weekly but often more frequently. One staff member told us, "I feel it is working better now, boundaries have been broken down. We have come a long way." One member of staff told us, "We feel patients are getting better access to consultants." A senior member of staff told us, "Consultant availability is very good, with a good spread of visits and times. Their working

hours have changed recently and they are here early and late.”

Admission protocols were in place for the departments and staff were able to discuss these protocols with us.

Routine clinical surveillance of patients attending A&E

In our original investigation we found that patients were not being adequately or correctly monitored during their stay in A&E and we issued a Warning Notice in February 2012, requiring this to be addressed as a matter of priority.

The trust managed the improvements to this through the unscheduled care projects for both sites and the Harm Free Care project specifically the Early warning Score (EWS) and Physiological Observations Track and Trigger System (POTTS).

The trust had implemented a new policy detailing the minimum standards expected for patient observations and the support and training that staff were to have to ensure they were competent to carry out the observations needed. When we reviewed compliance against the Warning Notice in August 2012 we saw that there was a reduction in the amount of incidents of incorrect recording. Notifications to the National Reporting & Learning System (NLRs) indicated a small number of cases where observations were not carried out appropriately.

We reviewed the frequency and quality of physiological observations within the A&E departments in this visit. These had continued to improve and were being carried out regularly and correctly. We saw audits that confirmed the monitoring of compliance with the policy and spoke with staff who told us about the training they had received to improve the recording of observations. They told us that they rarely had problems now with either the POTTS or the early warning score (EWS). Outcomes from this project were monitored by the Acute and Emergency Medicine Divisional management board and reported upwards in monthly Board Reports as needed.

Generally patients expressed a high level of satisfaction with the treatment and service they received in both A&E departments. However we did get a mixture of comments from patients and relatives we spoke with in both hospitals. On one of the wards a patient's husband told us that there had been a problem with discharge medication where his wife had taken home incorrect tablets. Another told us about the problems he had had with the attitude of staff when he was asked to take his wife home during a Norovirus outbreak. This he said had been “a most distressing experience from what is usually good care”.

We were also told many positive things. A gentleman told us he had had full explanations about his care. A lady told us she was satisfied with the care on

the ward and she appreciated being helped by staff to wash, which was better than her experience some time previously on another ward. She also told us that when she pressed the alarm call for help if there was any delay in response staff apologised and explained why they were delayed. We were told by another lady, “I cannot fault the treatment or believe how quickly the time has gone.” One gentleman at Royal Lancaster Infirmary told us, “I am confident I got the right and best treatment available. I have full faith in the staff team. When I was poorly and being worked on I felt I could let go and let them get on with it.”

We saw a senior nurse speaking with two patients on one of the wards. Both patients appeared anxious and agitated and we heard the nurse giving careful explanations about the next steps in their care.

Discharge planning

Staff in the A&E departments told us that transferring patients to wards within the hospitals remained problematic at times, although improvements had been made since our last visit. They stated that the hospital’s beds were often full and they had to wait for patients to be discharged or moved. Staff told us that sometimes patient discharges were delayed but the majority of patients were now discharged more efficiently. This had been made easier recently by the creation of a ‘bed flow manager’ post to coordinate patient flow around and through the hospitals at both Royal Lancaster Infirmary and Furness General.

The trust had regular bed management meetings on both of the sites – three times a day. In Royal Lancaster Infirmary they used an electronic system that delivered information about bed occupancy in ‘real time’ that was updated at every meeting and could produce a print-out called the trust Capacity Statement. Furness General still relied on a paper-based system that was not always as up to date as the system at the Royal Lancaster Infirmary. This meant discharge staff spent a lot of time running around the hospital getting up to date information. Both systems gave identical results but the paper based system was more labour intensive. We were advised that the electronic system was about to be put in place at Furness General.

Bed management meetings were attended by ward managers; senior A&E staff; bed coordinators and the discharge team from each hospital. We were told that bed management meetings had greatly improved and were now more effective. A bed manager walked round the hospital approximately every two hours and the ‘flow manager’ visited the wards regularly. The lack of information because no-one ‘walked the hospital’ regularly to collate accurate information was something that senior medical staff had commented on previously.

The bed management meetings were now seen as more proactive in highlighting available beds in both the hospital and community setting, in

conjunction with provisional discharges and admissions, and the current alert status for the trust. At the bed management meetings the total bed occupancy within the hospital and the step down/rehabilitation wards throughout the trust's catchment area was discussed. The number of outliers across the hospital was also identified. The number of delayed discharges, and the reasons for these were also discussed and any solution, for example a move to a community hospital was discussed. If wards had infection control issues these were identified to aid decision making in bed management.

We saw that alternative treatment arrangements were also discussed, for example, a patient still in hospital who was medically fit to go home but continued to require intravenous antibiotics was going to be discharged into the care of the community nurses.

At both Royal Lancaster Infirmary and Furness General the complex discharge team met weekly and it was the responsibility of the designated site manager to consider discharges on a daily basis. Work had also taken place with Lancashire Social Services to implement 'Funding without Prejudice'. This was a flexible arrangement where discharge could be arranged and funding would follow the patient rather than having to wait for funding to be agreed before the discharge could happen.

We were also told that delayed discharges were being regularly monitored. The trust had set up improved links to Lorenzo (an electronic patient record system that provides one complete patient or user record that can be accessed across all care settings). However there was as yet no formal electronic database for collating discharge information. At the time of our visit it was recorded on a personally devised database at Furness General only. Ward staff were responsible for updating the system with the reasons why a discharge had been delayed.

A ward sister at Royal Lancaster Infirmary confirmed to us that they had lots of contact with the social worker and the discharge co-coordinator. They stated, "It makes our life easier for discharges." However we were also told that "there is an issue with access to social workers as they don't work weekends. We could discharge at weekends especially now the consultants are working much more flexible hours. It seems a shame that this is still a problem but it is outside the trusts control".

The trust had updated its discharge and transfer policy dated February 2013. It defines five key principles that all staff had to adhere to during the discharge process. The aim was to build a whole systems approach to assessment and the commissioning and delivery of the service, with the multidisciplinary team working together.

In accordance with the trust's discharge policy and procedure, the registered nurse discharging the patient was expected to be confident that the arrangements made for on-going patient care was safe and suitable prior to discharging the patient. The complex case manager was responsible for

ensuring that all complex discharges were managed in a coordinated and timely manner. We were told, “Complex discharge meetings are better developed and look at patient options and best interests with families. Each meeting can take up to three hours.”

However all the staff we spoke to identified that the remaining problems with bed management were around being able to discharge the patient into the appropriate community facility or to an appropriate rehabilitation establishment or residential / nursing home.

A member of staff told us, “The patient bed flow through this hospital (Royal Lancaster Infirmary) and pathway is much clearer and better for patients. Patients are now where they need to be and for the right length of time. Although there are still some problems, ward staff and A&E work closely together to try and move things along”. A number of ward managers and sisters spoke to us of the improvement in the flexibility of consultants'/doctors' shift patterns. This meant that patients had increased access to consultants. It was commonplace now for patients to be seen at 8.00 am or at weekends and this allowed for more timely discharge, treatments or access to discharge medication. Although this had generally been seen as a positive move, we were told that in one division the new shift patterns had put pressure on some consultants with a resulting increase in sick leave and an over-reliance on junior doctors.

We found that each hospital had different systems in place for working with social services in the discharge of patients. This was due to the fact they dealt with different county councils, that is Lancashire and Cumbria for Royal Lancaster Infirmary and Cumbria for Furness General. Within Cumbria, social service provision differed in the Barrow area to that of the South Lakes.

At Royal Lancaster Infirmary a physiotherapist told us that there had been “blocks” to the discharge system; however, they had seen improvements. They said, “I have seen better discharge planning for more complex cases.” A staff member did highlight to us that they saw that discharges back to, or as a new placement to, care homes caused a delay because “staff from the home want to reassess the patient but they do not respond in a timely manner. Community home care services can usually be introduced much quicker.” A member of the senior management team told us that there were some delays still in discharge for a ‘myriad’ of reasons ranging from funding; availability of after care; the response from social services; and “that some consultants are rather conservative in their approach to discharging patients”. Where necessary this issue was being performance managed by clinical directors. We were also told that difficulties were also due to issues relating to waiting for social workers and continuing care assessments. There were also problems with the availability of paediatric and adult mental health beds across the county.

At both sites a duty social worker from social services was now available five days a week based within the hospital. All the wards we visited at Furness

General commented on the improved working relationship with social services in the last few weeks. They confirmed that the daily presence of a duty social worker had greatly improved the discharge process.

We observed a daily ward round on one of the wards in the hospital and saw how the duty social worker was part of a multidisciplinary team approach. We saw an example of the ward manager alerting the social worker to the fact that although one patient was not quite ready for discharge they would require a care package later that week. The social worker was therefore pre-warned and was able to alert the social services team prior to the formal discharge assessment being requested via the electronic system.

A new electronic referral system, called STRATA, had been put into place to streamline and speed up the referral process to request a social work assessment. Duty Social Workers attended ward rounds where they were updated and briefed as to the possible support needs of people due to be discharged. We asked staff if they felt able to raise problems or issues about discharge with senior managers. Staff told us that they were more confident now in highlighting things that they felt were below acceptable standards of care in relation to difficulties discharging patients.

