North Cumbria University Hospitals NHS Trust

Evidence appendix

North Cumbria University Hospitals NHS Trust
The Pillars
Cumberland Infirmary
Newtown Road
Carlisle
CA2 7HY

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12 -13 July 2018
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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

Acute hospital sites at the trust

A list of the acute hospitals at the trust is below:

<table>
<thead>
<tr>
<th>Name of acute hospital site</th>
<th>Address</th>
<th>Details of services provided at the site</th>
<th>Geographical area served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary Hospital</td>
<td>Newton Road, Carlisle, CA2 7HY</td>
<td>Medical care, urgent and emergency services, surgery, maternity, outpatient and services for children and young people</td>
<td>Carlisle</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>Homewood Road, Hensingham, Whitehaven, CA8 8JG</td>
<td>Medical care, urgent and emergency services, surgery, maternity, outpatient and services for children and young people</td>
<td>Whitehaven</td>
</tr>
<tr>
<td>Penrith Hospital</td>
<td>Bridge Lane, Penrith CA11 8HX</td>
<td>Midwifery Led Birthing Centre</td>
<td>Penrith</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Sites)
Is this organisation well-led?

Leadership

The trust had a transitional leadership structure in place from April 2018 and had reflected the transition to an integrated healthcare system. Since our previous inspection in November 2016 there had been significant changes to the board structure.

The joint transitional executive management team formed in April 2018 consisted of seven executive directors who had responsibilities across both trusts and five non-executive directors. There was some stability in the non-executive directors for the trust, however, there had recently been one resignation and two had been appointed jointly across North Cumbria University Hospitals and the local mental health trust.

The chief executive role was a joint role, leading both North Cumbria University Hospitals NHS Trust and the local mental health trust. The chief executive also led the local sustainability and transformation plan providers alliance. The chief executive was on a long-term secondment from another NHS trust outside the Cumbria area.

Since our last inspection in November 2016 the executive director of nursing role had been held by four different people. Much of the change had occurred from April 2018 and support had been provided by a deputy director of nursing seconded from a neighbouring organisation.

The current executive director of nursing had been seconded to the trust on a part-time basis in August 2018, however, was due to take up the full-time post in September 2018. A deputy director of nursing supported the director of nursing and each care group had an associate director of nursing.

During our core service inspections, staff told us there was a lack of visibility of the executive leadership team in some areas. Due to the significant number of changes at board level, some staff did not know who the executive leaders were.

The trust pharmacy department was entering a period of significant change with the retirement of the Chief Pharmacist and the recruitment of a new Director of Pharmacy jointly the local mental health trust. The trust’s Medicines Safety Officer post had been vacant since December 2017, but a joint position with Cumbria Partnership had been recruited to. No formal arrangements were in place, but we were advised that pharmacy leadership would be provided by the local mental health trust in the interim two-week period before the new Director of Pharmacy came into post. The role of Non-Medical Prescribing Lead was also unfilled on departure of the Chief Pharmacist. All trust Non-Medical Prescribers had been alerted of the need to complete their revalidation prior to that time.

The finance director was an experienced NHS accountant who had worked across both commissioning and provider organisations. They had previously worked for the local mental health trust, however, had taken over the joint role across both organisations in 2017. The director of finance had a significant portfolio which covered finance, business planning, IT, estates and at the time of the inspection was also covering human resources, workforce and organisational development. A director of human resources had recently been appointed and was due to take up their position in November 2018.

Of the executive board members at the trust, one was from a British Minority Ethnic (BME) background and 33.3% were female. Of the non-executive board members none were from a BME background and 16.6% were female. This meant that BME and females were under represented at board level.
<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>0.0%</td>
<td>33.3%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>0.0%</td>
<td>33.3%</td>
</tr>
<tr>
<td>All board members</td>
<td>0.0%</td>
<td>33.3%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Board Diversity)

The chair and chief executive both had an understanding of the key challenges and strategic direction although there seemed a strong focus on the external transformation towards the integrated healthcare system. The executive team were able to identify the challenges the trust faced across all sectors, the plans in place to meet those challenges and the current strategic direction for the trust within the wider healthcare system in Cumbria. Board members had a range of skills, knowledge and experience to perform its role.

Providers are required to ensure that directors are fit and proper to carry out their role. This includes checks on their character, health, qualifications, skills, and experience. The trust guidance on compliance with the fit and proper person requirements set out the expectations when executive directors were appointed. NHS Improvement led on the appointment of non-executive board members; this was to ensure the board was support by a mix of experience, qualities and skills. Both executive and non-executive directors were subject to checks including Disclosure and Barring Service checks, references and checks that candidates are not barred from being a director. We found that fit and proper person checks were in place. Employment records of the five most recently appointed directors or non-executive directors provided evidence of meeting the requirement.

There was no formal leadership strategy to develop and enable leaders within the organisation. However, a draft joint workforce strategy and plan for the period 2018-2020 was awaiting board approval and publication. The draft strategy linked workforce planning to the strategic direction of both the North Cumbria University Hospitals Trust and the local mental health trust and identified the current and future challenges and proposals to address these at trust level and selected services.

At our previous inspection in December 2016, we found that due to capacity and staffing arrangements the trust could not provide a seven-day pharmacy service. There was no weekend clinical pharmacy service and a dispensing service was only provided for three hours on a Saturday morning. However, an emergency duty pharmacist was on call out-of-hours including at the weekend. NHS Benchmarking data 2016/17 indicated that this level of service was lower than average for both clinical and dispensary services. The trust’s Hospital Pharmacy Transformation Plan [HPTP] identified that further significant investment in clinical pharmacy would be needed to move to a seven-day service, setting a target date of 2020 to achieve seven day services.

The trust’s internal Omitted Doses audit (June 2017) found that the most frequently recorded reason for omitting doses of medication was ‘medicine not available’. And, although trust figures for medicines reconciliation were broadly in line with the national average (Medicines Safety Thermometer), the trust did not have a seven-day pharmacy service so, for patients admitted on a Friday evening, this would not be completed by a pharmacist until the following Monday which meant that patients may not receive their medications over the weekend.
There was no formal programme of joint visits to trust services by the non-executive directors and the governance team, this was in the process of being developed. During a focus group we were provided an example of a non-executive director visit to the West Cumberland Hospital. We were unable to identify if these visits were taking place through reviewing the board minutes and much of the engagement stated occurred in the Cumbria Partnership trust. There was no evidence of patient stories being presented to the trust from those at North Cumbria University Hospitals. This can be a story regarding a patient’s own experience of the care and treatment provided by the trust or a story from a member of staff regarding the care they provide to patients.

**Vision and strategy**

The trust had clear vision and values which prioritised quality and sustainability. The overall vision of the trust was to “Build a new integrated health and care system together, using our collective capabilities for a healthier and happier population”. The trusts values had been developed in 2013, but were being reviewed in order to create a common set of values with the local mental health trust.

The case for change was identified in September 2017 and laid out the joint executive arrangements between North Cumbria University Hospitals NHS trust and the local mental health trust. There were three scenarios considered namely:

1. Provider alliance
2a. Fully integrated MCP
2b. Single acute and community provider ACO
3. Hybrid model: Accountable care and population health

The preferred option was scenario 3 and all partners work working towards this option:

The strategic case for joint executive arrangements is identified as the common purpose which was described as:

- We want to crystalise a common purpose, culture and direction effectively with our workforce and partners.
- We need to create more effective arrangements to support our clinical strategies/healthy community approaches.
- This is a financial case that we must realise.
- We need to support our workforce to be more effective overall through increased flexibility, innovation and role design.
- Our capacity (leadership, managerial, technical) is too stretched at present to sustain it as is.
- A ‘joined up’ approach has the long-term potential better for citizens reflecting whole place and all groups.

Staff interviewed within the five core services we inspected, the leadership team and staff we spoke to in focus groups and drop in sessions talked about the values of the organisation and how they linked to their employment and the service provided. The values were visible on the trust website, on posters and documents. However, during our core service inspection it was clear operational staff were uncertain about the strategic direction of the trust.

The strategic objectives at the time of our inspection were described as the “4’S's”:

**Staff**

- Develop our workforce
- Be a great place to work
- Embed the right culture

**System working**
- Developing a platform for a future Integrated Health and Social Care System (IHCS)
- Transforming services for patients

Service quality
- Continually improve the quality of our services
- Improve quality as measured by our regulators

Sustainable finances
- Deliver the financial strategy
- Improve efficiency

The trust was actively involved in the local sustainability and transformation plans with the chief executive being the local lead of the provider’s alliance group. Sustainability and transformation plans are a local five-year view for the NHS in each of the 44 geographical areas in England. They had been developed by the local health and social care system and set out a longer term and broader ambition for improved health and wellbeing, as well as setting out how health and social care services would be delivered locally. From the strategy, operational plans were developed to reflect the changing challenges and opportunities for the trust.

The 2018/2019 joint operational plan was agreed by the board in April 2018 and reflected the changing financial position and the trusts involvement in the local sustainability and transformation plans. The progress against delivery of the strategy and business plans was monitored and every quarter the board of director’s reviewed progress. We saw evidence which was presented to the board in June 2018 which showed the current position of the system wide strategy. The trust described its ambition to support the development of population health and wellbeing systems to deliver sustainable care which was responsive to the local populations needs. A population health and well-being system was formed through integrated health and social care teams who worked with individuals, carers and families in communities and supported them through changes to the current health system.

The joint board assurance framework identified key risks in relation to delivering the trust strategy. There were a number of key strategies which were not in place. There was no mental health strategy although there were mental health policies; in its place the trust was using the Cumbria Partnership NHS Foundation Trust strategy. Also, there was also no patient engagement strategy or equality and diversity strategy and it was not clear when or if these would be developed.

There still was no formal maternity strategy in place this was identified in both our 2015 and 2016 inspections. The public consultation which had taken place during our 2016 inspection, had noted a preferred option but a decision was yet to be taken on the future of maternity and children and young people’s services within the trust.

The trust’s medicines optimisation strategy was due to be refreshed. We were advised that development of an overarching Medicines Optimisation strategy for 2019-2024 would be developed encompassing the combined priorities of both North Cumbria University Hospital Trust and the local mental health trust. The trust pharmacy service development plan had been reviewed, with reference to the revised professional standards [RPS Professional Standards for Hospital Pharmacy, 2018]. Additionally, a pharmacy training needs assessment had been completed and forwarded to Education and Training. An allocation of resources for technician training had been secured through the Northern School of Medicines Optimisation [Health Education England].

Culture

The overall culture of the trust was patient focused. At ward level, staff were motivated by wanting to provide the best care for patients and they spoke positively about the care they delivered. They
told us compassionate quality care was a priority. Most staff we spoke with during the unannounced core service inspection said they were proud to work at the trust. We found staff were trying their best to maintain the quality of care, despite the challenges of the staff numbers as such morale was variable. We found there was respect between specialities and we saw examples of team working between staff of different disciplines and grades. Most front-line staff told us they felt valued by their peers and local leaders. We found staff were supported in their roles, however, stated that communication and the visibility of the senior management team could be improved. This was confirmed by the 2017 staff survey which showed the percentage of staff reporting good communication between senior managers was 22% which was much worse than the national average of 33%.

**NHS Staff Survey 2017 – results better than average of acute trusts**

The trust had four key findings that exceeded the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key findings</th>
<th>Trust score</th>
<th>National average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF11. Percentage of staff appraised in last 12 months</td>
<td>93.0%</td>
<td>86.0%</td>
</tr>
<tr>
<td>KF16. Percentage of staff working extra hours</td>
<td>68.0%</td>
<td>72.0%</td>
</tr>
<tr>
<td>KF20. % experiencing discrimination at work in last 12 months</td>
<td>10.0%</td>
<td>12.0%</td>
</tr>
<tr>
<td>KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>25.0%</td>
<td>28.0%</td>
</tr>
</tbody>
</table>

**NHS Staff Survey 2017 – results worse than average of acute trusts**

The trust has 26 key findings worse than the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust score</th>
<th>National average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF 1. Staff recommendation of the organisation as a place to work or receive treatment</td>
<td>3.5</td>
<td>3.8</td>
</tr>
<tr>
<td>KF 2. Staff satisfaction with the quality of work and care they are able to deliver</td>
<td>3.8</td>
<td>3.9</td>
</tr>
<tr>
<td>KF 3. Percentage of staff agreeing that their role makes a difference to patients / service users</td>
<td>88.0%</td>
<td>90.0%</td>
</tr>
<tr>
<td>KF 4. Staff motivation at work</td>
<td>3.8</td>
<td>3.9</td>
</tr>
<tr>
<td>KF5. Recognition and value of staff by managers and the organisation</td>
<td>3.3</td>
<td>3.5</td>
</tr>
<tr>
<td>KF 6. Percentage of staff reporting good communication between senior management and staff</td>
<td>22.0%</td>
<td>33.0%</td>
</tr>
<tr>
<td>KF7. % able to contribute towards improvements at</td>
<td>0.7</td>
<td>0.7</td>
</tr>
<tr>
<td>KF 8. Staff satisfaction with level of responsibility and involvement</td>
<td>3.8</td>
<td>3.9</td>
</tr>
<tr>
<td>KF 9. Effective team working</td>
<td>3.6</td>
<td>3.7</td>
</tr>
<tr>
<td>KF10. Support from immediate managers</td>
<td>3.6</td>
<td>3.7</td>
</tr>
<tr>
<td>KF 11. Quality of appraisals</td>
<td>2.8</td>
<td>3.1</td>
</tr>
<tr>
<td>KF 12. Quality of training, learning or development</td>
<td>4.0</td>
<td>4.1</td>
</tr>
<tr>
<td>KF 13. Quality of non-mandatory training, learning or development</td>
<td>3.2</td>
<td>3.3</td>
</tr>
<tr>
<td>KF 14. Staff satisfaction with resourcing and support</td>
<td>45.0%</td>
<td>51.0%</td>
</tr>
<tr>
<td>KF 15. Percentage of staff satisfied with the opportunities for flexible working patterns</td>
<td>38.0%</td>
<td>36.0%</td>
</tr>
</tbody>
</table>
For two of the areas in the survey the trust’s performance was similar to the national average.

The overall engagement score for the trust (3.6) was below the national average of 3.8 and amongst the lowest 20% of all trusts. The response rate of 50% was amongst the highest 20% of all trusts.

The trust score was in the worst 20% of trusts for the question KF7 “Staff ability to contribute towards improvements at work (the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work.)”

In comparison with national averages:

- Trust scores were worse than average or in the worst 20% of all trusts for the majority of questions relating to:
  - Appraisal and support for development – Trust scores were amongst the worst 20% of all trusts, for two and in the top 20% of all trusts for one of the three questions.
  - Job satisfaction – Trust scores were in the worst 20% of all trusts for all six questions.
  - Patient care & experience – Trust scores were in the worst 20% of all trusts for two and below average for one of the three questions.
  - Violence, harassment and bullying – Trust scores were amongst the worst 20% of all trusts for two, below average for three and amongst the top 20% of trusts for one of the six questions.
  - Managers – Trust scores were amongst the worst 20% of all trusts for all three questions.
  - Errors and incidents – Trust scores were worse than average for one, in the worst 20% of all trusts for two and average for one of the four questions.
  - Health and wellbeing – Trust scores were average for one, below average for three and in the bottom 20% of all trusts for one of the three questions.

- Trust score showed a mixed performance for questions relating to:
  - Working patterns – Trust scores were within the top 20% for one and in the bottom 20% of all trusts for one of the two questions.
Equality and diversity – Trust scores were better than average for one and below average for one of the two questions.

(Source: NHS Staff Survey 2017)

Staff Diversity

The trust provided information on their staff diversity as from April 2018 below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>White%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non clinical staff</td>
<td>0.4%</td>
<td>18.4%</td>
</tr>
<tr>
<td>Nursing staff</td>
<td>0.8%</td>
<td>29.1%</td>
</tr>
<tr>
<td>Medical staff</td>
<td>2.9%</td>
<td>4.7%</td>
</tr>
<tr>
<td>Support staff</td>
<td>1.0%</td>
<td>31.8%</td>
</tr>
<tr>
<td>Other</td>
<td>0.9%</td>
<td>40.9%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Diversity (WRES Report))

This meant that proportion of BME staff was significantly less than white employees.

Workforce race equality standard 2017

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for KFs 25, 26, and 21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

Note that for question 17b, the percentage featured is that of “Yes” responses to the question. In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

The difference between BME and white staff is statistically significant for all four indicators at this trust.