The discharge lounge at Furness General was situated in the elderly care day hospital at Furness General and was no longer in use as it was judged to be risky. We were told by staff that patients did not like to use the facility because it was at the back of the hospital and hard to find. If relatives parked on the main car park patients had to walk through the hospital that was quite a long way. Added to this, discharged patients were in the same environment as elderly day care patients and this was felt to be distressing for both the patient waiting for discharge and the patient attending the day hospital. The day hospital closed at 5pm so any patients still waiting for discharge then had to be transferred back to the ward they came from. We were told, "Patients feel like they are being dumped." However patient discharges had improved without the use of the discharge lounges.

We were told that a new proforma had been introduced the 'Continuing Care Discharge Assessment Form'. This was filled in by the lead nurse on the ward and for every patient who had, or required, social work input. Tasks were rated to flag up any areas of need the patient might require on discharge straight away to avoid delay. Staff no longer had to wait for patients to be declared medically fit before they could start the discharge process with the social work department.

Moving forward, the trust was planning to set up new discharge planning workshops for the multidisciplinary staff team. A senior member of staff told us, "We have been a bit behind here in Barrow but I am now very excited about the new team approach to discharges." A member of the senior management team told us that the trust was developing properly functioning urgent care networks. The CCGs and partnership operating procedures had introduced key target times for when patients should be discharged. They

also said, “We are empowering ward staff to manage discharges, we have multidisciplinary teams now on each site for the management of complex cases. We have submitted our actions plans to Monitor. We recognise we need consistency throughout the trust.” We noted on one Board report that the average length of stay was down from seven days to five.

Discharge medication

In the original investigation we were told that delays in a number of patient discharges were due to being unable to get hold of discharge medication or ‘to take out’ medication (TTO) in a timely manner. We found that both the pharmacy departments in Furness General and Royal Lancaster Infirmary were busy and at times struggled to meet demand for TTOs. However improvements had been made by extending pharmacy opening hours to include weekends. Ward staff were also working closely with the pharmacy to reduce discharge delays around access to TTOs. An example of this was that some wards were proactively ordering TTOs a day or two in advance, which ensured they were available when a patient was discharged. Many staff felt there was no longer an issue around waiting for TTOs.

Specific initiatives that had been set up to speed up the discharge process included, on wards 37 and 39 at Royal Lancaster Infirmary, the pharmacy trialling a new scheme where there was a mobile pharmacy set up on the ward. There was also a pharmacy clinic based in the HOT clinic in A&E to dispense medications quickly. This clinic was also open for longer hours and at weekends.

In the future the trust is planning to develop facilities in the medical admissions unit at Royal Lancaster Infirmary to offer the same service. We were told “this has made a difference, as previously it had caused a lot of problems on the wards with people waiting all day for medicines, with patients and families hanging around that made them cross.” Another person told us “the pharmacy situation has dramatically improved”. We were also told that “the new system for a pharmacist on the ward was good and medications were received on the ward by lunchtime.”

At Furness General we were told that there had been a lot of work around TTOs and although this had improved there were still more delays here than at Royal Lancaster Infirmary. Within the previous six weeks, the pharmacy at Furness General had increased their weekday opening hours and there was now a roving Saturday pharmacy with a mobile service going up to wards and working extended hours. This combined with dedicated consultants who worked staggered shifts meant prescriptions were more readily available. On Ward 9 we saw that patients’ TTOs had been ordered and dispensed the day before so they were available when the patient was ready to go home.

Rehabilitation services

The trust had worked with service providers in the development and implementation of referral guidelines for access to rehabilitation services at Westmorland General Hospital.

Access to Westmorland General Hospital rehabilitation services was restricted to patients who lived in South Cumbria. This was because of funding issues between Lancashire and Cumbria clinical commissioning services. To alleviate this, the trust had opened its own step down/rehabilitation unit, the Ripley Suite, at Royal Lancaster Infirmary to accommodate patients who were funded by Lancashire services.

Ward 9 at Furness General had been developed as a short stay ward and there were plans in place to reconfigure the discharge services. The Ripley Suite at Royal Lancaster Infirmary had been developed as a step up / step down facility and for on-going rehabilitation. We spoke with two Occupational Therapists who told us, “The changes with step up/step down facilities was a really good project. It was very innovative and will give more scope for working with colleagues in the community. It has just started but already shows promise.”

Within Royal Lancaster Infirmary wards 21 and 22 had been refurbished and ward 21 had been re-branded as the Ripley Suite. This was classed as an intermediate care ward where patients could receive up to three weeks rehabilitation. At the time of our visit this was being used mainly as a step down facility for patients in the hospital but there were plans in place for GPs to access this service instead of admitting patients straight into the main hospital. There were dedicated physiotherapists and occupational therapists on this ward to assist further with rehabilitation.

We were also told that there was a much closer working relationship with the community assessment teams i.e. Short Term Intervention Team (STINT) for Cumbria and Rapid Emergency Access Co-ordinator Team (REACT) for North Lancashire. This enabled the step up/step down units to have greater control over admissions and discharges.

On ward 21 we saw that all patients had rehabilitation plans in place and discharge was being arranged. Some of these patients told us, “They (staff) are feeding me up as I have lost a lot of weight” and “I have some ‘wobbliness’ and muscle weakness. I am getting on well with my physio and it’s a treat being dressed and in the day room.” Finally, we were told, “I am glad to be on this ward as they (staff) are all working towards getting me home.”

We identified good practice around the sharing of information within dementia care. The trust had adopted the butterfly scheme to give appropriate care for people with dementia while they are in hospital. A wide range of staff had completed the Stirling 12 week course in dementia care and the cross site

dementia lead was well known across all sites where she had identified and trained dementia champions. We spoke with several dementia care champions on the wards at Furness General who all agreed that patient care had improved as a result.

2.3 Co-operating with other providers

Recommendation 13

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

Partly met

Engaging with other partners

At the previous visit, both the trust and NHS partners reported that, historically, there had been difficult relationships between them. The focus for this review was to see whether working relationships had improved during the last six months.

The trust provided us with evidence of liaison with local commissioners regarding rehabilitation and mental health services. For example, it had worked with CCGs and had consulted key stakeholders to develop a model of care for intermediate care services at the Royal Lancaster Infirmary. At the end of February 2013, an update to the Acute Medicine Divisional Board noted a phased implementation from April 2013 focusing on the step down facility. The step up facility admission criteria had yet to be agreed.

Minutes of the trust's Contract Review Group meetings indicated issues with delays in input from mental health crisis teams for both A&E departments. The issues mainly related to support provided by Lancashire Care rather than Cumbria Partnership NHS Foundation Trust (CPFT). We also saw correspondence around the availability of the psychiatric liaison service at Furness General and its attendance at A&E to manage acute referrals.

Prior to our review we talked with various partners regarding how they saw their current working relationships with the trust. We were told that in the last six months there had been an improvement in joint working between the A&E departments and ambulance crews, but that the trust had seen an above average increase in the number of patients presenting themselves for emergency treatment. This was mirrored across many hospitals in the country. Both partners had developed an action plan to try to address turnaround times. However, there had been little change due to the high turnover/admission rates into the A&E departments over the winter period.

A member of staff from the North West Ambulance Service (NWAS) told us that there was "some good work being done in the hospitals and there was a good relationship with senior managers". However this had taken a long time to develop due to "no-one being appointed into a substantive role and managers being 'fluid' in the trust". This issue had been addressed with the

appointment of Clinical Directors and Service Delivery Managers at the trust. We were told that the trust had started to develop a better and more standardised approach to emergency care in both hospitals. There were now regular meetings between the Service Managers from NWAS and the trust.

NWAS liaison officers worked in both A&E departments from 11am into the early evening, managing admissions and waiting times and keeping the emergency crews up to date. These posts were funded by the locality Clinical Commissioning Groups (CCGs) who were considering increasing the roles to full time as they seemed to be working well, improving patient flow and making a difference to patient outcomes.

We were told by the trust that there had been major developments in the partnership working between mental health partners Cumbria Partnership NHS Foundation Trust and themselves, with the emergence of the 'Better care, together' project (see above).

Cumbria Partnership NHS Foundation Trust was also working closely with the trust in several joint forums in response to the 2012 Ofsted/CQC report on children's services. We had been involved in assessing the progress of this work and had seen that all partners were making an appropriate contribution to meeting the standards necessary to improve Cumbria's safeguarding for children.

When we contacted the Local Involvement Networks (LINKs) services for both North Lancashire and Cumbria they informed us that they were not aware of any problems with the trust around communication. LINKs aimed to give citizens a stronger voice in how their health and social care services were delivered. Its role was to find out what people wanted, monitor local services and to use their powers to hold them to account. This role has subsequently been taken over, and expanded, by Healthwatch.

With regards to involvement of the newly formed CCGs, we were told that both groups were working with the trust and were helping to fund specialist roles such as the role of the safeguarding champion.

We spoke with the commissioners from Lancashire County Council. They told us that over the last six months relationships with the trust had improved. There were now multi-disciplinary teams that included the trust, the CCG and other stakeholders working on both scheduled and unscheduled care.

We were told that there were better working relationships with the local Hospice, Social Care and Looked after Children. There were still however, concerns with the provision of child and adolescent mental health services (CAMHS) in Cumbria. Cumbria Partnership NHS Foundation Trust has completed a review of this service and is working to improve the provision of CAMHS across the county.