(Source: NHS Staff Survey 2017)

The 2017 staff survey identified that the percentage of staff experiencing harassment and bullying or abuse from staff in the last 12 months was found to be 49.4% for BME staff compared to 25.9%
of White staff this was a 23.5% difference compared to the England average of a 28.6% of BME staff and 24.2% of white staff with a 4.4% difference between them. Additionally, the percentage of staff.

The trust recognised that there was more to do in terms of the WRES results from 2017. However, there was no North Cumbria University Hospitals NHS Trust specific action plan, instead the trust was using the local mental health trust action plan. The trust had commissioned an independent review into how the trust handled diversity, in particular with black Asian and minority ethnic (BAME) staff. The review identified that the lifting of the trust out of special measures in March 2017 was a positive motivating factor. The report identified 18 recommendations with the main recommendation being a strategic way forward.

The 2018 joint equality and diversity report identified that joint staff networks were in the process of being developed, however these were not in place at the time of our inspection.
Friends and Family test

The Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.

The trust scored slightly above the England average for recommending the trust as a place to receive care or treatment from June 2017 to October 2017 and similar to the England average from November 2017 to May 2018.

(Source: Friends and Family Test)
Sickness absence rates

The trust’s sickness absence levels from were higher than the England average from March to August 2017 and below the England average from September 2017 to January 2018. The overall trend shows a decrease in sickness rates.

(Source: NHS Digital)

We noted during the core service inspection there was a West Cumberland/Carlisle split. Many front-line staff identified more with their hospital base rather than the trust as a whole. Following our 2016 inspection the trust had made some improvements to cross site working; the joint transitional OD plan 2018/19 underpinned further work. Due to the location of each site the trust had made use of technology by using video conferencing to join meetings and additional meetings were often held off site in between the two main hospitals.

We spoke with the Freedom to Speak Up Guardian at the trust. They had been in post since 2016, had received training to undertake the role and was active in the national network of guardians. The guardian held a senior nursing position in the surgical care group and had a good understanding of their role. The guardian worked flexibly to meet the needs of staff contacting them although was only able to allocate one half day a week to the role. The role had been well publicised, they did ‘walk arounds’ in the acute trust and community and staff knew who the guardian was. The chief operating officer was the accountable officer and the freedom to speak up guardian met the chief executive officer three times a year. We heard examples where concerns raised by staff had been appropriately escalated and dealt with. They produced an anonymous report for the board annually. We found there was only one person in the role of guardian and there were no champions or dignity at work advisors among staff groups, however, plans were in place to train ambassadors. We discussed the ability to undertake the role of freedom to speak up guardian and also being in a senior nursing role within the trust with the guardian. They were aware of the potential conflict and staff confidence to share their concerns. Steps were being put in place to help with this conflict namely the development of the freedom to speak up ambassadors.
General Medical Council – National Training Scheme Survey 2018

In the National Training Scheme Survey 2018 by the General Medical Council the trust performed the same as expected for all indicators.

(Source: General Medical Council National Training Scheme Survey)

We spoke with the guardian of safe working; they report to the board quarterly and they believed the executive team were aware of what junior doctors do. The guardian of safe working has also taken junior doctors along to board meetings to provide a different perspective of working within the trust. The trust board supported the role which was introduced on a national basis to protect patients and doctors by making sure doctors were not working unsafe hours.

The trust celebrated success and recognised the achievements of staff through the annual staff awards celebrations and a ‘glimpse of brilliance’ scheme, which also shared staff success through the trust social media pages.

Managers across the trust said they were able to address poor staff performance where needed and received guidance from the human resources team when required.

There was access to an occupational health service for staff which provided counselling services and access to help with physical health needs, such as physiotherapy.

In response to concerns raised by the Safety and Quality Committee regarding the low completion rates of the Medicines Safety Thermometer data in some ward areas, steps were being taken to promote ownership at ward level. ‘Druggles’ (medicines safety huddles) were being trialled to promote discussion of the audit findings, drug alerts and to highlight areas for improvement. The pharmacy team also produced ‘Meds Matter Alerts’ to both highlight themes identified from analysis of trust medicines incident data and to share learning from local and national reports.

The senior leaders identified there was an awareness of the longstanding financial problems of the trust amongst operational staff. This included a focus on the positive contributions staff could make to improve efficiency relating to smart procurement and reducing waste.

Governance

The trust had a board of executive directors and non-executive directors which was a joint board with local mental health trust who was also governed by the governor’s council. The trust board was formed of executive directors with responsibilities across both trusts and five non-executive directors. Executive and Non-executive directors had the experience, skills and knowledge necessary to effectively perform their role.

The trust chair was appointed in 2013. Both the chair and chief executive were able to discuss the trust strategy, its delivery and the key risks that the organisation faced and had confidence in their team. At the time of inspection there was a lack of clarity surrounding some aspects of the executive portfolios.

A committee structure was in place and each committee reported directly to the board. The committees were:

- Quality and safety aligned committee
- Finance investment and performance aligned committee
- Clinical management group
- Audit and risk committee
- Charitable funds committee
Work plans had been agreed by the board prior to our inspection, however these were yet to be embedded.

The trust had restructured between April 2018 and July 2018 from a divisional structure to care groups. These were:

- Medical
- Surgical
- Children and Families
- Mental health
- Community services

The medical and surgical care groups pertained only to the trust and the children and families care group spanned across both trusts. Each care group had a management team, which was referred to as the triumvirate. This triumvirate reported to the board through executive leads.

The quality and safety committee provided oversight of the clinical governance structure. Each care group had quality and safety committee’s which reported to the weekly patient safety panel. There were lines of communication between service clinical governance meetings, network clinical governance meetings, care group clinical governance meetings and then into the trust wide clinical governance group. We reviewed a sample of minutes from clinical governance meetings. These showed a structured approach and included audit, incidents, risk and patient experience.

Governance structures within the trust had recently been reconfigured, however, at the time of our inspection these were not embedded either at ward or board level. We were told governance was added to the executive director of nursing portfolio when the previous director of governance left the trust in 2017. We found that governance structures were not robust and we were told this could be attributed to the number of governance leads which had been in place since April 2018. At the time of inspection, the executive director of nursing post had recently been appointed and was already working in the position on a part time basis.

**Board assurance Framework**

North Cumbria University Hospitals trust the local mental health trust have aligned their board assurance framework. The trust received confirmation in May 2018 of west north-east Cumbria’s inclusion as a ‘wave 2’ integrated health and care system (IHCS).

The two have agreed joint strategic objectives. This has been done using the principles of both trusts’ previous objectives but with the aim of an integrated health and care system. Their focus are on four objectives

1. Staff
2. System working
3. Service quality
4. Sustainable finances

In the trust board of directors evaluation of the IHCS it was found the improvements delivered through integrated working had been recognised by NHSI and NHSE who have confirmed that the trusts are operating within one of the most rapidly improving system in England. The trust recognises that as they move towards full integration of services, consideration needs to be given into how they identify and learn from improvements. Formal evaluation to take place in autumn 2018.

There are eight risks with residual (current controls) that are RAG rated red, indicating there is little or no evidence available that systems and processes are being applied or implemented within relevant trust services or little or no evidence that outcomes are being achieved and significant risks identified relating to current performance.
Of these eight there are four with a RAG rating score of 20. As shown below:

- Financial sustainability is not achieved as the effectiveness of cost reduction plans and implementation of new service models does not deliver the anticipated financial benefits set out in our long-term plans
- Vulnerable services become too unstable to continue during the implementation of wider transformation programmes across Cumbria and North East
- Infrastructure developments are not sufficiently enabling of transformation
- Fragility within primary care impacts our ability to effectively manage patient flow

(Source: Trust Board Assurance Framework)

The board assurance framework (BAF) was joint between both North Cumbria University Hospitals Trust and the local mental health trust. We saw it had been agreed by the joint board in the July 2018 board meeting. This detailed the top strategic risks as determined by the board, and stated the agreed assurance level and risk score for each strategic risk and any gaps in the risk controls that affected strategic ambitions.

During our core service inspections, we found varying applications of governance and oversight both at ward and triumvirate levels. For example, there was a lack of audit and action plans and sharing of learning within the urgent and emergency care core service. We found some wards did not have regular meetings to discuss current issues and concerns within the care group. Some wards had governance folders however these were not up to date. This meant the triumvirate were not always sighted on operational matters.

The Medicines Management audit report to the Quality and Risk Committee in July 2018 was rated as providing substantial assurance, identifying a shortfall only in the completion of medication training. Completion rates 85% for medicines management and 83% for calculating drug dose against a trust target of 95% [Q4 2017/18]. NHS Improvement was due to complete a three-day review of Pharmacy in October 2018.

However, the trust had reported a ‘Never Event’ (Never Events are serious incidents that are wholly preventable, NHS England) involving administration of medication by the wrong route in October 2017. A similar ‘Never Event’ was reported in another area of the trust in 2016/17, raising concerns around embedding learning from investigation into these incidents.

The trust achieved the CQUIN target and was meeting targets in terms of reducing both carbapenem and piperacillin-tazobactam usage, but not for total antibiotic consumption. It was of concern that, as seen at our previous inspection, the trust was failing to meet all its internal audit standards for antimicrobial prescribing. For example, only 75% of the medical wards audited were achieving the trust standard for choice of antibiotic. The target for recording antibiotic ‘stop/review’ was only achieved on 29% of surgical and 33% of the medical wards audited [June 2018 audit data]. Antimicrobial ward rounds are only carried out on ITU and admission units due to capacity. However, the trust planned to join the ARK programme [Antimicrobial Reduction and Konservation] in October 2018 to look at consumption and use of antimicrobials.

A medicines safety campaign, ‘ROARRRRR on medicines’ was undertaken in November 2017 to highlight importance of the ‘6 rights of medicines administration’ in response to a number of serious incidents and the reported ‘Never Event’. Processes were also reviewed to try and reduce the number of missed doses due to the medicines being unavailable. The impact of these changes was still being assessed.

The trust completed a trust annual prescription chart audit. Concerns regarding adherence to trust prescribing standards for example, the prescribing of ‘when required’ medicines and for clearly recording the prescribers name and contact details were identified both in 2017 and 2018 audits. We found similar shortfalls during our core service inspection. We raised these concerns following our site visit; in response to this the trust had set up a ‘Task and Finish Group’ jointly with the local...
mental health trust to review the format of the trust’s prescription chart with a target completion date of December 2018.

We looked at six historic serious incidents to see how the trust applied duty of candour. We found in all cases that families and carers had been contacted and were given an explanation of what had happened and where appropriate, an apology.

Families were asked to help formulate the terms of reference for the incident investigation and when they raised concerns, if these had been followed through. We saw that the root cause analysis (RCA) was not always clear, and there could have been further detailed investigation. There had been some training on RCA so more recent serious incidents had been better investigated. All of the serious incidents we reviewed had been signed off by the quality and safety committee and shared with the clinical commission group.

The trust reported using a best practice approach to efficiency planning, there was a programme management office which provided oversight and programme management capability. It was not clear to what extent improvement tools such as model hospital and getting it right first time (GIRFT) had been used to develop cost improvement plans.
Management of risk, issues and performance

The executive director of nursing and quality was the safeguarding lead at board level and sat on the local safeguarding boards. A safeguarding framework, reviewed in October 2016, was in place for adults and children and the trusts duty under the Care Act 2014. The framework identified clear lines of responsibility and accountability for safeguarding, the role of the trust safeguarding committee, as well as defining types of abuse.

We found the level three safeguarding children training did not meet the intercollegiate guidance for training. The intercollegiate guidance states staff should receive multi-disciplinary and inter-agency training, delivered internally and externally. It should include personal reflection and scenario-based discussion, drawing on case studies, serious case reviews, lessons from research and audit, as well as communicating with children about what is happening. However, the level 3 safeguarding children’s training was reported to be online. Following discussion with the safeguarding lead it was reported staff had the option to undertake additional reflective sessions, however, this was not mandatory.

The safeguarding policy also contained information in relation to ‘Prevent’, part of the government’s counter-terrorism strategy which is a multi-agency approach to safeguard people at risk of radicalisation. The framework identified how to access further current guidance and information on referral processes from the local safeguarding boards.

Finances Overview

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£252m</td>
<td>£246m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(£47m)</td>
<td>(£40m)</td>
</tr>
<tr>
<td>Full cost</td>
<td>£299m</td>
<td>£286m</td>
</tr>
<tr>
<td>Budget</td>
<td>(£49m)</td>
<td>(£44m)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Finances Overview)
The trust provided a document detailing their 20 highest profile risks.

<table>
<thead>
<tr>
<th>ID</th>
<th>Title</th>
<th>Description</th>
<th>Risk score (current)</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Strategy and systems</td>
<td>The Trust is not able to implement a viable clinical strategy which addresses the clinical fragility of services and sustains acute care longer term across North Cumbria.</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>1.2</td>
<td>Strategy and systems</td>
<td>The health and social care partnerships and cross organisational working arrangements within North, East and West Cumbria are not clearly defined in order to ensure the STP is delivered, including future organisational form of the Trust.</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>1.3</td>
<td>Strategy and systems</td>
<td>Lack of capacity and capability to deliver the Trust objectives alongside the STP and ACO requirements.</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td>2.1</td>
<td>Operational flow and delivery</td>
<td>The urgent care system is unable to sustain the improvement trajectory required to reach consistent attainment of the A&amp;E 4 hour standard.</td>
<td>20</td>
<td>12</td>
</tr>
<tr>
<td>2.2</td>
<td>Operational flow and delivery</td>
<td>The Trust does not have the required capacity in place to deliver 18 weeks resulting in patients not receiving timely care and loss in income.</td>
<td>20</td>
<td>6</td>
</tr>
<tr>
<td>2.3</td>
<td>Operational flow and delivery</td>
<td>The Trust has low numbers of cancer pathway cases and limited workforce for management of cancer pathways which may result in patients not receiving timely care or treatment and failure of the 62 day cancer pathway.</td>
<td>12</td>
<td>4</td>
</tr>
<tr>
<td>2.4</td>
<td>Operational flow and delivery</td>
<td>The Trust does not have robust governance and monitoring processes in place to manage the PFI contract at CIC, thus impacting on the Trusts ability to meet key standards, including cleaning.</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td>2.5</td>
<td>Operational flow and delivery</td>
<td>The Cumberland Infirmary is not compliant with Fire Safety Regulation due to fire compartmentalisation.</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>2.6</td>
<td>Operational flow and delivery</td>
<td>WCH delays to Phase 2 site redevelopment resulting in continued use of retained estate that requires major upgrade. This potentially has multiple failures of mechanical, general estates and fire safety standards.</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td>2.7</td>
<td>Operational flow and delivery</td>
<td>The Cumberland Infirmary does not have critical electrical infrastructure back up relating to single electrical feed from the main substation in Carlisle that was flooded in 2015 resulting in the Trusts ability to maintain service provision and standards of care.</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>2.8</td>
<td>Operational flow and delivery</td>
<td>The Trust fails to deliver its financial plan due to non-delivery of CIP, increased expenditure on temporary staffing and reduced income.</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>2.9</td>
<td>Operational flow and delivery</td>
<td>Lack of a sustainable capital replacement programme, resulting in capital investment decisions not being taken in accordance with the greatest clinical risk/need.</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>3.1</td>
<td>Patient and staff experience</td>
<td>The Trust fails to make improvements to the experience of staff, including staff engagement and communication.</td>
<td>12</td>
<td>4</td>
</tr>
<tr>
<td>4.1</td>
<td>Workforce and leadership</td>
<td>The Trust is unable to recruit and retain sufficient permanent and trainee medical staff thus impacting on the Trusts ability to maintain service provision and provide quality patient care. Additionally this risk affects system transformation in key work streams such as stroke, paediatrics and maternity.</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>4.2</td>
<td>Workforce and leadership</td>
<td>Ongoing challenges with the recruitment and retention of nursing staff in order to ensure safe staffing levels are consistently achieved across all wards and departments.</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td>4.3</td>
<td>Workforce and leadership</td>
<td>The Trust fails to develop and embed the well led principles from ward to board resulting in poor governance and risk management.</td>
<td>15</td>
<td>4</td>
</tr>
<tr>
<td>4.4</td>
<td>Workforce and leadership</td>
<td>The Trust does not develop its culture whereby staff can openly challenge and raise concerns.</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>5.1</td>
<td>Patient safety and quality</td>
<td>The Trust fails to learn lessons from serious incidents (SI) and harm.</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td>5.2</td>
<td>Patient safety and quality</td>
<td>The Trust does not have a systematic approach to quality improvement, thus impacting on the prioritisation and delivery of associated quality and safety improvements.</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>5.3</td>
<td>Patient safety and quality</td>
<td>The Trust fails to implement robust governance processes to demonstrate full compliance with the CQC standards.</td>
<td>10</td>
<td>5</td>
</tr>
</tbody>
</table>

(Source: Trust Corporate Risk Register / Board assurance framework)

An electronic system was in place for recording risk and mitigating actions. Staff had access to the electronic risk register at team and core group level and were able to record and escalate risks as needed. The electronic system held all risks recorded across the trust and could report at team, care group or trust level. We found that the risks identified on the care group report/register were articulated as issues of concern and included both ‘acceptable risk’ and ‘significant risk’.

Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact. All risks entered on the trust risk management system were assigned a current risk rating. Controls were identified to mitigate the level of risk and recorded with an action plan. There was evidence that the controls in place were reviewed and updated and that the risk rating was reviewed following the mitigating actions taken. The trust’s corporate risk register included risks that scored 10 and above. We found core service risk registers mirrored the corporate risk register. Of the 36 risks documented on the corporate risk register, nine were attributed to the individual core services. The risk management policy was ratified in August 2018. Identified risks on individual care group risk registers scoring 15 and over was automatically escalated to the corporate register and reviewed by the clinical management group.

We identified during our core service inspection the medicine management policy did not meet national best practice, namely in relation to the checking for maximum and minimum fridge
temperatures. This had not been added to the corporate risk register upon our return for the well led inspection.

There was a significant risk to the delivery of the financial control total in 2018/19. There was adverse performance against plan of £3.6m at quarter one and there is £5m of high risk cost improvement schemes. Those board members interviewed were sighted on these risks and were committed to achieve the end of year financial target. There was good understanding of the key drivers for the trust’s underlying financial position related to split site working, PFI and premium workforce costs. All aspects featured in the trust’s improvement plans although it was recognised that solutions focused largely on the medium term. There was focus on a revised workforce model based on enhanced roles as the traditional medical model was not sustainable in the health economy.

There was a formal contingency plan to address the potential financial gap in 2018/19. Moderating in year service developments and further work with the local commissioning group was expected to yield some improvement. The trust reported they were maintaining regular dialogue with NHS Improvement on the financial position.

There was a monthly performance review with care group teams co-chaired between the chief operating officer and the director of finance. The accountability framework which included performance management was yet to be fully embedded within the care groups.

Both the North Cumbria University Hospitals Trust and the local mental health trust boards had agreed to formally merge, as this would maximise the benefits of integration in a large geographically dispersed location but relatively small economy in terms of health service provision. Board members were clear that there was no alternative plan, it was reported the risk of merger was the option of lesser risk. The joint working between the two providers was found to have already broken down organisational barriers and joining up patient pathways.

Performance reporting varied between care groups, the trust recognised more work was required to develop a standard performance reporting framework. This would mean that each care group reported in the same way and would mean a more robust reporting framework.

**Information management**

The trust had a digital strategy for across both the North Cumbria University Hospitals NHS Trust and the Cumbria Partnerships Foundation Trust. The strategy identified the aims of the trust from 2017 to 2021 and aligned to both NHS England initiatives and local strategies. The strategy was underpinned by five key themes: digital care records, infrastructure, technology enabled care and information management and governance. The strategy also proposed creating a digital care board that would report to the trust board. This digital care board would monitor progress against the strategy and agree investment priorities.

Staff across the organisation had access to an electronic dashboard which provided performance data in a timely and accessible format. We saw how the dashboard provided details of current staff training and current risks. The dashboard provided a high-level overview but allowed access to more detailed information at individual, team or core group level to assist with the management of the service.

During our core service inspection, we raised concerns with the implementation of the electronic observations in the medical care group, however, during the well led inspection we were provided with assurance our concerns had been resolved.
The trust had an audit programme of national and local audits. National audits completed included:

- National Bowel Cancer audit
- National emergency laparotomy audit
- National Hip fracture audit
- National vascular registry
- ICNARC
- National Paediatric diabetes audit
- National ophthalmology database audit
- National audit of inpatient falls
- National audit of dementia
- National prostate cancer audit
- Trauma audit and research network
- National joint registry
- National maternity and perinatal audit.

The trust had effective arrangements to ensure that data or notifications were submitted to external bodies as required. Incidents, including serious incidents, were reported as required to the NHS national reporting and learning system (NRLS) or the NHS strategic executive information system.

The lead role for information technology was a joint role between Cumbria Partnership NHS Foundation Trust and North Cumbria University Hospitals NHS Trust, and was supported by an experienced team.

The trust did not have electronic prescribing and medicines administration [ePMA]. ePMA was identified on the trust’s medicines optimisation strategy with a target date of December 2020. However, funding had not yet been secured and there were no current bids for funding. Electronic discharge was being rolled out across the trust but this was not DM&D [Dictionary of Medicines and Devices] compliant. Compliance with DM&D helps minimise the risk of errors when transferring electronic information.

Medicines Safety Thermometer data was also collected manually by nurses. Manual data collection is time consuming and may be a factor in the low completion rates on some wards. The trust was trialling the use of an electronic system to promote patient engagement and understanding of their medicines. IT was identified as a limiting factor in the use of this new system due to limited access to the required hardware.

**Engagement**

There was a strong external focus from the chief executive, chair and wider board due to the significant work on the integrated care system. Relationships with the local CCG and local authority were strong. The board were all sighted the strategic direction which the whole system was signed up to, and this was seen as positive. However, we were concerned the board did not have the right balance between internal and external focus and whether sufficient time was being spent on the performance of the trust.

The trust was working actively with stakeholders, including commissioners and other providers in Cumbria, in the delivery of local sustainability and transformation plans and a move to the forming of an accountable care organisation in the area. An accountable care organisation is the body that manages an agreement where providers of health and social care work together to provide services to a local population and are accountable for all care.

The trust had a range of communication systems in place to ensure that staff, patients and carers had access to up to date information about the work of the trust and the services they used. The
trust used social media to regularly share information about trust services, national and local health initiatives such as the flu vaccine. The partnership news was published weekly on the internet and was targeted at staff. The trust talk magazine, published quarterly, was targeted at patients, members of the public and staff and celebrated the achievements of the trust and its staff.

We reviewed the minutes of regular meetings with clinical commissioning groups, NHS England and NHS Improvement and CQC regarding contracting and quality. There was evidence of areas of challenge and response or assurance being provided.

There was no patient experience strategy, however, the trust did implement the ‘15 steps’ programme to gain some insight to the patient experience. We were told non-executive directors (NEDs) were involved with the 15 steps programme, however, it was highlighted that NEDs did not talk to patients during their ward visits. We spoke with the head of patient experience and they were unable to identify if any changes had occurred as a result of patient experience feedback.

**Learning, continuous improvement and innovation**

The continuous improvement team and organisational development team had merged under the Cumbria learning and improvement collaborative. The collaborative known as “CLIC” brings together NHS and social care organisations within the Cumbria and Morecambe Bay areas to make positive changes “by leading and embedding a culture of collaboration for continuous learning, continuous quality improvement, and living within our means”. Improvement toolkits were made available to staff through CLIC. An engaging for improvement toolkit was available which was opened to other partners in the local area this year.

The complaints team received all informal and formal complaints. They worked within a policy on the handling of concerns and complaints. There was information displayed around the trust telling people how to raise a concern or complaint with the patient advice and liaison service (PALS). However, we found there was no direct link between the complaints team and the patient experience team.

We reviewed five complaints as part of our well led review and found concerns were investigated confidentially, in a timely way and lessons were shared. However, information provided found that almost one in five complaints were re-opened; this meant findings were not always accepted. The complaints team were not subject to NED scrutiny.

In each case complainants were kept informed and communication with them was personalised. Complaints were discussed at patient safety meetings which were widely attended. Actions from these meetings were shared with staff via various means such as newsletters or discussion at ward meetings. During the core service inspection, all staff we spoke with were able to provide examples of when practice had changed following the result of a complaint.

The chief executive officer (CEO) was actively engaged with the complaints process especially when clinicians were unable to meet the deadlines for investigations, they were invited to the CEO’s office to explain why this was the case.
Complaints process overview

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Current performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>30 working days</td>
<td>95% compliance, 99% achieved</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>30 working days</td>
<td>95% compliance, 99% achieved</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Number of complaints resolved without formal process in the last 12 months?</td>
<td>1054 PALS</td>
<td>From: April 2017 – March 2018</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview)

Number of complaints made to the trust

The trust received 256 complaints from April 2017 to March 2018. The surgery and medical care core services received the most complaints with 102 (40%) and 66 (26%) respectively.

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>102</td>
<td>40%</td>
</tr>
<tr>
<td>Medical care</td>
<td>66</td>
<td>26%</td>
</tr>
<tr>
<td>Urgent and emergency care</td>
<td>37</td>
<td>14%</td>
</tr>
<tr>
<td>Other</td>
<td>13</td>
<td>5%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>10</td>
<td>4%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>8</td>
<td>3%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>7</td>
<td>3%</td>
</tr>
<tr>
<td>Maternity</td>
<td>7</td>
<td>3%</td>
</tr>
<tr>
<td>Critical care</td>
<td>3</td>
<td>1%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>3</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>256</strong></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

A learning from deaths policy had been in place for one year and complied with the ‘Learning from Deaths’ national guidance in 2017. The Trust identified cases for review through any case identified as a patient death when coded. We reviewed seven death reviews during our well led
inspection and found they were comprehensive, and action plans were developed when appropriate. Prior to inspection it was communicated that the trust was a mortality outlier in one condition in 2017. This meant that deaths associated with aortic aneurysms were higher than expected. The trust was in the process of developing action plans as requested by CQC and Dr Foster.

The trust was active in the learning disabilities mortality review (LeDeR) approach to reviewing deaths. They followed recommendations from the ‘MAZAR’ independent report. This meant they reviewed and challenged practice especially when a death of person was unexpected to ensure lessons were learned and good practice shared between relevant organisations.

The trust had been identified had been one of the nine disablement service centres across England to provide enhanced services to veterans who lost a limb because of their service in the armed forces.

We reviewed five serious incident investigations and found evidence that families were informed and involved in each of them. Incidents were thoroughly investigated and learning used to help prevent reoccurrence.

**Accreditations**

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which of the trust’s services have been awarded an accreditation.

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Pathology Accreditation and its successor Medical Laboratories ISO 15189</td>
<td>Diagnostic Imaging (additional service)</td>
</tr>
<tr>
<td>UKAS ISO 9001:2015 for the accreditation of Radiotherapy and Radiotherapy Physics Services</td>
<td>N/A</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Accreditations)

The trust placed a successful bid to provide joint training for pre-registration pharmacists with Carlisle Heath Care enabling trainees to experience both hospital and GP practice pharmacy as part of the NHS England pilot scheme.

A pilot was underway to improve support to high risk patients through efficient joint working between medical and frailty pharmacists with the orthopaedic team.
Acute services

Cumberland Infirmary

Evidence appendix

Cumberland Infirmary
Newtown Road
Carlisle
CA2 7HY

Tel: 01228 523444
http://www.ncuh.nhs.uk

Date of inspection visits:
12 -13 July 2018
17 – 19 July 2018
28 – 30 August 2018

Urgent and emergency care

Facts and data about this service

North Cumbria University Hospital NHS Trust operates from two district general hospital sites; West Cumberland Hospital (WCH) in Whitehaven and Cumberland Infirmary (CIC) in Carlisle. This report relates solely to Cumberland Infirmary in Carlisle.

CIC operates an emergency assessment unit; a 30-bedded unit for medical admissions.

The admission unit is supported by Acute Care Physicians (ACP). Emergency surgical admissions at CIC are via a 12 bedded and six trolleys surgical unit.

CIC also operates an emergency ambulatory care unit Monday to Friday supported by the acute medical and surgical consultants as well as nurse practitioners.

The CIC unit operates six chairs and two trolleys 9am – 8pm.
(Source: Routine Provider Information Request (RPIR) – Context acute tab)

Details of emergency departments and other urgent and emergency care services

- Cumberland Infirmary (CIC)
- West Cumberland Hospital (WHC)

(Source: Routine Provider Information Request (RPIR) – Sites tab)

The consultant-led emergency department at Cumberland Infirmary, Carlisle was open 24 hours a day, seven days a week, to provide an accident and emergency service for children and adults. In the year April 2016 to March 2017 the trust saw 92,105 patients attended the accident and emergency department across both Cumberland Infirmary and West Cumberland Hospital. 55,104 of these patients attended Cumberland Infirmary. Paediatric attendances (children age 0 to 16)
represented approximately 18% of patients who attended the accident and emergency department across the whole trust.

There were separate entrances for walk-in patients with a seated waiting area. Reception was used by both walk in patients and ambulance crews booking patients in to the department.

There were 19 bays in the department, 10 of which were in the majors’ area and could be made available for isolation of patients. There was a separately equipped ophthalmology treatment room, a designated mental health room and a separate area of the department designated for children, with a children’s waiting area and a children’s treatment room.

The resuscitation area comprised three bays, which included one equipped for paediatric patients.

The emergency department was a designated trauma unit.

The radiology department was adjacent to the department and easily accessible.

There was a private relatives’ room with comfortable chairs, a telephone and drink making facilities.

During our inspection in July 2018 we visited the accident and emergency department at Cumberland Infirmary on 17, 18, 19 July. We spoke with 33 members of staff, including managers, doctors, nurses, non-clinical, and ambulance staff and volunteers. We reviewed 11 patient records in detail and a further seven looking for specific information.

Inspectors spoke with eight patients and relatives, observed the interaction of staff with patients, and observed a team huddle in progress. We reviewed comments from people who contacted us to tell us about their experiences, information from external stakeholders and reviewed performance information about the hospital.
Activity and patients throughout

Total number of urgent and emergency care attendances at North Cumbria University Hospitals NHS Trust compared to all acute trusts in England, April 2016 to March 2017

From April 2016 to March 2017 there were 91,773 attendances at the trust’s urgent and emergency care services as indicated in the chart above.
(Source: NHS England)

Urgent and emergency care attendances resulting in an admission

The percentage of A&E attendances at this trust that resulted in an admission increased in 2016/17 compared to 2015/16.

In 2016/17 and 2015/16 the proportions were higher than the England average.
(Source: NHS England)
Urgent and emergency care attendances by disposal method, January to December 2017

<table>
<thead>
<tr>
<th>Disposal Method</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to hospital</td>
<td>24,528</td>
</tr>
<tr>
<td>Discharged*</td>
<td>54,216</td>
</tr>
<tr>
<td>Referred*</td>
<td>11,060</td>
</tr>
<tr>
<td>Transferred to other provider</td>
<td>645</td>
</tr>
<tr>
<td>Died in department</td>
<td>139</td>
</tr>
<tr>
<td>Left department#</td>
<td>2,418</td>
</tr>
<tr>
<td>Other</td>
<td>288</td>
</tr>
<tr>
<td>Not known</td>
<td></td>
</tr>
</tbody>
</table>

* Discharged includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

Mandatory training completion rates
The trust set a target for mandatory training of 95%.
In urgent and emergency care the 95% target was not met for any of the mandatory training modules for which medical staff were eligible.

Cumberland Infirmary - urgent and emergency care department
A breakdown of compliance for mandatory training courses as at March 2018 for qualified nursing staff in the urgent and emergency care department at Cumberland Infirmary is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information governance</td>
<td>43</td>
<td>41</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines management</td>
<td>42</td>
<td>38</td>
<td>90%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Duty of candour</td>
<td>43</td>
<td>38</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>43</td>
<td>38</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk management</td>
<td>43</td>
<td>38</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, trips and falls level 1</td>
<td>43</td>
<td>38</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Calculating drug doses</td>
<td>42</td>
<td>37</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>43</td>
<td>37</td>
<td>86%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety</td>
<td>43</td>
<td>37</td>
<td>86%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
At Cumberland Infirmary urgent and emergency care department the 95% target was met for one of the 28 mandatory training modules for which qualified nursing staff were eligible. A further one module had a completion rate of 90%. We had concerns about the compliance level of nursing staff as this meant we had no assurance that staff were following the trust policies and procedures.

A breakdown of compliance for mandatory training courses as at March 2018 for medical staff in the urgent and emergency care department at Cumberland Infirmary is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand hygiene (clinical)</td>
<td>12</td>
<td>9</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>ILS (adults)</td>
<td>3</td>
<td>2</td>
<td>67%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>12</td>
<td>8</td>
<td>67%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; handling level 1 clinical (3 yearly)</td>
<td>12</td>
<td>7</td>
<td>58%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>12</td>
<td>6</td>
<td>50%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>News</td>
<td>12</td>
<td>6</td>
<td>50%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Trust doctors’ patient safety programme</td>
<td>12</td>
<td>6</td>
<td>50%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Duty of candour</td>
<td>12</td>
<td>5</td>
<td>42%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>12</td>
<td>5</td>
<td>42%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>12</td>
<td>5</td>
<td>42%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk management</td>
<td>12</td>
<td>5</td>
<td>42%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, trips and falls level 1</td>
<td>12</td>
<td>5</td>
<td>42%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>ALS (adults)</td>
<td>5</td>
<td>2</td>
<td>40%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
At Cumberland Infirmary urgent and emergency care department the 95% target was not met for any of the 26 mandatory training modules for which medical staff were eligible. We had concerns that medical staff were not up to date and may not be following trust policies and procedures and were not safe in their practice.