The provision of adult mental health services for the trust, as identified above, was a problem. We were told by Cumbria Partnership NHS Foundation Trust that a psychiatric liaison officer was now available in each hospital but we were unable to speak to either of them during the review. Between November 2012 and the beginning of February 2013 there had been eight delayed discharges due to an inability to obtain timely mental health input. Reviewing this information, we found that six of these were caused by the lack of availability of the Crisis Resolution and Home Treatment Team. Cumbria Partnership NHS Foundation Trust has currently completed a review of this service and we are awaiting the findings of that review.

The trust used a modified SAD PERSONS scale. (The modified SAD PERSONS scale is used to predict whether a person might harm themselves or commit suicide). The trust tended to use this as a trigger tool as to whether they needed to call the community mental health team. However, staff had not been trained to use the tool and the score can easily be manipulated to involve the community mental health team whenever staff felt they were required. There were no mental health liaison nurses in either A&E although Royal Lancaster Infirmary was planning to employ an RGN with an interest in mental health to support mental health patients in the department. The effectiveness of this approach will be evaluated in due course.

2.4 Safeguarding people from abuse

<p>Recommendation 14</p> <p>Develop a safeguarding adults training strategy and ensure that all staff complete the appropriate level of safeguarding adults and children training.</p>	<p>Met</p>
<p>Recommendation 15</p> <p>Ensure appropriate representation and attendance at internal and external safeguarding meetings.</p>	<p>Partly met</p>

Safeguarding training

A joint assessment of children’s safeguarding had been carried out in 2012 by Ofsted and CQC across the trusts and local authorities in Cumbria and Lancashire. Full details of the findings can be found in those published reports. As a result the trust had been working closely with local commissioners and other stakeholders to improve the services provided. CQC has been involved in assessing progress against the recommendations made in that report.

The trust established two projects to address safeguarding issues and additional staff were recruited to implement the Children’s Safeguarding Policy and provide safeguarding training for identified staff.

The Training Strategy – Adults and Children’s Safeguarding April – July 2013 covered the trust’s position at the end of March 2013 and outlined the safeguarding team’s strategy throughout April – July 2013 to achieve 80% compliance in adult and children’s safeguarding across the trust and 95% - 100% training in key areas. The strategy detailed responsibilities; reporting mechanisms and information flows both internally and externally. The policy had been approved by the trust Board.

The policies reflected local and national developments; recommendations and guidance and the planned content and implementation of education and training. They also specified the pathway staff needed to take to access appropriate safeguarding training.

A review of training compliance showed that there were to be 14–16 training sessions per month to cover the whole trust. The trust was also customising sessions for the new junior doctor intake in August 2013.

Level 3 training was being offered in high risk areas such as A&E and women and children's wards. By the first week in May 2013, all A&E staff across both sites were allocated to complete level 3 children's safeguarding training.

With regards to adult safeguarding level 1 the trust was expecting to have trained 80% of all staff by July 2013. In addition to this from April 2013 all staff attending children's safeguarding level 2 and 3 would also undertake adult safeguarding level at level 1.

Managers monitored compliance of training for staff and there was time allocated to release staff to attend training and to have opportunities to consolidate any learning outcomes. Monitoring was via internal audit; board reports; the Safeguarding Adult and Children's Committee and the Women and Children's Services (WACS) Divisional Governance Group.

When we looked at what the trust had actually achieved in relation to its plan for children's safeguarding level 2 training, we saw that out of the staff identified as needing to complete safeguarding training:

- Trust wide – 47% had been trained (1,227 trained + 249 booked from a total of 3,153).
- In the emergency departments – 98% had been trained (Royal Lancaster Infirmary – 100% - Furness General 85%).
- In the women and children's division – 85% had been trained (338 trained + 30 booked from 432 total) – (Furness General 88%, Royal Lancaster Infirmary 82%, WGH 100%).

In relation to children's safeguarding level 3 we saw that:

- For nursing staff identified as needing level 3 training – three had completed and the rest were allocated on three study days the week commencing 29 April 2013.
- For medical staff: none had completed the training but the five identified as needing level 3 training had a booked date allocated to them.

Dates had also been set for a week of customised emergency department training for the last week of April 2013 (Royal Lancaster Infirmary) and first week of May 2013 (Furness General).

In relation to adult safeguarding level 1:

- For nursing staff, nine had completed the training, 12 staff were booked on the training and the remaining staff were to be trained over three study days the week commencing 29 April 2013.
- For medical staff, four had completed the training and 14 were booked on a training session.
- For the remaining staff (reception and administrative staff) identified as requiring this training, only one had completed the training with eight

booked onto a training course.

In summary, 1888 staff had received level 2 safeguarding training (with 2,450 still to train) and 91 had received level 3 safeguarding (with 251 still left). In order to meet demand, the level 2 training was being accelerated with more dates being added throughout April to July 2013.

As well as training modules the trust had developed a new safeguarding page on their intranet site to provide staff with information on contacts, training, information leaflets, guidance notes and news.

Safeguarding meetings

The Clinical Governance and Quality Committee report dated 13 March 2013 detailed the trust's safeguarding project. It identified that the children's safeguarding project had expanded to encompass many of the aspects of adult safeguarding and set up a single trust wide safeguarding scheme. It confirmed that the trust continued to work with its commissioners and partners across both counties and that it had formed closer working relationships with both partners. We had first-hand experience of trust Executive Directors attending partnership meetings along with CQC to ensure improvements were made to children and adult safeguarding across Cumbria.

Safeguarding champions had been identified and an arrangement for their training was well under way. Key performance indicators (KPIs) for the safeguarding system had been developed and were monitored by the trust Board using a dashboard system.

From 13 April 2013, the safeguarding team were going to be accommodated in a single central core office with a single telephone point and email address for easier and speedier access.

Other events had been put on by the trust in February 2013 to promote the awareness of safeguarding and to make sure staff were aware of the revised policies and procedures. One of these included speakers from the Lancashire Safeguarding Board; the trust Non-executive Director for Safeguarding; the local Police Protection Unit and the trust Lead Nurse.

The trust still had a vacancy for named nurse for safeguarding children at Furness General and the named doctor's involvement with safeguarding was often compromised because of his substantive workload. However the trust was aware of these issues and clinical risks had been identified on the trust's risk register. One of the two deputy Chief Nurses had safeguarding as part of her portfolio of work and was supporting staff with safeguarding issues for both adults and children until an appointment was made. Staff we spoke with at both sites were aware of the policies and procedures around safeguarding; one doctor at Furness General was able to give us an example of how the

team had informed the safeguarding team following a concern about a child.

Minutes from the safeguarding children's and adult team operational meeting showed that it was a multidisciplinary meeting with clinical staff involvement fortnightly. This meeting was attended by the Deputy Chief Nurse Furness General, The Named Midwife, the Lead Nurse Safeguarding Adults, the Named Nurse Safeguarding Children (Royal Lancaster Infirmary) and the Lead for the Safeguarding Project in the trust. We could not see any medical staff input into these meetings.

The Chief Nurse had been appointed as the Vice Chair of the Cumbria Safeguarding Adults Executive Board (CSAEB). We had first-hand evidence of the Chief Nurse's attendance at these meetings as well as their involvement from the minutes.

We spoke with one of the hospital Social Workers who told us that that staff were good at identifying and referring safeguarding issues with most referrals coming via A&E. They also confirmed that clinical staff worked well with the social work team. We also spoke to staff at all levels who confirmed that they had completed e-learning on safeguarding vulnerable adults and felt much more confident in their responsibilities.

2.5 Safety, availability and suitability of equipment

<p>Recommendation 16</p> <p>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.</p>	<p>Met</p>
<p>Recommendation</p> <p>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.</p>	<p>Met</p>
<p>Recommendation 18</p> <p>Ensure that systems are in place in accident and emergency departments so that sufficient resuscitation equipment is available.</p>	<p>Partly met</p>

Availability of equipment and training

The trust had systems and processes in place to manage medical devices. Its intranet site had a medical devices page which contained links to policies, equipment inventory and training resources for each type of equipment. Specific key performance indicators for Medical Engineering to monitor and minimise the turnaround times for repairs were identified to ensure that the minimum disruption to services occurred due to equipment failure. A small pool of loan equipment was retained by Medical Engineering for re-use/loan in the event of failure.

The availability and suitability of equipment at the Royal Lancaster Infirmary had improved significantly since we visited in February 2012. The equipment we saw was fit for purpose and available in sufficient quantities. This was true for accessories such as leads and Non Invasive Blood Pressure (NIBP) cuffs and consumables.

When we spoke to the Head of Medical Device Management it was clear this was as a result of a programme of work to assess, and where necessary, re-equip the A&E departments, although this seemed to have progressed much

further at Royal Lancaster Infirmary than at Furness General. As a result, vital signs monitors and infusion devices were now standardised across the Royal Lancaster Infirmary emergency departments.

When we asked if there remained any areas of concern we were told the blood gas analyser was frequently unserviceable but that there were two others close by in the hospital. We were later told that there were plans to purchase an additional machine.

At Furness General where there appeared less progress on the re-equipping of the A&E department, we were told that there were plans to improve this but the matron to whom we spoke could not give us timescales or an overview of the project. We did not see recent incidences of equipment not being available when required.

We asked about how staff were trained in the use of medical devices and how their competence was assured. We asked if there were departmental leads for this and we spoke to a nurse who had taken on that role at Royal Lancaster Infirmary. They were confident and knowledgeable about the approach to medical device training and had the relevant information to hand. We were told that each member of staff had had their training needs assessed for each piece of equipment that they used. The records were kept on the trust's intranet but there was also a paper file kept in some departments.

The training matrix for medical device training was derived from the trust's inventory of medical devices and personnel records, both of which were accurate. We saw that training needs had been identified and followed up for nursing staff.

There were no records available that demonstrated that this exercise had taken place for medical staff, although we were told some medical staff had completed some equipment training and that equipment training would be cascaded to all relevant medical staff.

We further understood that this system had recently been integrated into the trust's Training Management System (TMS) and this allowed performance and gap analysis to take place within departments and divisions. We were also assured that this information would allow the gap in medical staff's device training to be addressed. It was clear from a demonstration of the TMS and reports that we requested that this system was capable of providing the necessary information.

We discussed the training approach to the introduction of new standardised infusion devices. We were told that training had been specified as part of the purchase of the equipment and as such both direct training and "train the trainer" cascade training had been carried out by the manufacturer. This approach was judged to have been successful because of the involvement of equipment management professionals in the procurement and

implementation of this project that ensured good practice was followed.

We spoke to Clinical Skills Trainers about the effectiveness of this training and they were positive about the knowledge and confidence that staff had when they came to their sessions.

Replacement of equipment

We interviewed the Head of Medical Devices & Engineering and asked about any systems to plan the replacement of medical devices. We were told that the trust held an accurate inventory of medical devices using a proprietary computer system. We asked about the systems for device procurement and disposal and we were assured that all medical devices were recorded on this system together with their date of purchase. We saw that the location and departmental and divisional ownership was recorded for each device. This was said to have helped considerably in locating equipment more rapidly between departments, especially when patients had been transferred with equipment from A&E or another ward in the hospitals.

It was further explained how each category of medical device was assigned an estimated lifespan and how this enabled reports supporting the replacement planning process to be produced.

We asked whether there was a medical devices management group that would fulfil the requirements of DB2006(05) (the guidance produced by the Medicines and Healthcare Products Regulatory Agency (MHRA) on managing medical devices that is currently under review itself). It was explained that the Medical Equipment Capital Group fulfilled this role and directed the trust's devices strategy that included the planned purchase of equipment. This group was chaired by the Medical Director.

Resuscitation

The trust told us that it had improved the management of resuscitation equipment in both A&E departments. Additional equipment was procured during the improvements to the Royal Lancaster Infirmary A&E. Standardised equipment was now provided on each resuscitation trolley. A schedule of checks was undertaken usually at shift changes and records were kept. Historically cardiac arrest audits had been recorded on paper with details of equipment used. The trust Resuscitation Group had oversight of this audit data to enable changes in practice to improve outcomes. Recently action had been taken to record cardiac arrests on the Incident Reporting system to facilitate better data collection for auditing and reporting.

In general both A&E departments had sufficient emergency equipment available.

However at Royal Lancaster Infirmary there were no adult EZ IO needles (Intraosseous needles for vascular access). This was reported to us as a resupply issue rather than them not having been ordered. There was no Broselow tape available (this helps calculate the weight of a child in resuscitation situations) however there was an age, height and weight chart on the wall instead of a Broselow tape to prompt this. We could not corroborate whether there had been any incidents of delay in resuscitation attempts due to any absence of equipment.

At Furness General the paediatric resuscitation trolley was sealed and was only checked every four weeks or after each use. The trolley mirrored the one kept on the paediatric ward but there was no reference to how these had been designed. The A&E trolley included a Sodium Bicarbonate Polyfuser which is not considered a first line resuscitation fluid in paediatrics. There was also Gelofusine on the trolley which is unusual for paediatric emergency use particularly in relation to the risk of hypersensitivity to starch. Staff when questioned were unable to tell us why these two products were available for use in a paediatric emergency.

There were no advanced life support (ALS); advanced paediatric life support (APLS/EPLS) or advanced trauma life support (ATLS) algorithms on display to prompt staff during paediatric emergencies. We were unclear as to how staff would be able to remember drug dosages and be able to calculate weight and drug dosages if they were not familiar with paediatric medications. No policy folders were visible in the resuscitation room.

Many A&E staff had completed the Safe Transfer and Retrieval (StaR) course. As Furness General is some distance from definitive paediatric and/or trauma care, this was a positive move.

At Royal Lancaster Infirmary there was an appropriate policy for staff who attended the helipad to bring patients into A&E. Appropriate personal protective equipment (helmets and high visibility clothing) was available.

At Furness General staff reported that most casualties were transferred from or to helicopters by the ambulance service. However we were told that nurses occasionally undertook this role but no policy was available.

It was clear that the review of the emergency departments at Royal Lancaster Infirmary had resulted in a department that was more amenable to patient flow and more appropriately equipped. That process seemed to be “work in progress” at Furness General and was much less well developed.

The practice of the paediatric ward helping out in the A&E appeared to be an informal one. It is of concern that the resource appeared limited. This concern is compounded by the seeming willingness of nursing staff at Furness General to leave all aspects of paediatric resuscitation to others, including checking equipment. The worse case scenario of a simultaneous paediatric cardiac arrest on the paediatric ward and one in the A&E at

Furness General at the same time, albeit unlikely, is possible. It would be expected that there was a group of nurses and doctors on all shifts in the A&E who were able to manage a paediatric arrest without the added support of the paediatric team. Appropriate training at all grades is one aspect of this, but also all staff need to be familiar and competent with the equipment likely to be used. This was not apparent at Furness General A&E. This situation may change with the appointment of the advanced nurse practitioner (RSCN).

2.6 Staffing

<p>Recommendation 19</p> <p>Review its human resource information systems and ensure that accurate data is available for the entire organisation, so that robust data reporting is ensured.</p>	Met
<p>Recommendation 20</p> <p>Establish a workforce strategy and plan that looks at: the current staffing establishments and skill mix; recruitment and retention; contingency and succession planning.</p>	Partly met
<p>Recommendation 21</p> <p>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.</p>	Partly met

Human resource information, workforce strategy and staffing needs

The trust had employed an interim Workforce Planning Project Manager to support work on developing workforce plans linked to service changes and the cost improvement programme. The Human Resource Business Partners reviewed staffing usage in all areas by comparing establishment against contracted and weekend hours; temporary staffing usage (bank and agency), vacancies and sickness as part of the trust's 'Big 6' projects which examined discretionary spend and the use of contingent labour. This is an on-going project. Detailed information on workforce including sickness absence and vacancies formed part of the monthly performance management reports and was discussed at those meetings. Medical and nurse staffing projects were looking at how to improve deployment through improvements in job planning and matching capacity and demand, and reviewing the establishments of all wards and departments to ensure they were at the correct level.

In December 2012 the trust was under-achieving its 3.5% target for sickness absence but was on plan to achieve turnover rates. Appraisal and mandatory training completion was also noted to be on plan to be achieved or, in the case of mandatory training, had been achieved.

We spoke to members of the Human Resources (HR) team about the trust's HR systems and they told us that systems had undergone improvement

since our previous visit. We were shown a good example of this contained in the Integrated Board Report that detailed information on medical and nursing staffing costs, including agency and locum spending. This was broken down by division and reasons for any agency usage had been identified. The report also contained the trust's performance for sickness, turnover, training and the completion of mandatory training. We also looked at the Emergency Care Recovery Plan for April 2013 that detailed a reconfiguration of beds on sites, an acute medical workforce strategy, improvements to internal systems to give effective management of speciality wards, improvements to external systems that concentrated on support from Cumbria Partnership trust with improved community services and Local Authority support from care homes.

We were given a demonstration of the Training Management System (TMS) and when we posed questions about the training of nursing staff at the Royal Lancaster Infirmary in Advanced Paediatric Life Support the manager was able to quickly provide information that correlated well with what we were told by staff in the emergency departments.

During our visit we asked for more detailed information to be provided such as the use of bank and agency staff; staffing establishments and vacancies, as well as completion of training. This information was provided, correlated with other sources and demonstrated that effective information systems were in place.

We asked senior staff in HR what progress had been made on workforce planning and were told it was being led by the Interim Director of HR and the Interim Workforce Planning Manager. We saw a Workforce Planning & Strategy Framework Document for 2013/2014 that had a version control schedule indicating it was started in late February 2013 and was in final draft form at the time of our visit. This document was written in the context of the trust's strategic objectives and organisational priorities and established a process for moving forward with workforce planning. We understood that meetings had been planned during the following 5-6 weeks within the divisions to extend this further.

Staff told us that staffing levels and skill mix had been reviewed in the departments on both sites and a number of new staff had been recruited to a variety of posts.

When we visited the A&E at Royal Lancaster Infirmary we asked about skill mix. Both staff and managers told us it had been considered and, as a result, new and appropriate staff had been recruited. We also observed managers planning staff rotas for the department taking staff numbers as well as skill mix into account.

Staff at Royal Lancaster Infirmary were positive about the improvements to staffing levels and we saw from performance management reports at public board meetings that the use of agency and bank staff had reduced.