Managers in the department told us they closely monitored training compliance however the mandatory training levels were still very poor. Staff told us they could monitor their own training progress using an online system.

We had concerns about the low compliance rates for both medical and nursing staff for life support training particularly in an emergency department.

We spoke with staff about access to training. They told us that it was often difficult to access training due to staffing pressures in the department. Staff said they sometimes did e-learning courses on their days off, in their own time.

Training was predominantly accessed via e-learning. None of the staff we spoke with expressed any concerns about the standard of training although some told us e-learning was hard to navigate.

Staff of all different disciplines and grades told us they were encouraged to learn and gain new skills and experience. This was arranged through their annual personal development plan.

Staff told us that training compliance had recently been linked to annual increments as a way of ensuring staff were up to date.

**Safeguarding**

**Safeguarding training completion rates**

The trust set a target of 95% for completion of safeguarding training.

**Cumberland Infirmary urgent and emergency care department**
A breakdown of compliance for safeguarding training courses from as at March 2018 for **qualified nursing staff** in the urgent and emergency care department at Cumberland Infirmary is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 2</td>
<td>19</td>
<td>18</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>43</td>
<td>36</td>
<td>84%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 3 (core)</td>
<td>24</td>
<td>15</td>
<td>63%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Cumberland Infirmary urgent and emergency care department the 95% target was met for one of the three safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses as at March 2018 for **medical staff** in the urgent and emergency care department at Cumberland Infirmary is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 3 (core)</td>
<td>11</td>
<td>5</td>
<td>45%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>12</td>
<td>3</td>
<td>25%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>1</td>
<td>0</td>
<td>0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Cumberland Infirmary urgent and emergency care department the 95% target was not met for any of the safeguarding training modules for which medical staff were eligible.

*(Source: Routine Provider Information Request (RPIR) – P40)*

We were very concerned about the poor compliance of training rates. We were not confident that any staff were up to date with the latest safeguarding guidance and there was a risk to patients that staff may miss something of concern.

We were also concerned that the trust had made a decision to make safeguarding children level three training e-learning. This was against intercollegiate guidance which says level three training should be face to face.

Safeguarding training included specific training about safeguarding topics such as child sexual exploitation, people trafficking and female genital mutilation (FGM).

The department had processes in place to gather information about patients relating to safeguarding and were linked to a national database of information about children who were at risk of harm or abuse.

When children and young people checked in at reception, reception staff routinely referred to the national database to check for any safeguarding or other concerns. When concerns were identified, this was noted on the patient’s CAS card visible for the triaging clinician to see.

Triaging clinicians accessed two different electronic systems to check for history of safeguarding or other concerns about the safety of children brought to the department. At CIC we were assured that this process was followed.
At CIC, the electronic record keeping system also made it mandatory for staff to complete a CWILTED (condition, witness, incident, location, time, escort, description) assessment for children and young people. We saw evidence in Safety and Quality Committee minutes that records were audited to ensure CWILTED was being used. The minutes noted completion was at 100%.

We looked at the records of some children and noted that clinicians were not considering, or asking some key questions of patients about domestic violence, female genital mutilation or child exploitation. However, when we spoke with staff about these issues they displayed a good knowledge about them.

We spoke with a number of staff from all disciplines about the action they would take if they were concerned about the safety and welfare of patients, both adults and children. They demonstrated knowledge of the reporting process and were able to describe the signs to look for and the action they would take.

The IT system in the department routinely showed how many times a child had attended the trust ED services in the last 12 months and in their lifetime as a way of highlighting if there were any safeguarding concerns.

The registered sick children’s nurses (RSCNs) in the department acted as paediatric liaison nurses. They made sure notifications were sent to health visitors and school nurses to inform them of patient attendances.

We saw minutes of safeguarding meetings where current issues were discussed. The minutes highlighted concerns about the safeguarding training of staff contracted in to the department. The trust was seeking assurance from the external provider that all relevant staff working in the department had undergone the appropriate level of safeguarding training.

**Cleanliness, infection control and hygiene**

The department was generally clean and we saw cleaning staff carrying out their duties during our inspection. Rooms were visibly clean, patient rooms were cleaned in between patients and waiting room seats and flooring were in an acceptable condition.

Patient toilets were clean and we found the environment in the department was compliant with infection prevention and control standards. However, there were a number of areas where we had concerns about cleaning standards.

We found that toys in the children’s area were very dirty. We spoke with cleaning staff who told us they were not responsible for cleaning toys. We spoke with a member of nursing staff who told us cleaning staff were responsible. It was unclear who was responsible but the toys were not clean and posed a risk of spreading infection.

We also found dead insect bodies in a trolley drawer in room D. This would indicate that the drawers had not been cleaned out for some time.

We found the sluice was unlocked throughout the inspection. This meant that cleaning fluids and other substances hazardous to health could be easily accessed by members of the public. There
was a risk to patients if these substances were mishandled or ingested. The sluice itself was clean.

Staff could call cleaners to the department ‘out of hours’ if required. However, staff told us at the inspection that the hours a general assistant were present in the department had been reduced therefore reducing the cover in the department.

Health care assistants were responsible for general cleaning and wiping of patient equipment such as blood pressure machines. We witnessed staff carrying out cleaning of equipment between patients.

There was sufficient personal protective equipment (PPE) such as aprons and masks available to staff. We routinely saw staff using this, latex gloves and other equipment and disposing of it correctly during our inspection. However, we did not witness staff regularly washing their hands. Additionally, we witnessed one member of staff carrying out a urine sample test who did not wash their hands afterwards.

We noted that some of the psychiatric liaison staff who visited the department were not bare below the elbow and had false nails or were wearing nail varnish. This was not in line with infection prevention and control policies.

Neither medical nor nursing staff were meeting the trust’s training target of 95% for infection prevention and control. Nursing staff were at 81% for hand hygiene and 79% for infection prevention and control. Medical staff were at 75% for hand hygiene and 25% compliance for infection prevention and control.

The department had solid walled cubicles for patients who required isolation for the prevention and management of actual or potential infection.

We looked at the areas where equipment was cleaned and these were visibly clean and there were cleaning schedules in place for all equipment.

Mattresses we checked were in good condition and met infection prevention and control standards.

Environment and equipment

We spoke with staff about the environment in the department. They told us that plans had been approved on the first day of our inspection, for the department to expand and create extra space for adults, children and major incidents as well as treatment cubicles and space to work collaboratively with local GP services.

However, at the time of our inspection we had some concerns about the environment of the department. We looked at the designated mental health room and found the room was not fit for purpose. It did not meet with PLAN (Psychiatric Liaison Accreditation Network) standards for a designated mental health room. We found the room had a number of ligature risks such as taps and door handles, a trolley, a missing ceiling tile with access to the cables and pipes in the ceiling space, oxygen cylinders with piping that could be used for strangulation or as a weapon, doors were not barricade proof and could be locked from the inside, there were no viewing panels on.
doors, no light furniture that was missile proof and a panic bar that was behind the trolley was out of reach of staff.

We spoke with senior staff in the department about the room and raised our concerns. We asked if a risk assessment of the room had been carried out and were told that it had not. Senior staff told us that the room also doubled up as a cubicle, hence the presence of the oxygen cylinder and trolley. They assured us that if the room was needed as a mental health room, the room would be cleared of risks. However, some of the risks were fixtures and fittings in the room and could not be removed. Staff told us sometimes patients with purely mental health conditions waited in the relatives’ room. We found that this room also had a number of ligature risks such as a telephone (with long cable) and kettle with cable and was not a safe environment for a person at risk of suicide or self-harm.

We carried out an unannounced follow up inspection one month later. We viewed the mental health room. The department had undertaken significant work to improve the room. A new solid ceiling was in place, door handles and locks were ligature proof and barricade proof, the taps had been replaced with ligature free sensor taps and a new call bell panic alarm system was being built in to the wall so that there were no exposed cables. New heavy missile proof furniture had been ordered to furnish the room. The room was yet to be finished when we visited however we could see significant action had been taken and the environment was a great improvement since our previous visit.

There was a separate small waiting room for children, one dedicated cubicle and one resuscitation bay designated as a children’s bay. At the time of the inspection, the children’s waiting area was continually full, and the one cubicle had been divided in half by a screen, to accommodate two children on a number of occasions. The children’s area was not large enough for the demand on the service. However, we were aware that the children’s area would increase in size once the future plans had been completed.

Consulting and treatment cubicles were an adequate size and contained the necessary patient equipment. Some cubicles had solid walls with doors and some had curtains.

The department did not have a room that could be used in the event of chemical, biological, radiation or nuclear (CBRN) contamination. However, equipment including the decontamination tent and protective wear was easily accessible and readily available. A new decontamination area was planned for the new extension and the senior staff acknowledged that although there was a facility to accommodate a CBRN incident, the facility needed to improve.

Equipment in the department had been safety checked. All of the electrical equipment we checked had up to date tests.

Equipment was serviced and maintained in line with manufacturer’s guidelines, as there were maintenance contracts in place. To ensure accuracy, equipment was regularly calibrated.

We saw there were sufficient supplies of all equipment. This meant if there was a mechanical breakdown, a spare machine was available.

We checked some of the stock held in the store rooms. We found supplies were in date and stock was rotated.
We checked resuscitation trolleys and were unable to find checklists, or signed lists to show that regular checks had been made to ensure all equipment was present and in date.

The waiting area used by adult patients was adequate with sufficient seating for patients and relatives that met infection control specifications. The triage room and reception desk faced on to the waiting room so staff could monitor the waiting room. For staff safety, the reception desk had a Perspex window but despite having gaps for patients to speak in to, we saw it was hard for staff and patients to hear what was said. This also proved a barrier if a patient wanted to speak confidentially to a member of reception staff.

Assessing and responding to patient risk

The department used a system called Manchester Triage to assess the level of urgency which a patient needed to be seen. Triage is an important step in the care of a patient as it is the first opportunity for a member of the clinical team (usually a nurse) to look at a patient, speak with them about their symptoms and make a decision about whether the patient can wait to see a doctor or needs to be seen as a matter of urgency.

We spoke with nursing staff about triage. They told us that any member of qualified staff could triage as long as they had completed their triage training and had been assessed as competent. We had some concerns that relatively newly qualified and inexperienced nursing staff could be carrying out triage.

At the time of our initial inspection the department did not use rapid assessment and treatment (RAT) during busy times to make sure patients were seen and assessed quickly.

When we returned a month later to carry out an unannounced follow up inspection, RAT had been introduced on a trial basis for six weeks. Medical and nursing staff we spoke with told us the new system was very effective and made sure patients were seen very quickly by a senior clinician. They thought patient safety had improved as a result because tests were carried out at initial assessment and referrals for x-rays and scans made at an early stage in the patient journey. We saw an example of a patient brought to the department with suspected sepsis who was seen via the RAT process and received their infusion of antibiotics within 10 minutes of arrival.

The challenge for the department was that RAT required additional staff and additional funding was needed to recruit staff to ensure RAT was sustainable in the long term.

The department had also introduced a minor injuries queue managed by a junior doctor to see and treat patients who attended with a minor injury such as a simple limb injury.

The department had good links with the ambulatory care department and patients who met specific criteria could be referred there from the ED.

There was emergency medical equipment in the department and staff were experienced at dealing with sick patients. There were senior staff on hand to support less experienced staff until at least midnight and then by telephone after this time.

Patients with allergies were given a red wristband to ensure that they were easily identifiable.
Staff were required to record known patient allergies in patient records. One of the nine records we looked at did not record whether the patient had been asked about allergies.

The department had an adult sepsis pathway. There was no paediatric sepsis pathway in place however the trust told us this was in development and in the meantime a regionally recognised pathway was used. We were assured by this. There had been no evidence of harm to paediatric sepsis patients.

The adult sepsis pathway followed best practice. However, at the time of the inspection, we were not assured that staff were following the pathway. This was because the department had seven serious incidents relating to sepsis, of which, only one patient survived but had to be moved to intensive care.

We sought assurance from the trust about whether they also had concerns about the treatment of patients with sepsis. The trust provided us with meeting minutes that demonstrated sepsis being discussed at infection control meetings, patient safety meetings and the trust board.

The trust provided us with evidence from sepsis clinical audits. These showed that although the department was not meeting the 100% compliance for screening all possible sepsis cases and treating all septic patients with one hour, there was an improving picture in compliance. For example, in quarter one of 2017/2018, 53% of patients who should be screened, were screened. In quarter one of 2018/2019, this had improved to 82%. Of patients with a confirmed diagnosis, in quarter one of 2017/2018, 61% received antibiotics within an hour as is good practice. In quarter one of 2018/2019 this had improved to 83%.

The trust had identified two sepsis lead nurses and the department had a sepsis champion nurse whose task it was to promote the use of the sepsis pathway and ensure patients received the correct treatment in a timely manner.

The department used the national early warning score (NEWS) for adults and the paediatric early warning score (PEWS) for children to assist in monitoring patients and identifying when a patient’s condition was deteriorating. We looked at nine records. NEWS or PEWS was recorded in eight of the records.

Staff told us they were aware of the action they should take if patients deteriorated and there was a process in place for staff to follow. However, when we looked at the results of the regular NEWS audits carried out, we identified some themes. Monthly audits looked at a small number of records (less than ten) and measured against set standards. The NEWS audit results showed staff were poor at recording evidence of escalating a deteriorating patient, poor at recording a response to the escalation and poor at recording whether there had been any intervention. Therefore, we did not have assurance that any action had been taken, any response received or any intervention taken place.

There had been 55 incidents identified as ‘Treatment / procedure - delay / failure’. Not all of these related to failure to escalate but there was a theme of follow up actions not being taken for example, neurological observations after a fall, head CT not ordered and patient not cross matched for a blood transfusion. They suggest that staff were not always following up on actions needed by patients.
The department’s ‘Vital Signs’ audit of April 2018 also showed there was room for improvement, highlighting that staff were not always using escalation stickers, documenting action taken or recording vital signs within 60 minutes. The report also highlighted a risk related to NEWS being recorded in three different places and recommended that this should be streamlined.

Clinical staff were trained in a minimum of immediate life support (ILS) or paediatric immediate life support (PILS). Training figures showed that only two out of three medical staff and 17 out of 38 were up to date with their ILS training. PILS training figures showed medical staff were not completing this training and five out of 16 were up to date with the training.

RCEM guidance states that at least one member of the medical staff in the department overnight should be trained to advanced life support (ALS) and advanced paediatric life support (APLS) level. Information from the trust showed only two members of staff were trained to ALS and two to APLS level. This meant that the trust did not have at least one member of ALS and APLS trained staff working overnight every night.

Nursing staff training figures showed only one nurse had completed their ALS and one nurse had completed their APLS.

We were not assured that staff had undergone appropriate life support, paediatric life support and trauma life support training as per Royal College of Emergency Medicine (RCEM) guidance.

**Emergency Department Survey 2016**

The trust scored “better than” other trusts for two of the five emergency department survey questions relevant to safety. The trust scored “about the same” as other trusts for the remaining three questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the</td>
<td>9.0</td>
<td>About the same as other</td>
</tr>
<tr>
<td>ambulance crew before your care was handed over to the emergency</td>
<td></td>
<td>trusts</td>
</tr>
<tr>
<td>department staff?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>7.3</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be</td>
<td>7.3</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>examined later. From the time you arrived, how long did you wait before</td>
<td></td>
<td></td>
</tr>
<tr>
<td>being examined by a doctor or nurse?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>9.0</td>
<td>About the same as other</td>
</tr>
<tr>
<td></td>
<td></td>
<td>trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel threatened</td>
<td>9.8</td>
<td>About the same as other</td>
</tr>
<tr>
<td>by other patients or visitors?</td>
<td></td>
<td>trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)
Median time from arrival to initial assessment (emergency ambulance cases only)

The median time from arrival to initial assessment was slightly worse than the overall England median for all months over the 12-month period from April 2017 to March 2018.

Patients at the trust waited on average 3.5 minutes longer from arrival to initial assessment than the England average. Waiting times were consistently higher over the period April 2017 to March 2018, with patients waiting on average 11 minutes from arrival to assessment.

The overall trend over the period worsened slightly from a ten minute wait in April 2017 to 13 minutes in March 2018. Waiting times increased slightly over the winter months of December 2017 to January 2018.

Ambulance – Time to initial assessment from April 2017 to March 2018 at North Cumbria University Hospitals NHS Trust

(Source: Source: NHS Digital - A&E quality indicators)

Further information from the trust showed that the average handover time for CIC was between 14 minutes and 20 minutes thus the information in the graph above appears to be incorrect.

Percentage of ambulance journeys with turnaround times over 30 minutes for this trust

Cumberland Infirmary

From May 2017 to April 2018 there was a slight upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Cumberland Infirmary.

Ambulance: Number of journeys with turnaround times over 30 minutes - Cumberland Infirmary

(Source: Source: NHS Digital - A&E quality indicators)
On average 42% of ambulance journeys had a turnaround time over 30 minutes with the overall trend increasing from 37% in May 2017 to 44% in April 2018. Percentages increased in December 2017, reaching its highest point of 49%. Although percentages decreased in January 2018 to 40%, a slight increase can be seen during the winter months of February to March 2018.

**Ambulance: Percentage of journeys with turnaround times over 30 minutes - Cumberland Infirmary**

*Apr-17*

![Ambulance turnaround times graph](image)

(Source: National Ambulance Information Group)

**Number of black breaches for this trust**

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. From April 2017 to March 2018 the trust reported 628 “black breaches”.

Month on month black breaches reported varied between 21, the lowest number reported in August 2017, to the highest number of 113 reported in December 2017.

High numbers were reported in April 2017 (75), and during the winter months of December 2017 (113) and January 2018 (81).

When we spoke with managers about black breaches they explained these were due to flow through the hospital and volume of patients to the department. There were escalation processes in place. They also told us that if RAT continued to be funded throughout the winter months, this would assist with managing black breaches.

![Black Breaches graph](image)

(Source: Routine Provider Information Request (RPIR) - Black Breaches tab)
**Nurse staffing**

The trust reported the following qualified nursing staff numbers as at March 2018 and April 2018 for urgent and emergency care by site:

<table>
<thead>
<tr>
<th>Location</th>
<th>March 2018</th>
<th></th>
<th>April 2018</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
<td>Fill rate</td>
<td>Actual WTE staff</td>
</tr>
<tr>
<td>Cumberland Infirmary</td>
<td>25.9</td>
<td>33.2</td>
<td>78.0%</td>
<td>29.8</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16)

**Vacancy rates**

From April 2017 to March 2018, the trust reported a vacancy rate of 22.1% for qualified nursing staff in urgent and emergency care. This was higher than the trust target of 5.0%. The high vacancy rates do not appear to correlate to the high fill rates. This has already been queried with the trust who have assured us that the figures are correct.

From the information provided above, there was a vacancy rate of 3.4 WTE staff in April 2018. This equated to a vacancy rate of 10.2%

A breakdown by site is shown below:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total vacancies (WTE)</th>
<th>Total number of staff establishment (WTE)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>193.3</td>
<td>864.9</td>
<td>22.3%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

From May 2017 to April 2018, the trust reported a turnover rate of 5.3% for qualified nursing staff in urgent and emergency care. The trust did not have a specific target but benchmarked against other organisations.

The trust did not provide any data for Cumberland Infirmary.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**

From May 2017 to May 2018, the trust reported a sickness rate of 4.2% for qualified nursing staff in urgent and emergency care. This was slightly above the trust target of 4% however, the sickness rate for CIC was above the target at 5.9%.
The breakdown by site can be seen below:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total absence days</th>
<th>Total WTE days available</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>1,205.3</td>
<td>20,303.6</td>
<td>5.9%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

From April 2017 to March 2018, the trust reported that 31.8% of qualified nursing shifts in urgent and emergency care were filled by bank staff.

The trust was unable to provide comparable data for agency and shifts left unfilled, due to system restrictions.

The breakdown by site is shown in the table below.

<table>
<thead>
<tr>
<th>Site</th>
<th>Bank shifts</th>
<th>Total shifts</th>
<th>Bank shifts as a proportion of total shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>556.0</td>
<td>1,651.0</td>
<td>33.7%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Bank and Agency tab)

We had concerns about nurse staffing in the department. When we met with the management team, they were unable to tell us how many whole time equivalent nursing staff were employed for CIC ED. They were also unable to tell us how many vacancies there were, what the establishment should be and what actual staffing numbers were.

We asked the management team and other staff how staffing numbers were calculated, whether a BEST assessment or other staffing level assessment tool had been used. The management team told us staffing levels were calculated based on the knowledge and experience of the matron. There appeared to be no analysis of previous attendances or consideration of growing demand and acuity of patients documented. There appeared to be no structured or formal approach to working out staffing levels.

We also had some concerns about the high number of bank shifts used. This could suggest that the department staffing establishment needed to be formally reviewed using an established tool to ensure the trust employed and deployed sufficient staff to meet the needs of patients.

We were concerned about the number of staff deployed on the days of our inspection. Staff told us that the actual staffing levels on the days of our inspection met the planned staffing levels however, we saw that staff were not able to spend time with patients and had difficulty meeting their needs. For example, we did not see comfort rounds being carried out and patients told us they were not offered food or drinks in the department. A comfort round is a regular check on patients to see if they need any assistance such as a toilet break, pain relief or food and drink.
Ambulance crews we spoke with told us triage was variable and sometimes they had to wait for triage as no nurse was available thus delaying handover and assessment of patients. This could be a contributory factor for the number of black breaches in the department.

Staff we spoke with told us staffing in the department was still a problem because it did not take in to account variations in the level of sickness of patients and other needs they may have, such as for patients living with dementia or with a mental health condition who needed constant monitoring for their own safety.

At the time of the inspection, the department had three registered sick children’s nurses (RSCN) who covered the department from 8am until 8pm every day. The department was in the process of recruiting more to make sure there was 24 hour seven days a week cover. When an RSCN was not on duty, adult trained nurses saw paediatric patients. Staff were unable to tell us what additional training adult nurses had undergone to be able to treat children.

**Medical staffing**

The trust reported the following medical staffing numbers as at March 2018 and April 2018 for urgent and emergency care by site:

<table>
<thead>
<tr>
<th>Location</th>
<th>March 2018</th>
<th>April 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Cumberland Infirmary</td>
<td>18.6</td>
<td>25.8</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – P16)*

Doctors staffed the department 24 hours per day seven days a week. There was consultant cover from 8am to midnight. This met the Royal College of Emergency Medicine (RCEM) standard of consultant cover 16 hours each day.

However, RCEM guidance ‘Rule of thumb’ states that overnight cover should be provided by staff at minimum specialist trainee level four (ST4) to ensure the correct level of competency of the most senior staff. They should be an ST4 and always have both advanced life support (ALS) and advanced paediatric life support (APLS). The department was not meeting this standard.

Doctors of all grades told us that consultants stayed as long as they were needed and would return to the hospital if their skills or experience was needed. Consultants either lived within 30 minutes of the department of stayed on site when they were on call.

Consultants were flexible and when the department was busy or had very seriously ill patients, consultants often worked beyond their designated hours to support patients and staff.

Paediatric cover was by either ED consultants when present or by a paediatric consultant out of hours.

We observed doctors discussing patients and handing over relevant information to colleagues. We had no concerns about this process. It was efficient and effective.
The trust reported to us that medical staff were fully up to date with revalidation requirements.

**Vacancy rates**

From April 2017 to March 2018, the trust reported a vacancy rate of 36.9% for medical staff in urgent and emergency care. This was higher than the trust target of 20%. However, at the time of the inspection consultants in the department told us that six new consultants had been recruited and recruitment was underway for two registrar grade doctors.

The high vacancy rates do not appear to correlate to the high fill rates. This has already been queried with the trust who has assured us that the figures are correct.

A breakdown by site is shown below:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total vacancies (WTE)</th>
<th>Total number of staff establishment (WTE)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>76.2</td>
<td>301.6</td>
<td>25.3%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

From May 2017 to April 2018, the trust reported a 44.4% turnover rate for medical staff in urgent and emergency care. This was much higher than the trust target of 13%.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total leavers (WTE)</th>
<th>Average number of staff establishment (WTE)</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>7.0</td>
<td>11.4</td>
<td>44.1%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**

From May 2017 to May 2018, the trust reported a sickness rate of 0.8% for medical staff in urgent and emergency care. This was lower than the trust target of 4%.

The total for this site can be seen below:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total absence days</th>
<th>Total WTE days available</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>38.0</td>
<td>5,256.3</td>
<td>0.7%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Bank and locum staff usage**
The trust was unable to provide this data broken down by site or core service, due to system restrictions under the previous recording method.

We spoke with staff in the department and they told us use of locum staff was low and the department was not reliant on them. Medical staff told us the department was always covered with consultants staying to provide cover when required. The recruitment of six new consultants also contributed to this.

The trust tried to use regular locums and made sure that they had access to the appropriate IT systems to retrieve results.

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

**Staffing skill mix**

As at January 2018, the proportion of consultant and junior (foundation year 1-2) staff reported to be working at the trust were higher than the England average.

**Staffing skill mix for the 27 whole time equivalent staff working in urgent and emergency care at North Cumbria University Hospitals NHS Trust.**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>36%</td>
<td>30%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>12%</td>
<td>14%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>19%</td>
<td>33%</td>
</tr>
<tr>
<td>Junior*</td>
<td>33%</td>
<td>23%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

**Records**

All members of staff were required to attend information governance training. We found that 67% of medical staff and 95% of nursing staff had completed this training against a trust target of 95%.

All staff were required to complete medical records management training. We found that 25% of medical and 86% or nursing staff had completed this training against a trust target of 95%
The electronic record system in the ED had the facility to alert staff about specific needs of patients such as those living with a learning disability or mental health needs. There were also alerts for violent patients and patients with previously diagnosed conditions.

The department used an electronic system to record patient attendances. This was on display in the nurse’s stations away from the sight of the public. This ensured that patients’ personal information was not seen by other patients in the department.

Staff used paper and electronic records to record patient information.

Once a patient was discharged from the department, the patients GP was sent a copy of the patient’s full medical record from the admission. This included their treatment plan and any medication changes. Reception staff sent these out to each practice in a bulk mail each day.

We looked at the paper records of nine patients, adults and children. We found there were some gaps in recording of information. For example, pain scores were not always recorded (4/9 not recorded), comfort rounds were not always documented (7/9 not documented), falls risk assessment (4/4 where appropriate, not documented), pressure assessment (3/5 where appropriate not documented).

We found four records where observations were not documented at the required frequency and there were long gaps in time between sets of observations being carried out.

We also found an example of a patient who had been started on intravenous fluids with no fluid chart.

We found three patients who had not had their patient safety checklist completed.

Of the records we looked at all had been fully dated and timed throughout and initial NEWS scores were recorded. However, there were two sets of records which did not have evidence of a second NEWS score despite a recheck being due.

**Medicines**

We had some serious concerns about the practices used in the department to manage medicines.

Staff told us they disposed of controlled drugs (medicines that have very strict policies and procedures in relation to their management) by squirting any unused medicines into a sharps bin or down the sink. Both practices were against the trust policy. The policy says controlled drugs should be disposed of in one of two ways; if under 5ml, the medicine should be emptied in to a pharmaceutical waste contained, documented and witnessed by a registered practitioner, if over 5ml “liquid medications must be rendered irretrievable. Liquid medications must be released from their container onto a trust approved absorbent material and placed in to a pharmaceutical waste container”.

The department used large, electronic, temperature-controlled medicine storage units.
We asked a pharmacy inspector from CQC to visit the ED to look at the processes in place. They witnessed staff obtaining medication from the medicines storage unit without having the patient’s prescription with them. They also witnessed one member of staff ask another to retrieve medicines from the storage unit on their behalf. The first nurse had not seen the prescription and did not know which patient the medication was for, yet retrieved the medicine and handed it to their colleague to administer. This practice is extremely risky for the patient who could potentially receive the wrong medication or the wrong dose. The staff did not follow trust policy for the dispensing of medicines. From our observations this had become custom and practice and did not occur only in exceptional circumstances such as an emergency situation.

We looked at the storage of medicines within the department and specifically within the resuscitation area. We identified a number of concerns. For example, fluids placed in the warmer had not been dated therefore it was unclear how long they had been there. Fluids were stored in unlocked cupboards; different doses of mannitol were stored together and therefore there was a risk that these could be mixed up and the wrong dose given. We also found glucose 20% and 50% stored together. This posed the same risk.

Medication fridge temperatures were not regularly checked and recorded as such. Staff were required to record maximum and minimum temperatures to ensure that medicines were consistently stored within the correct temperature range. We found gaps in the records. Ambient temperatures in rooms where medicines were stored were also unchecked. We found the maximum fridge temperature had been exceeded however there was no evidence that staff had taken any action, such as reporting the incident to the pharmacy team. We addressed this with the nurse in charge on the day of our inspection who consulted the trust pharmacy team.

Patient group directions (PGD), which allow some registered health professionals, such as nurses, to give specified medicines (such as painkillers) to a predefined group of patients without the patient having to see a doctor, were used in the department. Not all eligible staff had signed to say that they understood them and were working within their guidance. Advanced care practitioners who were originally trained paramedics used a combination of PGDs and medicines they were allowed to use as qualified paramedics until they were fully-qualified non-medical prescribers. We were not able check PGDs to make sure all relevant staff had signed and were deemed competent as the person who was responsible for them was on long term absence from the trust.

Medical gases were stored safely.

Incidents

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From June 2017 to May 2018, the trust reported no incidents classified as never events for urgent and emergency care.

(Source: NHS Improvement - STEIS)
Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 11 serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from June 2017 to May 2018.

Of these, the most common type of incident reported was treatment delay meeting Serious Incident criteria with seven incidents (64%).

No site was allocated for one incident (Treatment delay meeting SI criteria).
Site specific information, for the remaining ten incidents can be found below:

- Cumberland Infirmary: four incidents.
- West Cumberland Hospital: six incidents

(Source: NHS Improvement - STEIS (01/05/2017 - 30/04/2018)

There were some common themes in the serious incidents we looked at. There had been seven incidents of sepsis where patients had come to harm. Six patients died and one went to intensive care. The trust had also done some thematic analysis and carried out investigations to identify if any changes to practice were needed. Common causes included failure to diagnose and failure to start appropriate treatment in a timely way.

The trust reported 444 incidents in the two emergency departments from October 2017 to June 2018.

Two of the incidents were reported as deaths, six were reported as severe harm, 14 were reported as moderate harm, 177 were reported as low harm and 245 were reported as no harm.

The most commonly reported incident category was patient accident (152) followed by treatment/procedure (96), medication (54), access, admission, transfer, discharge (39) and
infrastructure including staffing (23). However, staff told us they had been instructed not to report staffing shortages in the incident reporting system.

We looked to see if there were any common themes in the incidents. We found 17 incidents where sepsis or septic were mentioned, five where a stroke was mentioned and nine where diabetes or DKA (diabetic ketoacidosis) were a factor.

Information the trust gave us showed that the department had taken action as a result of incidents, used Duty of Candour appropriately and fed back to staff when errors had been made, so that lessons could be learned. We looked at the root cause analyses and action plans to assure ourselves action was being taken.

We spoke with staff about their responsibilities around duty of candour. Providers of healthcare services must be open and honest with service users and other ‘relevant persons’ (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. Staff were familiar with the phrase, ‘being open and honest’. Senior staff in the department took responsibility for the formal duty of candour process. They could describe it and give examples of when they had used the process.

Staff we spoke with told us they received some feedback about incidents they had reported at morning huddles. Feedback and lessons learned were also disseminated via these huddles.

We discussed incidents with staff. All the staff we spoke with were aware of the process for reporting incidents and had access to the electronic reporting system. All staff of all disciplines told us it was their responsibility to report any incidents they were involved in and did not rely on staff from other disciplines to take the lead.

Managers told us that all staff groups took responsibility for reporting incidents and were encouraged to do so. Managers also told us there was a strong self-reporting culture.

Senior staff in the department attended mortality and morbidity meetings held within the hospital however department managers said these were not as frequent as they would like them to be.

**Safety thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within ten days of the suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported five new pressure ulcers, eight falls with harm and four new urinary tract infections in patients with a catheter from April 2017 to April 2018 within urgent and emergency care.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at North**
Cumbria University Hospitals NHS Trust

1. **Total pressure ulcers (5)**

2. **Total falls (8)**

3. **Total CUTIs (4)**

A total of five pressure ulcers were reported for urgent and emergency care. No pressure ulcers were reported for the majority of months over the period April 2017 to April 2018. Pressure ulcers reported were irregular with one reported in May, three in July 2017 and one in January 2018. No apparent trend could be identified.