Specifically in relation to the A&E departments, the Division of Emergency Medicine through the Emergency Matron who now worked across the trust reviewed the issues around skill mix within Furness General. Following this it was recognised by the trust that additional support was required and an Advanced Nurse Practitioner (ANP) started 1 January 2013 with a second person due to start. Two new Health Care Support Workers (HCSWs) had also been employed. Staff in the department confirmed this. We were also told that the Division of Emergency Care had developed the role of an ANP paediatrics based at Furness General on a middle grade doctor's rota. We were unable to confirm that this post had been appointed to.

The trust's Integrated Performance Report for the period ending 31 January 2013 noted that medical staffing recruitment remained the key area of concern with two consultant and eight middle / junior doctor grade vacancies currently. In some areas the trust was looking to fill vacancies with nurse practitioners/nurse consultants.

We know through meetings with other trusts and Clinical Commissioning Groups in Cumbria and Lancashire that the trust is not unique in being unable to attract certain staff groups to work at its hospitals. This is a Cumbria-wide problem and something that the two clinical commissioning groups are looking at county-wide.

The trust told us that they were looking at different ways of working such as clinicians having some sessions at tertiary centres, for example Preston, to give more rounded experience. There had also been some recruitment days for nursing students who were just about to qualify to try and attract them to work at the trust.

2.7 Supporting workers

<p>Recommendation 22</p> <p>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.</p>	Partly met
<p>Recommendation 23</p> <p>Explore and develop strategies for delivering services with different staff groups so that reliance on difficult to recruit staff groups is reduced.</p>	Partly met
<p>Recommendation 24</p> <p>Explore and develop strategies for joint working and delivery of services across the trust, ensuring effective utilisation of skills, knowledge and experience.</p>	Partly met
<p>Recommendation 25</p> <p>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.</p>	Partly met
<p>Recommendation 26</p> <p>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.</p>	Partly met

<p>Recommendation 27</p> <p>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.</p>	<p>Partly met</p>
<p>Recommendation 28</p> <p>Ensure that suitably qualified and experienced paediatric staff are available at all times within the accident and emergency department.</p>	<p>Not met</p>
<p>Recommendation 29</p> <p>Ensure that appropriate supervision is provided to junior medical staff at the Royal Lancaster Infirmary, especially out-of-hours and at night.</p>	<p>Partly met</p>
<p>Recommendation 30</p> <p>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.</p>	<p>Partly met</p>

Recruitment and developing staff

The Division of Acute Medicine undertook a recruitment drive to recruit suitable staffing to vacant posts within the A&E at Royal Lancaster Infirmary.

We spoke to staff in the A&E at Royal Lancaster Infirmary about whether nurses with Emergency Nurse Practitioner (ENP) or Advanced Nurse Practitioner (ANP) roles were able to work effectively without covering other nursing duties. One nurse working in the ENP role told us that this was the case and it was due to the recruitment of permanent staff. They also told us that the physical separation of the minor and major treatment areas meant that they were able to lead the treatment of minor cases without being interrupted.

At Furness General health care support workers (HCSWs) had been taken on in a new role in A&E. The department was now trialling more flexible shift patterns for these posts. A specific-training programme had been designed to improve the skills of HCSWs to carry out phlebotomy (taking blood), electrocardiograms (ECGs), blood pressure (BP) and pulse recordings.

Paperwork for observations had been redesigned to rate and score observations on the Physiological Observation Track and Trigger system (POTTS). There were clear measures/triggers to flag up if indicators went beyond specific thresholds that required a counter signature from a qualified nurse. A senior member of staff told us, “They (HCSWs) are invaluable and have freed up nursing time.”

We were told by a junior doctor at Furness General that staff were better skilled within the A&E and roles were more proactive. They also said that the Matron was more involved and there were more key Nurse Practitioner roles within the department. Minor surgery and observations had been disseminated down to staff so that doctors were able to undertake more surgical work. “Money was diverted from the surgical department for extra staffing to be used in A&E for us to carry out these minor procedures.” Nurses had been trained and competency checked to allow them to do minor treatments. All this had helped to improve the monitoring of patients and their flow through the department.

A consultant told us that “triaging was more efficient now. It was happening more and we all work better as a team. Each person was triaged with improved monitoring. There was better use of nurses carrying out monitoring/screening and carrying out minor procedures such as chest drains.”

Access to training for nurses had improved and now any requests for training were mostly approved. Examples of recent training events for A&E staff were Advanced Paediatric Life Support (APLS) and male catheterisation. The A&E department had also put forward a second nurse to complete the Emergency Care of Children course at degree level.

One doctor at Furness General told us that they had put forward a training proposal around a diploma in cardiology techniques. They were to be sponsored by the trust to do this with an expectation that they would cascade training to other staff within the department as well as expand the service in the cardiology clinic.

Training database

The trust has invested significant time in its approach to managing training and the development of training plans across the trust, building them up from ward/department level to get an overall picture of what training was required.

We saw a demonstration of the trust’s Training Management System (TMS). This system had been developed and matured by the trust’s IT department since our previous visit. The system recorded individual training needs and completion of training for each member of staff in the trust. It was able to provide reports to demonstrate gaps and to monitor the training compliance of divisions, departments and individuals.

We saw how training requirements were defined in an individual's Personal Development Plans (PDPs) and identified as mandatory, job specific or developmental. This information was then recorded and monitored in the TMS. Each department had a TMS lead and there was support from Learning and Development Managers and a TMS administrator.

We also saw how the system was able to be adapted to meet need, such as the reporting of the medical device training records. One strength of the system was that staff had access to and updated their own records thus increasing the "ownership" of their individual training and the likelihood that they would comply. This system appeared both useful and well used.

The trust told us that there were occasional problems getting staff released for training and that the problem was worse at Furness General. Staff involved in a training role confirmed this telling us there was a high rate of "no shows" for their training at Barrow and this was linked to staffing levels. Staff were given the opportunity to attend training at whichever site they could to make sure of attendance. However travelling time and the distance between hospitals often made this difficult to do. We did see that medical staff had attended training across sites. One ward manager told us that attendance at training events had also been addressed by asking staff to book and attend training in their own time, with that time taken back later.

It was clear that with the introduction of the TMS the trust had information available to identify gaps in training, and we saw from the inclusion of mandatory training figures in trust Board papers that this was monitored at a senior level. We also saw detailed figures for both emergency departments that demonstrated that shortfalls in training had been identified and we understood that compliance with these targets was now a divisional performance indicator.

The trust told us that it was working to develop training plans that were built up from a ward and departmental level. When we interviewed Human Resource managers they told us that personal development plans (PDPs) were linked to trust, divisional and departmental objectives and we saw a sample PDP that demonstrated this. We were also told how identified training needs were then discussed at divisional level to identify common themes and pool training resources where necessary across the trust. This identified economies of scale, set standards and priorities, as well as allowing staff to meet people across the trust that they would not normally see.

In the future the trust is looking to adopt the Core Skills Framework, a component of which is the Skills Passport.

Whistleblowing and incident reporting

The trust provided a copy of their whistleblowing policy dated March 2012. This document encouraged staff to raise concerns, firstly through the normal line management arrangements but in certain circumstances through the trust's own whistleblowing helpline and ultimately relevant external bodies.

The trust also put forward their incident reporting system as a way for staff to raise concerns and assurance that any concerns would be followed up. We saw the notes of the Serious Incidents Requiring Review Panel (previously the Serious Untoward Incidents panel) for January 2013 that demonstrated that these incidents were followed up in a formal manner.

When we spoke to staff they told us they knew how to report adverse incidents and they would do so if needed. Staff were more confident that their concerns would be treated seriously now and they would be treated properly. Staff expressed more confidence in senior staff and although many said a change in culture was slow to happen most said change was happening for the better. We did highlight one incident to the trust where staff had not formally reported concerns over infection control issues through the electronic risk report although they staff stated they had reported the problem to their line manager.

The NHS Staff Survey for 2012 had a score for staff reporting errors that showed the trust was slightly higher than their peer group of acute trusts, although this was actually a fall from the 2011 survey. Of staff who witnessed errors, the number saying they or another had reported it was similar to other peer trusts.

Paediatric nurses in A&E

The trust had employed two additional Registered Sick Children's Nurses (RSCNs) to work within the A&E at Royal Lancaster Infirmary and had developed the ANP (RSCN) at Furness General. Additional training for A&E staff on paediatric physiological observations had been undertaken. Proposals were also being developed to explore the possibility of rotating paediatric staff through A&E.

There was close liaison and working arrangements between the A&E and paediatric wards in both hospitals. At Royal Lancaster Infirmary we saw that two RSCNs had been employed in the A&E department specifically to support children. At Furness General there were no specific RSCNs currently in the A&E department, but general nurses had been given additional training and enhanced skills to support the care of children. There was also the forward planning to recruit an advanced nurse practitioner (RSCN).

Staff at Royal Lancaster Infirmary felt it was extremely beneficial having RSCNs employed to work in the A&E department. However one paediatric nurse was seen working with adult patients in the ‘majors’ area, while paediatric patients were in the ‘minors’ area. This may be indicative of not utilising the paediatric nurses to their best effect and not the best use of skill mix. The recruiting of RSCNs should be applauded but not allowing them the opportunity to lead or influence A&E paediatric care may lead to low morale, and also misses the opportunity to develop the service in the best interest of the children and their families. The RSCNs in the Royal Lancaster Infirmary A&E department were on relatively junior pay scales / banding and we were told they did not currently get clinical supervision from the senior paediatric nurses in the hospital.