Urgent and emergency care reported eight falls from April 2017 to April 2018, all falls were reported between April to October 2017. The highest number of three falls each per month were reported in May and July 2017. One fall each in September and October 2017. Overall a trend of decline can be seen.

The service reported four Catheter acquired urinary tract infections (CUTIs). Three of these were reported during the winter months of December 2017 (2) and January 2018 (1). No CUTIs were reported for the remaining months in the period April 2017 to April 2018.

(Source: Safety thermometer - Safety Thermometer)

Is the service effective?

**Evidence-based care and treatment**

Staff in the department used a comprehensive variety of pathways and NICE guidelines together with Royal College of Emergency Medicine (RCEM) guidance to support them to achieve effective...
outcomes for patients in their care. However, there were occasions when staff did not adhere to the timings of pathways, such as the sepsis pathway.

We saw guidance on the trust’s intranet which staff had access to, for instance, around the identification and management of sepsis, which was based on NICE guidance. There were links to trust wide policies, standard operating procedures, checklists and additional support information. This meant staff could ensure patients were receiving best practice care and treatment.

New NICE guidelines were reviewed, reported on, and approved, and then training organised where applicable to ensure staff were aware of any changes in practice.

Patient safety and medication alerts were brought to staff attention and practice guidelines were changed in accordance.

**Nutrition and hydration**

**Emergency Department Survey 2016**

In the CQC Emergency Department Survey, the trust scored 7.3 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as other trusts.

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

We spoke with five patients and their relatives about hydration and nutrition needs. All of them told us they had not been offered a drink. Some of the patient had been in the department for more than two hours.

We did not see patients being offered food or drinks however staff told us that if patients needed to eat for medical reasons, food was available.

In the waiting area there were vending machines selling drinks and food however these were out of order. There were shops close by to buy drinks and snacks.

If a patient had special dietary needs, for instance a child patient, staff told us help could be obtained from the children’s ward, or alternatively the patient was admitted and then seen by a specialist dietitian on the appropriate ward.

If a patient was assessed as requiring fluid management, for example following vomiting, diarrhoea or dehydration, fluid balance charts were used to monitor and assess the need for additional fluids. We saw these in use.

**Pain relief**

**Emergency Department Survey 2016**

In the CQC Emergency Department Survey, the trust scored 6.2 for the question “How many minutes after you requested pain relief medication did it take before you got it? This was about the same as other trusts.
The trust scored 8.0 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

<table>
<thead>
<tr>
<th>Question – Effective</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q31. How many minutes after you requested pain relief medication did it take before you got it?</td>
<td>6.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q32. Do you think the hospital staff did everything they could to help control your pain?</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

The department had systems and processes in place to support staff to assess and record the pain patients had, including for patients who had difficulty communicating. We saw staff had access to appropriate pain relief medication.

We observed triage and witnessed patients being given pain relief if they needed it.

We looked at nine patient records (adults and children) and in four records we saw pain scores were not recorded on the patient’s record at initial assessment or reassessed subsequently, dependent upon the patient’s NEWS score or how often their repeat observations were required.

Patient outcomes

RCEM Audit: Moderate and acute severe asthma 2016/17

Cumberland Infirmary

The department was in the upper UK quartile for one standard:

- Standard 5: If not already given before arrival to the emergency department, steroids should be given as soon as possible as follows:
  - Adults 16 years and over: 40-50mg prednisolone PO (Orally) or 100mg hydrocortisone IV (intravenously)
  - Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
  - Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV

- Standard 5b (fundamental): within 4 hours (moderate). This department: 50.9%; UK: 28%.

The department was not in the lower UK quartile for any standard.

The department’s results for the remaining six standards were all between the upper and lower UK quartiles.

- Standard 1a (fundamental): Oxygen (O2) should be given on arrival to maintain saturations of 94-98%. This department: 16% versus UK: 19%.
• Standard 2a (fundamental): As per RCEM standards, vital signs should be measured and recorded on arrival at the emergency department. This department: 39% versus UK: 26%.

• Standard 3 (fundamental): High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the emergency department. This department: 28% versus UK: 25%. (Beta2-agonists (bronchodilators) are a group of drugs prescribed to treat asthma)

• Standard 4 (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. This department: 74.7% versus UK: 77%.

• Standard 5: If not already given before arrival to the emergency department, steroids should be given as soon as possible as follows:
  - Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV
  - Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
  - Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV

• Standard 5a (fundamental): Within 60 minutes of arrival (acute severe). This department: 29.3% versus UK: 19%.

• Standard 9 (fundamental): Discharged patients should have oral prednisolone prescribed as follows:
  - Adults 16 years and over: 40-50mg prednisolone for 5 days
  - Children 6-15 years: 30-40mg prednisolone for 3 days
  - Children 2-5 years: 20mg prednisolone for 3 days
This department: 52.3% versus UK: 52%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Consultant sign-off 2016/17

Cumberland Infirmary

In the 2016/17 Consultant sign-off audit, Cumberland Infirmary emergency department failed to meet any of the standards.

The department was in the upper UK quartile for one standard:

• Standard 2 (developmental): Consultant reviewed: fever in children under 1 year of age. This department: 23.1% versus UK: 8%.

The department was not in the lower UK quartile for any standard.

The department’s results for the remaining three standards were all between the upper and lower UK quartiles:
• Standard 1 (developmental): Consultant reviewed: atraumatic chest pain in patients aged 30 years and over. This department: 9% versus UK: 11%.

• Standard 3 (fundamental): Consultant reviewed: patients making an unscheduled return to the emergency department with the same condition within 72 hours of discharge. This department: 23% versus UK: 12%.

• Standard 4 (developmental): Consultant reviewed: abdominal pain in patients aged 70 years and over. This department: 6% versus UK: 10%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Severe sepsis and septic shock 2016/17

Cumberland Infirmary

In the 2016/17 severe sepsis and septic shock audit, Cumberland Infirmary emergency department was not in the upper UK quartile for any standard.

The department was in the lower UK quartile for three standards:

• Standard 2: Review by a senior (Specialist trainees level 4 or above ST4+ or equivalent) emergency department medic or involvement of critical care medic (including the outreach team or equivalent) before leaving the emergency department. This department: 35.4% versus UK: 64.6%

• Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. This department: 16.2% versus UK: 43.2%.

• Standard 7: Antibiotics administered: Within one hour of arrival. This department: 27.3% versus UK: 44.4%.

The department’s results for the remaining five standards were all between the upper and lower UK quartiles.

• Standard 1: Respiratory rate, oxygen saturations (SaO₂), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness ((AVPU) alert, voice, pain, unresponsive or GCS (Glasgow coma scale)) and capillary blood glucose recorded on arrival. This department: 52.5% versus UK: 69.1%.

• Standard 3: O₂ was initiated to maintain SaO₂>94% (saturations of oxygen in excess of 94%) (unless there is a documented reason not to) within one hour of arrival. This department: 36.7% versus UK: 30.4%.

• Standard 4: Serum lactate measured within one hour of arrival. This department: 41.8%
versus UK: 60%.

- Standard 5: Blood cultures obtained within one hour of arrival. This department: 38.4% versus UK: 44.9%.

- Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. This department: 28.3% versus UK: 18.4%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Vital signs in children 2015/16

Note: Cumberland Infirmary did not take part in this audit

(Source: Royal College of Emergency Medicine)

RCEM Audit: Procedural sedation in adults 2015/16

Note: Cumberland Infirmary did not take part in this audit.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast 2015/16

The trust did not take part in this audit.

(Source: Royal College of Emergency Medicine)

We formally requested details about re-audit results and changes made to practice as assurance that action has been taken. The trust provided us with assurance that action had been taken in relation to RCEM audit results. We saw the Vital Signs and the Sepsis re-audit reports and action plans. These showed that sepsis performance was being closely monitored and discussed extensively throughout the trust. Sepsis nurses has been employed and the ED had a sepsis champion. The latest sepsis audit results showed an improvement in performance but still some way to go to meet the standards for identifying patients who should undergo sepsis screening (82% against a target of 100%) and patients receiving antibiotics within the first hour (83% against a target of 100%).

We saw staff had access to a sepsis screening tool and a pathway to support them in identifying and managing a patient with sepsis. Information about sepsis was readily available to staff via the electronic patient record. However, the trust did not have a sepsis policy for children although when we requested further information about this, staff told us this was under development.

The department had a CQUIN (commissioning for quality and innovation) target for 2017/2018 related to sepsis. The trust did not fully meet the target (100%) for identifying patients at risk of sepsis or the target (100%) for administering antibiotics to septic patient within one hour.
Staff described how they had treatment plans for regular attenders to the department, particularly those with mental health diagnoses to support them in achieving the best outcome for such patients.

The trust provided us with evidence of local clinical audits taking place, such as record keeping for NEWS and vital signs, pain relief and sepsis.

**Unplanned re-attendance rate within seven days**

From April 2017 and March 2018, the trust's unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% and mostly slightly worse than the England average. There was a dip under the national average in October 2017 followed by a peak in December 2017.

Unplanned re-attendances were on average less than 0.5% worse than the England average at around 7.5%.

**Unplanned re-attendance rate within seven days - North Cumbria University Hospitals NHS Trust**

![Graph showing unplanned re-attendance rate](chart.png)

*(Source: NHS Digital - A&E quality)*

**Competent staff**

A mentor was allocated to newly registered staff who joined the department as part of their preceptorship and all staff joining the department for the first time also received an induction.

The induction programme included checking of competencies, such as, for airways, breathing, ventilation and oxygenation. Staff reported that the induction to the department was useful because there were items of equipment that they would otherwise have been unfamiliar with.
The department had nurse and doctor teaching sessions where specific topics such as equipment, medical conditions or treatments were discussed. This ensured staff from both disciplines were up to date with new developments or techniques.

The department carried out simulation training for staff to ensure they were able to work confidently in unknown scenarios. This was a learning exercise but also gave staff confidence in real life situations. This included CBRN scenarios when staff practiced erecting the decontamination tent and wearing hazardous material protection outfits.

Some staff in the department spoke about additional competency training they had done such as masters degrees or by undertaking paediatric immediate life support training. Other staff had taken on additional roles, such as sepsis champion.

Staff were competent in identifying vulnerable patients and referring them for specialist advice, such as from the psychiatric liaison team.

Senior staff told us that informal monitoring of the competency of staff was undertaken within the department and any concerns were addressed quickly with the staff involved.

**Multidisciplinary working**

The department operated 24/7 and staff we spoke with reported no issues with response times for diagnostic or pathology results that had been ordered.

Staff confirmed that they had 24/7 access to diagnostic services such as x-rays or computerised tomography (CT), which was available within an hour from the dedicated radiology suite.

Pathology support, such as blood testing was available 24/7 and staff reported no issues with the accessibility of the service or its response times which we were told was usually within an hour. The department could also carry out its own point of care testing for some blood tests.

The department worked closely with the frailty team to support patients who had additional health and social care needs. They were able to arrange access to equipment such as walking aids and could organise short term social care for patients. This meant that patients who were medically well enough to go home were supported to do so. Admission avoidance was better for the patient and assisted with bed availability and flow through the ED.

Staff were able to access patient information using an electronic system. This included information such as previous clinic letters, test results and x-rays. Staff could also access patient GP records with the agreement of the patient. This meant that staff had information about the most up to date medications, health conditions and symptoms to enable them to make a better diagnosis and treatment plan.

Staff could access support for patients living with autism or a learning disability via the trust wide learning disability team.

Patients could access support for addiction and substance misuse via the psychiatric liaison service.
The trust worked closely with local care providers such as community health teams to provide a 24/7 team who could support patients in their own homes and prevent admission and reattendance at the department.

**Health promotion**

Staff told us they offered health promotion advice to patients relating to smoking, weight loss and healthy lifestyles as well as specific advice about the patient’s condition.

There were some posters advising patients about support services like drug and alcohol services in the waiting room and around the department.

Staff were able to refer patients to support services if they thought patients needed additional help or support.

Staff were aware of safeguarding, domestic violence and sexual exploitation and could access appropriate support for patients who were at risk.

The frailty team could identify patients who were frail or elderly and who may need extra support to ensure a safe and effective discharge. This team worked closely with outside agencies to ensure that patients leaving the department were looked after so promoting better health amongst those vulnerable patients who had visited the department.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

**Mental Capacity Act and Deprivation of Liberty training completion**

**Cumberland Infirmary**

The trust reported that as at March 2018 Mental Capacity Act (MCA) training was completed by 70% of medical and nursing staff in urgent and emergency care compared to the trust target of 95%.

A breakdown per staff group is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental staff</td>
<td>24</td>
<td>11</td>
<td>46%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>49</td>
<td>40</td>
<td>82%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>73</strong></td>
<td><strong>51</strong></td>
<td><strong>70%</strong></td>
<td><strong>95%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

Note: The above figures include mental capacity Level 1 and level 2 training.

Over the same period Deprivation of Liberty Safeguards training was completed by 64% of medical and nursing staff within urgent and emergency care compared to the trust target of 95%.

Nursing staff had a completion rate of 67%, although this related to only two eligible staff.
members not completing the training.

A breakdown per staff group is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental staff</td>
<td>12</td>
<td>5</td>
<td>42%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>6</td>
<td>4</td>
<td>67%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>9</td>
<td>50%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Statutory and Mandatory Training tab)

Staff understood the importance of consent when delivering care to their patients and displayed a good understanding of the requirements of the Mental Capacity Act (2005) or knew where to obtain expert help, such as from the psychiatric liaison team.

Staff sought consent from patients prior to examination and treatment. In the majority of cases this was implied consent and not documented however when an intervention was required, formal written consent was sought. We saw in records of patients that staff had completed capacity assessments and used the correct forms to consent patients who were unable to consent. We saw an example of this being used with a patient who had fractured their femur and required surgery. The correct documentation was used.

Staff told us they explained procedures to patients and made sure they understood any risks and possible complications before asking them to sign. Consent forms were held within medical records.

Consent training was not recorded as a separate mandatory training module therefore it was unclear whether staff had undertaken consent training as part of another module of mandatory training or had not had consent training.

Staff in the department, particularly the RSCNs were able to accurately describe the tests for assessing competence to consent to treatment for patients aged under 16 years. Staff understood who could give consent on behalf of a patient and when an advocate or best interest decision should be used.

The Deprivation of Liberty Safeguards (DoLS) provide legal protection for those vulnerable people age 18 and over who are, or who may become, deprived of their liberty. The safeguards exist to provide a proper legal process and suitable protection in circumstances where deprivation of liberty appears to be unavoidable, in a person’s own best interests.

Staff were aware of the actions they should take if a patient was detained under the Mental Health Act and there was support available from the psychiatric liaison team if needed when this happened in the department.
Is the service caring?

Compassionate care

Friends and Family test performance

The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was better than for seven months and worse than the England average for five months from April 2017 to March 2018.

Recommendation rates over the period followed a decreasing trend. From April to July 2017 rates were consistently better than the England average. Rates between August and December 2017, varied from 2% below in August to 6.7% above in November and 5.2 above the England average in December 2017. Rates however fell and were below the England average from January to March 2018.

A&E Friends and Family Test performance - North Cumbria University Hospitals NHS Trust

(Source: NHS England Friends and Family Test)

During our inspection, we spoke with eight patients and their relatives, all of whom were happy with the care they received. They provided us with positive feedback about the attitude of staff saying they were kind, pleasant and professional.

Staff respected people’s dignity and cubicle doors and curtains were closed when care and treatment was being given. Patients described to us how staff treated them with respect and our observations corroborated this.

When we discussed care of patients with staff, there was a consistent message that staff wanted the patients to feel safe and cared for. Staff were working very hard and were dedicated to looking after patients throughout their ED journey.

In the patient led assessment of the care environment survey undertaken in April 2017, the Cumberland Infirmary site scored 75.2% for privacy, dignity and wellbeing against a national
average of 83.7%. There were no figures specifically for the emergency department at Cumberland Infirmary.

During our time in the department, we saw patients being treated with dignity and respect. Staff were conscious of the cultural needs of patients and made sure this was respected whilst delivering their medical care. When patients expressed a preference for a particular gender of nurse or doctor, the department tried to accommodate whenever possible.

Staff were very busy; however, they took the time to deliver care that was compassionate and we saw patients being treated with patience and kindness at all times from all members of staff at all levels.

**Emotional support**

Staff told us about how they would support patients who were distressed, by chatting to them and trying to distract them. Patients told us staff reassured them and tried to stay with them until they felt reassured. Staff told us this was not always easy due to the staffing demands in the department.

Staff told us they sometimes found it difficult to support people as much as they wanted to when the department was busy, however we saw staff going out of their way to make sure that no matter how busy the department was, patients received the emotional support they needed.

We observed all staff talking with patients and relatives in a calm way and offering reassurance to both concerned patients and their family members.

Staff offered support and gave information about support services available if this was required.

There was pastoral support available for patients of any or no religious belief.

**Understanding and involvement of patients and those close to them**

**Emergency Department Survey 2016**

The trust scored “about the same” as other trusts for all 24 questions in the emergency department survey questions relevant to the caring domain.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examine and treating you?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren’t there?</td>
<td>9.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If you’re family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>9.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>7.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>5.7</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
We saw patients being given information and supported to make decisions about the treatment they would like to receive. Parents told us that both they and their children were involved in discussions about treatment options.

During our inspection, we witnessed good interactions with patients. Staff took time to reassure patients and explain to them why they were waiting or what the next stage of their treatment or care was. This supported patients to make decisions about their treatment. People’s emotional and social needs were considered by staff.

Staff made sure information they gave was in a language that the patient and their family could understand without complicated medical terminology. Staff gave patients and relatives the chance to ask questions and time to think before making any decisions. Patients and relatives had no complaints about how information was presented to them.

Overall, patients told us staff responded compassionately when people needed help and supported them to meet their personal needs as and when required.

Staff helped people and those close to them to cope emotionally with their care and treatment.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

**Emergency Department Survey 2016**

The trust scored “about the same” as other trusts for the three emergency department survey questions relevant to the responsive domain.
<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>9.4</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

The waiting room for adults could accommodate wheelchairs and mobility aids and there were dedicated disabled toilets available. The children’s waiting area was small and would have difficulty accommodating a wheelchair or pushchair.

There were facilities, such as chairs and wheelchairs, for bariatric patients and trolleys designed for larger patients were available. Specialist bariatric equipment such as hospital beds were stored as part of the trust’s equipment library and could be requested when needed.

There were vending machines present in the department (out of order during our inspection) that relatives and carers could access and the hospital had a number of shops and places to purchase food. When we returned for our unannounced inspection a month later, the machines were fully functioning.

There were breast-feeding facilities available to allow privacy if required.

The trust had access to interpreting services for people whose first language was not English. Staff we spoke with told us that family members were sometimes used however; interpreting services were available if required via telephone. It is not best practice to use family members for a number of reasons including reliability of translation and patient confidentiality. Most staff were aware of how to access telephone interpreters.

The department had access to sign language interpreters for people living with hearing impairment.

There was a private relatives’ room at the entrance to the department. This was a pleasant environment with a telephone, tea and coffee making facilities and literature such as how to discuss a loved one’s death with a child and other practical advice.

When a patient passed away, whenever possible, they were moved to a side room so that family could have privacy to visit. There was no designated viewing room for relatives due to lack of space in the department.

Staff were aware of the possible cultural and religious differences within the local community when patients passed away. They were sensitive to the needs of the family and the community in those circumstances and understood what was required.

The staff we spoke with about patients living with dementia, or a learning disability all told us that they would treat patients as individuals and would try to involve family and carers in discussions...
about care needs. Dementia was a mandatory training module. Medical staff were 48% and nursing staff 88% compliant with training against a trust standard of 95%.

Some patients with learning disabilities had patient passports. When the patient or carer presented this at the department, staff used the information to assist them in making decisions about patient needs and wishes.

There was access to chaplaincy services for patients and relatives of different faiths or none.

Patients with only mental health needs waited in the mental health room or a cubicle close to the nursing station. These rooms had not been risk assessed at the time of inspection and were unsafe for patients at risk of self-harm or suicide. The designated mental health room had numerous ligature points, light furniture that could be used as a weapon and obscured vision in to the room because the window had been blocked. Staff told us they would risk assess every mental health patient who used the room and if necessary, remove the trolley and furniture and nurse the patient on a mattress on the floor if required. However, it would not be possible to remove all of the risks we identified.

Staff in the department had access to 24/7 psychiatric liaison support or child and adolescent mental health services (CAHMS). Young people needing support from CAMHS often had long waits to be seen. During our inspection, we saw a young person who was in the department for over 17 hours because they were waiting for the CAMHS team to see them. Any patient who presented with a mental health condition were referred to one of these teams.

Patients could access addiction services and there was an alcohol withdrawal pathway in place. We saw this being used during our inspection.

The trust offered staff training in conflict resolution as mandatory training however compliance figures were low with only 60% of nursing staff and 9% of medical staff having undergone the training against a target of 95%.

The department had a specific team who carried out a comprehensive assessment of frail or elderly patients present in the department with a view to carrying out a holistic assessment of their physical, mental and social needs and arranged safe discharge for them.

Access and flow

At the time of our inspection, we spoke with staff about waiting times. The department planned to introduce rapid assessment and treatment (RAT) in an effort to improve flow through the department. RAT involves a senior clinician (usually a consultant) working with a nurse to quickly make decisions about the care and treatment needs of patients. Using RAT can improve the flow of patients through the department and make sure the most poorly patients are seen quickly whilst less poorly patients can be sent to other departments or services, seen quickly, treated and discharged. Preliminary tests can also be requested so results are available when the patient is seen by a clinician.

Staff spoke with us about the problems they experienced with flow through the department. They explained that patients often had long waits within the department to be moved to a bed on a ward. This was because the hospital could not always discharge patients from wards efficiently
when the patients were well enough to do so. Staff also believed the hospital did not always have enough beds to meet the number of patients needing to be admitted or did not have a bed on the correct type of ward. Other examples of patients experiencing long waits included when the patient needed to be assessed for a mental health condition. Information below shows an increasing number of patients remaining in the department for more than four hours after a decision to admit was made.

When patients remain in the department in this way, it can cause delays for new patients coming in because there are no cubicles for them to be examined or receive treatment.

From our observations during the inspection over a one-hour period, walk in patients experienced waits of more than 15 minutes from checking in at the front desk to being seen in triage. National standards recommend that patients should be triaged within 15 minutes of arrival. This applies for both walk in patients and patients who arrive by ambulance. We looked at the information recorded by the trust. We had concerns that it did not accurately reflect the time patients waited for initial assessment. This was a concern at our previous inspection in 2016 when we told the department it must “Ensure medical and nursing staff use the computer system fully as intended so that patient real time events are recorded accurately and this is demonstrated through audit.”

We returned one month later to observe how long patients waited and how long was recorded on the IT system. We found that the times recorded matched the times we observed.

Information provided by the trust showed that patients arriving by ambulance on average waited 17 minutes to be handed over to ED staff. However up to 33% were waiting longer than 15 minutes for a handover from ambulance staff to hospital staff. Guidance issued by the CQC’s Chief Inspector of Hospitals states that handover should take place as quickly as possible and within 15 minutes. It also clearly states that patients’ care and treatment become the responsibility of the trust once handover has taken place. During our inspection we observed patients on trolleys and in wheelchairs waiting to have their initial assessment. They had been waiting for more than 15 minutes. Staff told us that when there was an influx of ambulance patients, there was a lack of use of triage to place patients well enough not to be on a trolley in to the waiting room.

Staff told us that patient waits to be seen by specialist staff such as surgeons or from other disciplines and departments were usually not too long. Physicians visited the department regularly to clerk in patients so patients were ready for transfer to the medical wards. The department also had some pathways in place, such as a fractured neck of femur (hip) pathway that meant patients could be transferred more quickly once a bed was available.

Staff also told us the department had good links with the intensive care unit and anaesthetists and intensivists came to the department if needed.

We saw patients were not moved from ED trolleys to hospital beds if they had long waits. This increased their risk of developing pressure damage.

**Median time from arrival to treatment (all patients)**

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust met the standard for all months over the 12-month period from April 2017 to March 2018.
From April 2017 to March 2018 performance against this standard followed an even trend with small variances month on month. We had some concerns about the validity of this information as it did not correlate with what we saw on inspection and was significantly different to the England average. At inspection we saw patients waiting longer than 10 minutes from arrival to initial assessment and by definition, longer than 10 minutes for treatment. We requested clarification from the trust who provided us with evidence to show patients waited an average of 59 minutes to see a doctor.

Trust performance was consistently much better than the England median, with patients waiting from 44 to 50 minutes less than the England median.

Median time from arrival to treatment from April 2017 to March 2018 at North Cumbria University Hospitals NHS Trust

(Source: NHS Digital - A&E quality indicators)

Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

From April 2017 to March 2018 the trust failed to meet the standard and performed mostly better than the England average.

From April 2017 to March 2018 performance followed a deteriorating trend. Rates were consistently better than the England average and followed an even trend from May to November 2017, although rates deteriorated from December 2017 to worse than the England average in January 2018. Although performance improved in February 2018, rates decreased again in March 2018.

During our inspection we saw patients in the department for more than four hours.
Four-hour target performance - North Cumbria University Hospitals NHS Trust

(Source: NHS England - A&E waiting times)

Percentage of patients waiting more than four hours from the decision to admit until being admitted

From April 2017 to March 2018 the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was mostly better than the England average.

From April 2017 to March 2018 performance followed a deteriorating trend, with an increase in percentages during the winter months of December 2017 and January 2018. Rates improved to below the England average in February 2018, although percentages increased again in March 2018.

Percentage of patients waiting more than four hours from the decision to admit until being admitted - North Cumbria University Hospitals NHS Trust


Number of patients waiting more than 12 hours from the decision to admit until being admitted

Over the 12 months from April 2017 to March 2018, two patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours
were in January 2018, no patients waited longer than 12 hours to be admitted for the remaining 11 months in the period.

During our time in the department we saw one patient waiting more than 12 hours from decision to admit. This was a patient who needed support from child and adolescent mental health services (CAMHS).

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients waiting more than four hours to admission</th>
<th>Number of patients waiting more than 12 hours to admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-17</td>
<td>189</td>
<td>0</td>
</tr>
<tr>
<td>May-17</td>
<td>223</td>
<td>0</td>
</tr>
<tr>
<td>Jun-17</td>
<td>124</td>
<td>0</td>
</tr>
<tr>
<td>Jul-17</td>
<td>106</td>
<td>0</td>
</tr>
<tr>
<td>Aug-17</td>
<td>168</td>
<td>0</td>
</tr>
<tr>
<td>Sep-17</td>
<td>204</td>
<td>0</td>
</tr>
<tr>
<td>Oct-17</td>
<td>198</td>
<td>0</td>
</tr>
<tr>
<td>Nov-17</td>
<td>215</td>
<td>0</td>
</tr>
<tr>
<td>Dec-17</td>
<td>406</td>
<td>0</td>
</tr>
<tr>
<td>Jan-18</td>
<td>571</td>
<td>2</td>
</tr>
<tr>
<td>Feb-18</td>
<td>303</td>
<td>0</td>
</tr>
<tr>
<td>Mar-18</td>
<td>527</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: NHS England - A&E waiting times)

**Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment**

From April 2017 to March 2018 the monthly median percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was slightly better than the England average. Performance followed a stable trend with small variances month on month. Trust performance was on average only 0.5% better than the England average over the period.

**Percentage of patient that left the trust’s urgent and emergency care services without being seen - North Cumbria University Hospitals NHS Trust**

![Graph showing percentage of patients leaving urgent and emergency care services before being seen](image)
Median total time in A&E per patient (all patients)

From April 2017 to March 2018 the trust’s monthly median total time in A&E for all patients was lower than the England average. The performance against this metric showed a slight increase in trend over this time period.

The longest median time spend in A&E at the trust were reported during the winter months of December 2017 and January 2018.

Median total time in A&E per patient - North Cumbria University Hospitals NHS Trust

We asked the trust for additional information about patient waiting time to treatment. The trust sent us information which showed that 50% of patients saw a clinician within 60 minutes of arrival, 70% waited less than 90 minutes to see a clinician and 80% waited less than 120 minutes (two hours) to see a clinician.

Learning from complaints and concerns

Summary of complaints

Cumberland Infirmary

From April 2017 to March 2018 there were 24 complaints about urgent and emergency care services at Cumberland Infirmary.

Most complaints were about medical staff (83%) while 13% of complaints were about nursing staff.

Out of the 24 complaints two were re-opened and re-closed within 30 days. Eight complaints
(33%) were upheld, eight (33%) were partially upheld, seven (29%) were refuted and one complaint was transferred to serious incidents.

Themes from the 24 complaints are shown in the table below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment / care - outpatient</td>
<td>11</td>
<td>46%</td>
</tr>
<tr>
<td>Treatment / care - inpatient</td>
<td>9</td>
<td>38%</td>
</tr>
<tr>
<td>Attitude of staff</td>
<td>2</td>
<td>8%</td>
</tr>
<tr>
<td>Access &amp; environment</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>Information &amp; communication</td>
<td>1</td>
<td>4%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

It was unclear from the information sent to us by the trust what action the trust took to address any issues emerging from complaints, such as speaking with staff or changing practice or procedures.

Patients and relatives, we spoke with were aware of how to make a complaint to the trust although none of the people we spoke with had made a complaint about the department. Patients were very complimentary about the department.

There was information about how to raise concerns about the department or the trust on display in the department and there were leaflets available for patients to take away with them.

Staff could describe to us the action they would take if a patient or relative complained to them. Staff would attempt to resolve any concerns but escalate to their line manager when this was unsuccessful.

Staff and managers told us that feedback was given to staff when they were part of a complaint. Additional training was offered as a way of supporting staff when the issue related to clinical care.

Information about complaints and incidents was discussed with staff at team meetings.

**Number of compliments made to the trust**

The trust was unable to provide data broken down per core service about the number of compliments received.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

**Is the service well-led?**

**Leadership**

The CIC emergency department (ED) was overseen by a chief matron, a matron, a general manager, a business manager and an associate medical director (AMD). The AMD was covering this work at the time of our inspection as the trust was in the process of recruiting to the clinical director role. The team told us that they were very proud of the resilience of the ED staff, although
they were unable to tell us the exact number of staff working in the department or the current number of vacancies at the time of our inspection.

At our follow-up unannounced inspection one month later, the clinical director had been appointed. When we spoke with them, they had many ideas about how to introduce new ways of working in to the department based on their previous experience working for different organisations.

Staff we spoke with in the ED gave a mixed response when asked about the visibility of the senior leadership team (SLT), with some describing them as very visible, and others saying that they were mostly absent from the ED and focused on other parts of the trust. The business manager, was present in the department during our inspection, and interacted with other staff, who clearly knew them. The chief matron and associate medical director did not come to the CIC department during our inspection.

Nursing staff we spoke with gave us mixed information about line management arrangements and who they could escalate concerns to. We therefore had concerns that nursing leadership in the department was not as strong and clearly defined as it could be.

The ED had a senior nurse lead who oversaw the daily management and requirements of the department. We met this person and found they were clearly focused on the challenges of the department in respect of performance and demand. They led a hard-working team committed to the ED and its patients.

Nursing staff we spoke with during the inspection told us that they felt well-led at a local level and had no concerns about their line management. They told us that the local management team was approachable and supportive.

Similarly, medical staff told us that their local leadership was supportive, inclusive, and provided good direction within the department and strong representation for the department within the trust. There was a lead consultant in the ED; a role which rotated six-monthly. Junior doctors were supported by their senior colleagues, mentors and education supervisors.

**Vision and strategy**

The trust had developed clear objectives and aims for 2018/19 in its This Is Us: Aims for the future document, which focused on four areas of priority for the year: staff; system working; service quality; and sustainable finances. The trust’s website displayed its vision, mission, and values.

The management team at CIC emergency department (ED) told us there was currently no formal ED vision/strategy in place (AMD advised this was to be prepared jointly with its trust partner following merger. However, plans had recently been approved for a building extension to accommodate more clinic rooms and a new children’s waiting room.

An emergency medicine and acute medicine strategy group had been formed. We saw minutes from these meetings, which included a draft of “Eight high impact system changes to improve medical patient safety”.

Managers in the ED were aware of the changing and increasing demands on the department and the types of issue that patients accessing the department were presenting with.
**Culture**

Senior staff were enthusiastic about their roles. They had clear plans to improve patient care. Clinical leads demonstrated knowledge, skills, and experience. There was a clear framework of responsibility and accountability. Staff at all levels understood their level of accountability and responsibility.

In the emergency department at CIC, staff we spoke with were passionate about the quality of care that they delivered. They were proud of the department, and described their commitment to deliver the best possible care.

We spoke with a number of staff from different disciplines about the culture of the department. Some staff expressed concerns about staffing levels. They felt that, particularly nurse staffing levels were not sufficient to meet the needs of patients but they had been instructed not to submit these concerns as incidents.

The NHS staff survey outcomes for 2017 showed a 54.4% return rate for the trust and reflected some of the feelings expressed by staff. The survey was made up of 88 questions separated into five themes. We found that, compared with 2016, 13 out of 88 questions showed outcomes that were significantly better, 72 showed no change, and three were significantly worse.