When there was no RSCN presence in the A&E at Royal Lancaster Infirmary staff obtained support and help from the paediatric ward as needed. Both A&E staff and paediatric ward staff felt this worked well and both sets of staff had developed close working relationships with each other. We were unable to speak to parents in the A&E to ascertain whether they felt the presence of RSCNs in the department improved the care and treatment of their child, as there were none available to talk to us at the time.

At Furness General the A&E department worked closely with the paediatric ward and staff from the ward attended A&E to help with the care and welfare of paediatric patients as and when needed. Staff within the A&E had had additional training in managing paediatric patients.

Staff supervision and performance management

The trust told us that the relocation of the acute medical unit at Royal Lancaster Infirmary had centralised activity and enabled better access to supervision for medical staff. The North Western Deanery had reviewed the trust as part of the Foundation Programme Review. Their report identified that the majority of trainees were appropriately supervised and were able to access senior supervision at all times. However it did state that the trust needed to further improve access to supervision in surgery at Furness General and medicine at Royal Lancaster Infirmary. The trust had also retained its Approved Practice Setting status following assessment by the General Medical Council in 2012, which meant it was judged a suitable setting for newly qualified doctors to work in. During the site visits we spoke to a number of junior medical staff about their supervision and no-one expressed any serious concerns.

We were told that consultants met once a month and looked at a few serious case incidents where they looked at “lessons learnt” and used them as a teaching tool with junior doctors.

When we carried out our site visit to the Royal Lancaster Infirmary we spoke to a senior consultant who gave examples of when some locum medical staff

had not been retained as they were felt not to be suitable.

We spoke to HR staff who told us that it was made absolutely clear that performance management was a key responsibility for all managers and that the trust had looked at what the barriers to performance management might be. The Medical Director confirmed that the trust was currently performance managing a number of clinicians.

We saw a copy of the performance improvement policy that was dated February 2013. This document gave a detailed account of how poor performance should be addressed and provided a toolkit for doing so.

Performance was monitored on a monthly basis across divisions and was reported as part of the monthly Performance Monitoring Reports. The Board was also kept informed of any medical performance cases through a monthly report.

We spoke to one manager who had used the previous performance management procedure and found it stressful but said that the eventual outcome for the ward and the member of staff concerned was positive.

The trust believed that having effective appraisals was a route to reducing poor performance and had made progress in addressing the completion and quality of appraisals. We saw evidence that appraisal rates were monitored at board level and we saw improved appraisal documents for 2013/14 that were intended to support managers in carrying out appraisals. The completion of staff appraisals had improved, rising from approximately 40% in July 2012 to 85% in February 2013.

Staff we spoke with told us that they had undergone an appraisal in the last nine months.

2.8 Assessing and monitoring the quality of service provision

<p>Recommendation 31</p> <p>Ensure that 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.</p>	<p>Partly met</p>
<p>Recommendation 32</p> <p>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.</p>	<p>Partly met</p>
<p>Recommendation 33</p> <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>	<p>Partly met</p>

Governance systems and processes

The Chief Executive commented that there had been significant progress with improving the trust's performance and that there was a continued commitment to progress the quality agenda. Actions taken by the trust included:

- Review of governance arrangements; strengthening of strategy and leadership and the elevation of quality and improvement to the highest organisational level.
- Improved capability of the trust to respond to risks and improve

performance.

- Enhancement of stakeholder engagement with the views of patients and staff being actively sought.
- New permanent appointments at, and below, Board level.
- Putting doctors at the forefront of running patient services with support from managers – appointment to five Clinical Director posts.

There had been improvements with the processes for monitoring service delivery and care – many it appears as a result of external inspections and reviews such as the trust's own clinical strategy review for health services in Morecambe Bay, CQC inspections and the PricewaterhouseCoopers review in 2012. The trust had used a project management approach to address issues and this appeared to have been useful, however there is always a risk that an improvement culture will not get embedded in clinical services with a reliance on project teams to sort out issues.

We were told that the Clinical Governance team had issues with increased levels of sickness and vacancies which meant it had been difficult for the new management arrangements to be embedded into the department and for the systems and processes surrounding governance to move on as far as the trust would have liked.

We interviewed a number of staff including Executive Directors and Non-executive Directors, managers, some staff in the quality and governance team and clinical staff members who were honest and open about the problems within governance and were able to articulate what the current position was and where the trust was going. Executive Directors and Non-executive Directors told us they were happier with the quality of the data that was produced for the trust Board meetings and with the system of reporting information where Clinical Directors and General Managers were asked to attend governance meetings on a rotational basis to report and feed back governance and quality measures. "I feel much more assured that the information we are now getting is more accurate and robust," we were told.

On the front line staff appeared to know what they should be doing in relation to governance but it was not always seen as a priority because of staffing problems and other issues. There was some feeling that governance actually exacerbated problems rather than sorting them. This indicated that the trust Board may not yet have been able to communicate effectively the rationale for governance or its benefits.

We reviewed a sample of Clinical Quality and Governance Committee agendas and minutes as well as the Integrated Performance Report dated 27 March 2013. There was clear evidence that quality issues were being addressed and there was evidence of challenge as well as quantitative data around key performance indicators. The Clinical Quality and Governance Committee Report (Quality Account 13/03/2013) was comprehensive giving quality targets and results. We also reviewed the 2 January 2013 Serious Incident Requiring Investigation (SIRI) agenda and the minutes from 30

November 2012. The minutes demonstrated challenge, scrutiny and recommendations. They included lessons learnt and the review of those lessons.

We saw evidence of a lessons learnt newsletter and discussions around lessons learnt at ward and team meetings. There was also extensive mention of a lessons learnt culture at board meetings. Staff told us that lessons learnt were used as reflective practice as part of supervision and at team meetings.

Consideration was seen to have been given to safeguarding, social care and the wider health economy. The trust Board Transition Programme Report for March 2013 demonstrated an openness of where weaknesses lay in terms of governance and included exception reports from different areas that were clearly RAG rated. It was clear where actions were required although there was no great detail of the action that was needed.

The trust appeared to have made some progress in addressing patient involvement within clinical services although there appeared to be evidence of better progress at Board level – perhaps as a result of Foundation Trust status. However few staff outside the senior management grades made mention of the Governors.

Overall, governance systems did not yet appear to be totally effective and there was still a need to embed committees and processes. The trust knows what it needs to do and is attempting to make the changes needed but that will take time for this to be embedded in working practice and benefits realised. The trust had recently commissioned a follow up independent review of its governance processes from PricewaterhouseCoopers that was undertaken just prior to our visit.

2.9 Complaints

<p>Recommendation 34</p> <p>Develop and improve 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.</p>	<p>Not met</p>
<p>Recommendation 35</p> <p>Conduct a review of its current resources allocated to the management of complaints to ensure compliance with compliant response times.</p>	<p>Partly met</p>

Complaints

The trust had recognised the need to respond to complaints within target deadlines (that is, 90% within 35 days) and to eliminate the backlog of overdue cases that currently existed.

A 'Complaints Management' project had been established in order to improve performance, including resolving cases consistently and conclusively and giving greater attention to complaints at the level that they arose.

Information gained from complaints was used to inform future practice and mitigate against similar issues recurring. This information as well as national learning, for example, arising from the Francis Report, was incorporated into the trust's Action Plan (Complaints). Information relating to complaint types, amounts of complaints and response times was reported to the trust Board. This included information about complaints that were handled at ward/department level that did not always then progress further because the complainant was happy with the initial response.

In April 2012 there was a backlog of 110 complaints, with an average response time of more than three months. It was acknowledged by the trust that responses had been of a poor standard with a pattern of repeat and or revisited complaints. Initially the majority of these historic cases were cleared (except three) but by August 2012 there was a new backlog of 93 cases against the 35-day measure. This had arisen as a result of staffing issues which included the long term absence of the complaints lead member of staff and the remaining staff having to absorb the additional workload of missing colleagues, as well as a large rise in the number of complaints received. During October to December 2012 the backlog was reduced to 37 cases.

For the period January to February 2013 a total of 136 complaints was received, compared to 76 for the same period in 2012. This and other data indicated that the incidence of complaints was increasing by approximately 20% year-on-year.

A report to the trust Board Meeting in May 2013 stated that, during April 2013, 30% of complaints were dealt with within the 35-day target, an improvement from March 2013, when it was 23%. There is however significant improvement still required.

The trust had ordered an independent review of its complaints handling and a copy of the report “Well Handled” was made available to us at the end of the inspection. This report had only been published on the day we received it so it was previously unavailable to us. The independent review “Well Handled” produced a report for the trust board that included the results from an audit of 90 completed complaint files. Included in this report was a review of the current complaints handling structures and recommendations to improve the current system. Twenty seven recommendations were outlined covering the whole of the complaints handling procedure from reviewing the current complaints policy to acknowledging best practice, reflecting the infrastructure of the trust, through to ensuring the accountabilities and responsibilities within each of the divisional teams when they were responsible for leading a complaints investigation.

Complaints information for the public

Throughout both the hospitals there was little information available to patients with regards to how to make a complaint. Where complaints leaflets were seen, these were out of date. One leaflet was dated June 2007 while another was dated January 2011. In discussions with staff they informed us that they assisted patients who wanted to make a formal complaint by advising them to write to the Chief Executive.

There was a PALs (patient advice and liaison services) on both sites. However the PALs team was more visible at Furness General Hospital. We did observe that information on how and when to contact PALs was available across the trust. When we spoke to a member of the PALs team they confirmed to us that there was only one part-time worker to cover the whole of the trust, and a part time agency worker who made the hours up to a full time equivalent post. We were told that when the PALs staff member was busy, other people could not get through on the phone. There still remained little evidence that the current arrangements with PALs did help or assist in improving access and support to patients with the complaints process.

Complaint handling

On review of the current customer care staffing structure, dated January 2013, we saw that there were 2.8 whole time equivalent case officers with two agency case officers and one case officer who was currently on long term sick leave. These staff were managed by an interim Head of Patient Service & Experience.

The trust had a policy for the management, investigation and resolution of complaints dated 5 June 2012. This detailed how the trust was to deal with complaints, with the change to complaints being handled by the actual directorate where the complaint arose, to make it more locally owned and to be able to establish a clearer picture of accountability and responsibility.

The “Well Handled” report (see above) commented on service improvements and lessons learnt. These included:

- The A&E to introduce a discharge policy for older people and patients suffering from dementia.
- Junior doctors’ induction to include discharge planning.
- Outpatient department staff to receive extra training on call handling.
- Electronic records being available in 12 months.

We talked to ward sisters about the management of complaints at department level. They explained to us that they felt they had more control over their own wards and could make changes with a minimum of ‘red tape’. They told us, “The process of handling complaints has been passed back to the ward to respond to. I feel this is much better as we can directly respond to the complainant and people seem to be happier for us to contact them as we have an understanding of their issues.” Because of this more immediate response we were told that many complaints did not progress through the process any further with the complainant being satisfied with the initial contact and discussion to rectify the problem or an immediate apology.

Staff also felt that receiving complaints to manage directly was better in helping them reflect on practice. They were able to identify two positive actions they took as a result of one complaint. A toaster had now been re-instated on the ward and toast was made in small batches to meet patient requests. The design of bedpans had also been changed as patients complained they were uncomfortable to use.

The ward sisters felt they were more pro-active in response to complaints and now people were invited back to the trust to discuss their concerns. We were able to see that the management of complaints had started to show improvements in service and patient experience. A member of staff told us that they also recorded complaints at ward level that came to them informally rather than going straight on to become a formal complaint to the Chief Executive. Staff felt it was good to listen and be able to resolve problems at

ward level.

When we discussed the training staff had in handling complaints we were told by every person we spoke with that there was no formal training in customer care available, apart from on the induction programme.

2.10 Records

<p>Recommendation 36</p> <p>Improve 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.</p>	Partly met
<p>Recommendation 37</p> <p>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.</p>	Partly met
<p>Recommendation 38</p> <p>Ensure that records about the care, treatment and support are clear, factual and accurately maintained.</p>	Partly met

Records management

The trust identified in 2011 an increasing clinical risk to patients in the availability of records at the point of care. Data showed outpatient note availability running at 90% and missing case notes represented 0.47% of the trust's clinical incidents and 5.5% of the trust's complaints. The project objective was to improve patient case note availability at point of care. The availability of medical notes as of October 2012 was 89.77% for inpatients and outpatients, in February 2013 it was 96% and in March 2013 it was 93.8% against a target of 95%. Compliance with information governance training for the medical records staff had improved from 50% to 85%.

The trust had implemented plans to significantly improve access to electronic patient records for doctors and nurses at the point of seeing patients. There are 750,000 to 1 million such records and the plan is to have 80% of records available by 2014. The remaining 20% are to have improved traceability through new systems.

The trust had created a new post of Chief Information Officer and had appointed an existing clinician to this post.

Within its standard operating policy the trust had added personal accountability for the individual who last had receipt of the records. This

covered not only all divisions but also during transportation. The patient records' action plan dated 29 October 2012 identified what actions were required to implement the business case, whose responsibility it was and a target date of December 2012.

Full implementation of the patient records' business case was approved by the trust Board in November 2012. This was to show improved availability of records, with increased and improved storage, security and retrieval of all clinical records. When we spoke to a member of the senior management team they confirmed that the move to an off-site location was on track but "an unforeseen development that was out of their control' had delayed the implementation." They also confirmed that the Board had given its full support to the implementation of the business case.

We were told by staff that any new documentation introduced had to be Lorenzo compatible so it could be incorporated into the new electronic notes system, and more records were now available electronically. One doctor told us that the use of Lorenzo had improved communication.

We spoke with medical secretaries in their office where we saw a number of care records stored. They told us that there was a backlog of 59 files due to staff shortages. They confirmed that they did not feel this delayed treatment but sometimes details of outpatient appointments were not always up to date due to the volume of patients seen and the requirement for them to type up notes, usually via Dictaphone. The medical secretaries confirmed that all letters generated with regards to individual patients were created within their electronic record. In order to achieve this, overtime and extra staff were introduced to clear the backlog.

One member of staff told us that the old way of dealing with medical records "was a stupid system. There was a lot of duplication and it was very frustrating". However they had started to see improvements recently with much more information being made available electronically. They also confirmed that they had been involved in the records development group for the new system.

A further staff member told us, "Medical records were a nightmare but Lorenzo is great. We need to make sure all staff can use it and are confident in the online system. The reception staff are great at finding old records – but online is so much better. We have instant access for complex on-going patients." However not all staff we spoke to were yet confident with the improvements that could be made by using electronic notes.

One example of the improved system was better access of notes when the patient had been to outpatients. Staff confirmed that "the newly introduced system of ward clerks doing an email request to medical records was improving the situation." However one person told us that "paper records are sometimes in a bit of a state – they are falling apart".

New emergency admission proforma had been standardised across the whole trust with a new system for accepting A&E referrals that now came through Lorenzo and via print out. This freed staff up from answering the phone. Staff were able to see a difference using the new referral system and it was felt to be speedier for patients and a more effective use of staff time.

Another example given to us where the use of Lorenzo had improved practice was around bowel surgery. The trust had monitored the estimated and actual length of stay for patients. This had shown that the actual length of stay had reduced and improved in the last six months.

We spoke to staff within the medical records department. They confirmed to us that there had been a problem with multiple files for the same patient and with the ability to file letters in a timely way. A new member of staff has been appointed to address this and this had made a noticeable difference. At this review we did not see any duplicate case notes in use or any inappropriate storage of medical records within the wards or departments we visited on both sites. There were still, however, some instances of cancelled admissions due to the absence of case notes, for example, the February Performance Management Report showed an absence of five case notes resulting in a cancelled operation. We were unable to see any figures for cancelled outpatient appointments as a result of missing medical records.

All the staff we spoke with in medical records confirmed that they thought the move to the new off-site premises would make a difference to the way they worked. It was explained to us that every set of notes would be bar-coded and this would help with record tracking. We were told that the tracer system was robust but that it did depend on everyone using it.

There was a transport system in place for the delivery and transport of records and information across all sites. This van visited all sites at least once a day to pick up/drop off records. However if records were needed in an emergency a taxi was used for door to door delivery. We were told that the medical records department in Royal Lancaster Infirmary was staffed 24 hours, 365 days of the year so records could be accessed at any time. At the other sites the matron had access to the records library. We were told that records transferred between sites were packaged in a blue plastic box secured by a plastic cable tie to prevent it being tampered with.

Staff confirmed they understood the need for the secure storage of records and this was seen to be in operation. They also confirmed that they were not aware of any records being completely lost. Any missing records were reported as a clinical incident and staff in the department were asked about what steps they took to find them. We were told that for the outpatient department there was usually a seven day turn round from request to appointment that meant there was time to retrieve records.

It was confirmed to us that there was cross site working within the records department. Staff helped each other out as required and their manager met

with them regularly either face to face or via telephone conference. Staff confirmed they were generally in touch with each other on a daily basis as patients travelled between sites all the time.

Missing records were raised in complaints on a number of occasions. The loss of records resulted in cancelled clinic appointments and cancelled operative procedures however board reports showed that the level of problems that occurred because of missing records had reduced. It was recognised by the trust that efforts had been made to solve the problems with improved access to records, off-site storage and the full implementation of an electronic system but this was unlikely to be fully in place before the end of the year.

When we spoke to staff on the wards they told us that there was usually no problem with patient records. Retrieving records was usually carried out at the point of admission. They confirmed however that staff occasionally had to go to medical records to retrieve the records themselves.

Maintenance of medical records

When we looked at the care records of patients we interviewed all, apart from one, contained up to date information, care plans and risk assessments. These records were in hard copy supported by information that was available electronically.

2.11 Leadership

<p>Recommendation 39</p> <p>Develop a trust wide clinical strategy and a culture of whole systems working across all the divisions to avoid silo working.</p>	<p>Partly met</p>
<p>Recommendation 40</p> <p>Ensure the 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 organization.</p>	<p>Partly met</p>

Leadership across the trust

A process of major service review and the development of a clinical strategy in conjunction with the local Clinical Commissioning Groups had begun. It is anticipated that this will be a political and public challenge. Regular updates are provided to the Board via the Transition Management Board.

Prior to and following our original investigation, there were considerable changes to the trust at Board level with resignations from the Chair of the trust Board, the Chief Executive and Medical Director as well as some other senior posts. The board itself had a number of vacancies. With the arrival of an interim Chief Executive and interim Board Chair new appointments were made to the board in executive and non-executive posts. At the time of our visit, there was a substantive Chief Executive who had been in post approximately eight months and a new trust Board Chair had just started. A number of new people with considerable transferable skills and qualities had been recruited to the trust board and the senior management team, to strengthen leadership and management across the trust. Board development days had been planned for all executive and non-executive directors to take place later in the year.

During our review we interviewed a number of executive and non-executive Board members including the Chief Executive, the Chief Nurse, the Deputy Chairman, the Medical Director and the Chief Operating Officer.

We had found during our original initial investigation, a lack of engagement and visibility from executives and senior clinicians across the hospitals. There had been a lack of cohesiveness with little evidence of cross-trust working

with different groups of clinicians and staff not working together. In addition there had been a lack of ownership and willingness by some senior clinicians to engage with managers to address important issues such as patient flow.

We found during this review that clinical leadership across the trust had been strengthened by dividing clinical services into five clinical divisions and appointing substantive clinical leaders to each division. The clinical divisions are:

- Acute and Emergency Medicine
- Elective Medicine
- Surgery and Critical Care
- Women and Children
- Core Clinical Services.

The trust took the decision to have Clinical Directors supported by a senior nurse or allied health professional and a senior manager rather than have a manager supported by a doctor, thereby putting doctors in the forefront of running patient services. We were told by the trust that Clinical Directors were now working closer with GPs and Clinical Commissioning Groups on the review of clinical services.

The NHS staff survey results for 2012 highlighted the trust's engagement score was in the lowest 20% compared with similar trusts.

In November 2012 in partnership with Monitor and an external consultancy, the trust participated in a pilot staff engagement survey. The survey was sent to all staff and was followed immediately by a series of focus groups hosted by an Executive Director to allow staff to explore the results and to suggest areas for improvement. Approximately 800 staff completed the questionnaire which was almost double the response for the trust's national staff survey. Positive results were received with regard to staff understanding their roles and what was expected of them, and working effectively with other teams. However several survey results indicated issues with communication throughout the organisation and uncertainty about the new Chief Executive and Board members. In addition, the open comment section in the survey provided very rich qualitative responses from both clinical and non-clinical staff. This indicated a level of interest and commitment to getting involved in improving the organisation from the workforce. Engagement levels varied greatly across the organisation and between professional staff groups. Non-clinical staff reported higher levels of engagement than clinical staff.

The trust commented that in some areas of the organisation the impact of recent reviews, external publicity and the hard work which had gone into recovery efforts was likely to have impacted on levels of staff engagement. They were also aware that the organisation was still in transition, with new leadership teams at both the corporate and divisional level. The visibility of these new leaders and their behaviours in forming relationships of trust will be critical in moving the organisation forward.

Staff told us they felt more supported now by senior staff within the organisation and that there was a greater visibility from senior staff and board members in the hospitals on a regular basis. We were told by a number of different staff that the new posts of Deputy Chief Nurse for Royal Lancaster Infirmary and Furness General had made a positive difference to the communication, support and speedier decision making that they now received. The clinicians we spoke to felt the changes made at divisional level had helped improve the levels of engagement with the trust Board and managers and they were able to have more responsibility for decision making in their departments.

Staff told us that senior managers and members of the trust Board visited each of the hospitals on a regular basis. A member of staff in the A&E department told us that the Chief Executive had recently visited Royal Lancaster Infirmary at night to discuss concerns about staffing levels and the lack of in-patient beds with the doctors and nurses on duty.

We were told that sisters and charge nurses from all three sites met regularly for training and information sharing. However we noted that junior staff did not tend to contact each other across sites and rarely visited the other sites. One staff member from Furness General told us “I think we should all go from A&E here and share more of the good practice we are doing, I would like to see how they do things there but haven’t been given the chance.”

One member of staff told us, “...feels so much better recently with the changes. The whole team has changed and we can feel a real difference. We are listened to and we can make things happen. We have confidence in the new Board and we see the Chief Executive quite frequently.”

Executive board members and non-executive board members told us they tried to be as visible as they could be and a number of staff told us they did see some of them around the hospitals. The non-executive board members that we interviewed were very active on various hospital groups. It was felt that one of the limiting factors for board members in respect of gaining more visibility and talking to patients and staff was that the trust Board was housed at Westmorland General Hospital where patient and staff activity was lowest. It was felt quite strongly by staff at Furness General that, although they did see some of the board members, they would like to interact with them more often.

Staff told us that they did not see the Chief Nurse very often although this had improved a little in recent months. The Chief Nurse had been very visible within the Women and Children’s Division because of the high profile nature of the problems in the division last year. When we asked the trust about the Chief Nurse’s visibility we were told that due to the Chief Nurse’s large remit, including professional nursing and quality and governance, it was still felt that it was not possible for her to be as visible as required, but that once the Director of Quality and Governance was appointed this situation would

improve. One of the reasons for appointing deputy Chief Nurses for each hospital was to improve the visibility of the senior nurses at department/hospital level

We saw a number of initiatives where the trust was attempting to develop a corporate identity and improve 'cross bay working'. There were now staff away days where senior nursing, medical staff and managers meet with the Chief Executive at an off-site location. These were started to improve communication between clinicians and the Board and to foster a trust wide approach to issues rather than each hospital working in isolation. The Chief Executive was positive about the changes at divisional level with Clinical Directors in post although it was acknowledged that each division was at different development stages.

A number of forums had been established/further developed to facilitate improved communications and these included:

- A Leadership Forum where the Chief Executive met with staff with a passion and commitment to 'improvement' on a six weekly basis.
- Regular staff briefing sessions where staff were updated first hand on progress with issues.
- Face to face informal update sessions were held by the Chief Executive at each hospital site.
- Improved Team Brief delivered monthly.
- Management conferences led by the Executive team on a quarterly basis.
- Use of social media e.g. Twitter and Facebook.
- A dedicated email address for staff to send suggestions and comments into the trust.
- A discussion forum on the staff intranet.
- A process for regular 'Temperature Checks' about how staff were feeling was being developed.
- 'Fresh Thinking', a new online news site to keep people informed was introduced in January 2013. This featured news from around the trust and enabled patients / the public to ask questions and make comments about anything happening within the trust.

The trust was continuing to look at how 'cross bay' working could work in practice as it was clear from talking to staff at both sites that although Clinical Directors, senior medical and nursing staff within divisions were working across the trust, the majority of other staff were not.

We were told that it was not common practice for staff generally at ward or department level to phone their counterparts at the other hospital for advice or to necessarily include them in decisions that they made in their ward or department to see if it was of any help on the other site.

Within the Women and Children's division after the compliance inspections in

2012 formal workshops had been undertaken to look at the culture of the trust and to make improvements in behaviours within that team across sites. This had not been developed for other divisions in the trust

When we spoke with many of the staff at Furness General an overriding concern was the clinical strategy review (reconfiguration of services) and the need to make considerable cost improvements. It was felt very strongly that cuts would be made that would compromise patient quality and that Furness General would likely be the worst hit. Staff felt that improvements had been made at Royal Lancaster Infirmary but that the pace of change was not quite so evident at Furness General. Staff acknowledged that much of this was probably due to waiting for the clinical strategy to be approved before spending money where it may not be necessary in light of the longer term plans

3. Conclusion

In our follow-up review we found evidence of an improvement in the safety and quality of care across the emergency care pathway in University Hospitals of Morecambe Bay NHS Foundation Trust, since our original investigation in January 2012.

Governance systems and leadership have been strengthened, with a new Chief Executive and Chairman and a number of new executive and non-executive members of the trust board. We believe changes in the management of the clinical departments across the trust, with the introduction of clinical directors supported by senior nurses and general managers, have the potential to promote local decision-making and improve patient care.

However, these changes are still very much in their infancy and are not yet fully embedded across the organisation. It is a concern that we had to take immediate regulatory action at the time of our follow-up visit, in response to poor infection control practices at Furness General Hospital.

Of the 40 recommendations in our original report, we judge seven to have been met in full; 30 to have been partly met; and three not met.

In respect of the three recommendations not met, there is a need for the trust to take urgent action to address the following issues:

- A cultural change programme needs to be 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.
- Suitably qualified and experienced paediatric staff need to be available at all times within the A&E department, particularly around the management of paediatric cardiac arrests, ensuring that there is a group of nurses and doctors on all shifts in A&E who are able to manage a paediatric arrest without relying on the input from the paediatric team from the ward areas.
- Complaints handling systems need to be improved to make sure that complaints are responded to fully and in a timely manner, demonstrating that changes to practice have been introduced as a result.

The trust must also ensure action is taken to address the 30 recommendations that were only partly met and we have asked for an updated action plan identifying the remedial action to be taken to address all the unmet and partly met recommendations.

The trust continues to face significant challenges and although we are pleased to report evidence of an improvement in the emergency care pathway, we remain concerned about the sustainability of this improvement in the future. With only seven of 40 recommendations met in full, there is still a great deal of work to be done to deliver the further improvements in the safety and effectiveness of services that are required.

Publication of this report marks the end of our Section 48 investigative activity. We will, however, continue to monitor the trust closely over the coming months until we are assured that the required service improvements are fully embedded and patients are receiving safe and effective services on a sustainable basis.

We will share the findings of our report with Monitor and NHS England and it will also be used by our Chief Inspector of Hospitals to inform the future inspection of the trust under our new intensive hospital inspection programme.

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