The top three findings from the NHS staff survey outcomes for 2017 compared to other acute trusts were the ‘percentage of staff appraised’, the ‘percentage of staff working extra hours’ and the ‘percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months’.

The lowest three findings from the NHS staff survey outcomes for 2017 compared to other acute trusts were ‘quality of appraisals’, ‘support from immediate managers’ and ‘percentage of staff reporting good communication between senior management and staff’. These results showed there was some improvement work to do.

Staff told us that they felt able to suggest new ways of working and to try new things to improve patient experience or the efficiency of the department.

Health care assistants, junior doctors, and nurses told us senior clinicians were keen to educate colleagues. They thought there was a very good learning culture and were very comfortable to ask questions to broaden their knowledge.

The atmosphere in the department showed that the focus of staff was on treating patients in an efficient way however staff also took time to support each other through difficult and stressful times.

The way we saw staff interact with each other demonstrated that there was professional communication between staff from different disciplines.

Staff we spoke with told us they could report concerns and incidents (other than concerns about staffing levels) without fear of reprisals and were confident that when issues were raised, they were dealt with appropriately.
If staff made errors they could report them and were confident they would be supported and managed fairly. Managers told us there was a strong culture of self-reporting within the department.

Staff felt that their hard work was recognised and they felt appreciated by their colleagues.

The department had security staff on duty 24 hours a day, every day. Access to the department was restricted and people could only enter using a swipe card or by being allowed entry by a member of staff. The department could be locked down easily in an emergency situation.

**Governance**

The senior management team told us that divisional management meetings, operational team meetings, and clinical governance meetings took place regularly. The risk register, incidents, complaints, and lessons learned were discussed. Matrons and ward managers disseminated information to staff via meetings and daily huddles, and notices on staff boards. We reviewed monthly divisional governance and safety and quality board meeting minutes for January and February 2018, which corroborated this.

We reviewed minutes from the emergency medicine operational board (EMOB) meetings. These covered strategic, operational, divisional, and business-unit items. The meeting chair updated action plans following the meeting, and these plans were revisited as a standing agenda item at subsequent meetings. We saw that sepsis pathways and delays in treatment for stroke patients were discussed.

We had concerns that there was a disconnect between senior management arrangements and the frontline staff working daily in the department. We were concerned that senior management were not fully sighted on the challenges face by front line staff and that governance did not flow to and from front line staff.

We had concerns about the governance of medicines. These concerns were identified in the trust’s medicines optimisation strategy for 2014 to 2019. The strategy outlined seven strategic challenges the trust must overcome to ensure delivery of safe and effective use of medicines, and described some early signs of improvement. Our observations of practice around medicines highlighted further work was needed.

Clinical audit reporting arrangements flowed from the monthly dashboard, via the emergency medicine operational board (EMOB), and the safety and quality committee, to the trust board.

The trust had appointed two ‘sepsis lead’ nurses in 2016, and the CIC ED had a named ‘sepsis champion’ nurse.

**Management of risk, issues and performance**

We examined the emergency department (ED) risk register. Senior managers confirmed that the risk register was a live document which was subject to ongoing review. They described their main areas of concern as sepsis screening and management, meeting the four-hour standard, and flow into and from the department.
The risk register cited flow, overcrowding, meeting the four-hour standard, corridor waits, accessibility of CAHMS, triage time and quality as the major risks for ED trust-wide. These were the issues that staff we spoke with in the department also felt were of greatest concern.

However, there were other issues not on the risk register that we identified as concerns. These included; use of the IT system to record timely information, nurse staffing, ambulance handovers and black breaches.

**Information management**

The trust had information governance policies and procedures in place to ensure that information was stored securely and protected patients' privacy and security. Information governance was a module of mandatory training. Nursing staff were 67% compliant and medical staff were 95% compliant against a trust target of 95%.

The department collected information used to monitor and manage performance. There were measures in place to monitor and manage the performance of the department against local and national indicators. These were closely observed by the management team. We carried out checks to make sure information recorded reflected actual activity accurately and found that it did.

The department used a number of IT systems to collect and share information such as test and x-ray results, admission and discharge times and ambulance handover times as well as patient records.

Staff were able to access patient information using an electronic system. This included information such as previous clinic letters, test results and x-rays. Staff could also access patient GP records with the agreement of the patient. This meant that staff had information about the most up to date medications, health conditions and symptoms to enable them to make a better diagnosis and treatment plan.

Some information such as test results and discharge letters were shared with GPs with the consent and agreement from patients.

Patients transferred to other services or sites took photocopies of their medical records with them.

Staff were aware of their responsibilities in relation to data protection and making sure that information was accurate and managed securely.

Overall, data protection principles were followed however, we did witness one terminal with patient information left unattended on three occasions.

Information governance including data protection and confidentiality was monitored and any incidents reported appropriately.

**Engagement**

The department participated in the friends and family test and CQC surveys.
Patients and those close to them could provide feedback on the CIC ED via the friends and family test (FFT) and the ‘two minutes of your time’ survey. They could also leave feedback on comments cards. Staff told us they promoted these methods of feedback to patients where possible. Information about giving feedback, including via PALS, was also displayed in the waiting areas, provided in leaflets, and available on the trust website.

Information about local and national charities and support groups was also on display. To collect staff feedback, the trust chief executive had held roadshows, and the senior leadership team had arranged staff forums and drop-in sessions. Staff we spoke with were aware of these sessions but told us it was often difficult to find time away from the ED to attend.

Staff were provided with information updates from senior managers via the trust intranet, email, and team meetings.

The FFT found that 57 out of 251 staff responding recommended the trust as a place to work.

Learning, continuous improvement and innovation

There had been some innovative initiatives to attract new staff including creating consultant posts with time on the air ambulance. This had led to two new consultants moving to the trust (one to CIC).

The trust had employed two sepsis lead nurses to support staff and ensure sepsis management was high on the agenda of staff.

We saw evidence that the department undertook work as a result of incidents to support staff learning.
Medical care (including older people’s care)

Facts and data about this service

The medical care service at North Cumbria University Hospitals NHS Trust (NCUH) provides care and treatment for:

- Care of the elderly (including a frailty assessment unit at Cumberland Infirmary)
- Stroke services including thrombolysis
- Neuro rehabilitation (Cumberland Infirmary only)
- Gastroenterology (including endoscopy)
- Renal (including renal dialysis unit)
- Cardiology and Coronary Care Unit (CCU) (Including the Heart Centre and Catheterisation Laboratory (Cath Lab) at Cumberland Infirmary)
- Respiratory care

(Source: Routine Provider Information Request (Acute) context)

There are 335 medical inpatient beds located across 19 wards. Cumberland Infirmary (CIC) held 13 wards with 220 of the 335 inpatient beds.

A site breakdown can be found below:

Cumberland Infirmary

- Beech A ward - 14 beds
- Beech B ward – 23 beds
- Cardiology and Coronary Care Unit (CCU) – six beds
- Elm A ward - 12 beds
- Elm B ward – 30 beds
- Elm C ward – 12 beds
- Larch and B wards – 30 beds
- Maple A ward – 17 beds
- Heart centre – 12 beds
- Willow A ward – 24 beds
- Willow B ward – 18 beds
- Willow C ward – 22 beds

The trust had 35,069 medical admissions from January 2017 to December 2017. Emergency admissions accounted for 20,126 (57%), 587 (2%) were elective, and the remaining 14,356 (41%) were day case.

Admissions for the top three medical specialties were:

- General medicine – 18,266
- Gastroenterology – 5,630
• Clinical oncology – 4,150

(Source: Hospital Episode Statistics)

Following a comprehensive inspection in 2016, the trust was required to complete the following actions:

The service must:

• Ensure care and treatment of service users is appropriate, meets their needs and reflects their preferences. Specifically, ensure the endoscopy pathway design meets service user preferences and care or treatment needs
• Ensure systems and processes are established and operated effectively to assess, monitor and improve the quality and safety of the services provided, and, evaluate and improve practice to meet this requirement. Specifically, review the escalation process involving ‘floor working’ to ensure the quality and safety of services are maintained; and,
• Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed across all divisional wards. Specifically, registered nurses to ensure safe staffing levels are maintained, especially in areas of increased patient acuity, such as non-invasive ventilation care and thrombolysis.

The service should:

• Continue to progress patient harm reduction initiatives;
• Revisit the ‘floor working’ initiative, particularly across Elm wards;
• Revisit thrombolysis cubicle bed utilisation to reduce potential unnecessary, inappropriate or inconvenient bed moves;
• Ensure IPC compliance improvement and consistency in standards, regarding catheter and cannula care;
• Ensure best practice guidelines for medicines related documentation is reinforced to all prescribers;
• Ensure oxygen prescribing is recorded and signed for accordingly;
• Ensure medicines management training compliance improves in line with trust target;
• Ensure National Early Warning Score (NEWS) trigger levels are adhered to (or document deviation/individual baseline triggers in the clinical records);
• Ensure fluid and food chart documentation is accurate to reflect nutritional and hydration status;
• Ensure staff are given time to complete all necessary mandatory training modules and an accurate record kept;
• Ensure all equipment checks are completed in line with local guidance;
• Continue to proactively recruit nursing and medical staff, considering alternate ways to attract, such as utilising social media;
• Ensure measures are put in place to support units where pending staffing departures will temporarily increase vulnerability;
• Ensure food satisfaction standards are maintained and where relevant improved;
• Develop an action plan to detail objectives to improve and progress diabetes care across the division;
• Evidence improvements in patient outcomes for respiratory patients around time to senior review and oxygen prescribing;
• Ensure all staff can access development opportunities in line with organisational/staff appraisal objectives protecting/negotiating study time where required;
• Ensure appraisal rate data recorded at trust level coincides with figures at divisional/ward level;
• Revisit the patient journey, booking and listing procedures at the endoscopy suite at the Cumberland Infirmary
• Continue to minimise patient moves after 10pm;
• Continue to work with community colleagues to develop strategies to minimise delayed transfers of care (DTOC) and unnecessary lengthy hospital stays for patients medically fit for discharge;
• Reinforce the benefits of dementia initiatives to ensure consistency of practice;
• Ensure the risk register is current and reflects actual risks with corresponding accurate risk rating; Ensure all actions and reviews of risk ratings are documented;
• Ensure progress continues against the quality improvement plan (QIP), realign completion dates and account for deadline breaches;
• Revisit medical rota management processes for junior doctors;
• Revisit modes of communications with staff to ensure efficiency whilst avoiding duplication;
• Ensure staff involved in change management projects are fully informed of the aims and objectives of the proposal and these are implemented and concluded in appropriate timeframes; and,
• Ensure divisional leads and trust leaders promote their visibility when visiting wards and clinical areas.

During our inspection, we spent time at CIC visiting all wards and clinical areas managed by the medical team. We spoke with 49 members of staff (including managers, doctors, nurses, therapists, pharmacists and non-clinical staff). Where appropriate we considered care and medication records (including electronically stored information) and completed 38 reviews. Our team met with 41 patients and relatives, observed shift handovers, multi-disciplinary team meetings (MDT), safety huddles, meal times and care being delivered at various time of the day and night.

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

Mandatory training completion rates

The trust set a target of 95% for completion of mandatory training. Ward staff told us there were occasional difficulties booking onto courses because they only accommodated 12 staff at any one time. Staff also told us that there was no time during working hours and came in on their days off to complete the training. All staff told us they would be paid for this time.
Trust level

The trust submitted data prior to inspection which showed the mandatory target was not met for 23 of the 26 mandatory courses. A breakdown of compliance for mandatory training courses as at March 2018 at trust level for qualified nursing staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving &amp; handling level 1 clinical (3 yearly)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, trips and falls level 1</td>
<td>303</td>
<td>294</td>
<td>97%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk management</td>
<td>303</td>
<td>292</td>
<td>96%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>303</td>
<td>285</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Duty of candour</td>
<td>303</td>
<td>282</td>
<td>93%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>303</td>
<td>280</td>
<td>92%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety</td>
<td>303</td>
<td>278</td>
<td>92%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines management</td>
<td>297</td>
<td>271</td>
<td>91%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>303</td>
<td>275</td>
<td>91%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>303</td>
<td>275</td>
<td>91%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia</td>
<td>274</td>
<td>244</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent level 1 &amp; 2</td>
<td>303</td>
<td>263</td>
<td>87%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Hand hygiene (clinical)</td>
<td>303</td>
<td>259</td>
<td>85%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Calculating drug doses</td>
<td>295</td>
<td>251</td>
<td>85%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control level 2</td>
<td>303</td>
<td>254</td>
<td>84%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health records management</td>
<td>303</td>
<td>242</td>
<td>80%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>News</td>
<td>235</td>
<td>177</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; handling level 2</td>
<td>301</td>
<td>213</td>
<td>71%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 01</td>
<td>290</td>
<td>190</td>
<td>66%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>ILS (adults)</td>
<td>235</td>
<td>149</td>
<td>63%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 02</td>
<td>290</td>
<td>181</td>
<td>62%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk management (board and senior management)</td>
<td>58</td>
<td>36</td>
<td>62%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>220</td>
<td>130</td>
<td>59%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Understanding end of life</td>
<td>303</td>
<td>176</td>
<td>58%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>BLS (adults)</td>
<td>52</td>
<td>28</td>
<td>54%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, trips and falls level 2</td>
<td>300</td>
<td>102</td>
<td>34%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In medicine the 95% target was met for three of the 26 mandatory training modules for which qualified nursing staff were eligible. Moving and handling level 1 clinical (3 yearly) had a 100% completion rate although there was only one staff member eligible to complete this training.

Apart from the three modules that met the 95% target, there were a further seven modules that had a completion rate above 90%.

The trust submitted data prior to the inspection which showed the trust target was not met for 25 of the 29 courses. A breakdown of compliance for mandatory training courses from as at March 2018 at trust level for medical staff in medicine is shown below:
### Cumberland Infirmary medicine department

A breakdown of compliance for mandatory training courses as at March 2018 for qualified medical professionals:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALS (adults)</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Hand hygiene (non-clinical)</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control level 1</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving &amp; handling level 1 non-clinical (3 yearly)</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>NG tubes</td>
<td>21</td>
<td>17</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>45</td>
<td>36</td>
<td>80%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; handling level 1 clinical (3 yearly)</td>
<td>43</td>
<td>31</td>
<td>72%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Hand hygiene (clinical)</td>
<td>43</td>
<td>29</td>
<td>67%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>News</td>
<td>37</td>
<td>24</td>
<td>65%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Calculating drug doses</td>
<td>34</td>
<td>22</td>
<td>65%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines management</td>
<td>34</td>
<td>21</td>
<td>62%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, trips and falls level 1</td>
<td>45</td>
<td>27</td>
<td>60%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk management</td>
<td>45</td>
<td>26</td>
<td>58%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>42</td>
<td>24</td>
<td>57%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Duty of candour</td>
<td>45</td>
<td>25</td>
<td>56%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia</td>
<td>43</td>
<td>23</td>
<td>53%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>45</td>
<td>24</td>
<td>53%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent level 1&amp;2</td>
<td>45</td>
<td>23</td>
<td>51%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Trust doctors patient safety programme</td>
<td>43</td>
<td>21</td>
<td>49%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>45</td>
<td>21</td>
<td>47%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety</td>
<td>45</td>
<td>21</td>
<td>47%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health records management</td>
<td>45</td>
<td>21</td>
<td>47%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>BLS (adults)</td>
<td>25</td>
<td>11</td>
<td>44%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control level 2</td>
<td>43</td>
<td>16</td>
<td>37%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 01</td>
<td>20</td>
<td>5</td>
<td>25%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 03</td>
<td>2</td>
<td>0</td>
<td>0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>1</td>
<td>0</td>
<td>0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>ILS (adults)</td>
<td>2</td>
<td>0</td>
<td>0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevention of suicide</td>
<td>1</td>
<td>0</td>
<td>0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In medicine the 95% target was met for four of the 29 mandatory training modules for which medical staff were eligible. Although four modules had completions rates of 100%, the number of staff eligible for these training modules were low; only two staff members for each of the four modules were required to complete the training.

Four modules had a 0% completion rate, although this relates to only one to two staff members that did not complete the training.
nursing staff in the medicine department at the Cumberland Infirmary is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving &amp; handling level 1 clinical (3 yearly)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk management</td>
<td>226</td>
<td>220</td>
<td>97%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, trips and falls level 1</td>
<td>226</td>
<td>220</td>
<td>97%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>226</td>
<td>216</td>
<td>96%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Duty of candour</td>
<td>226</td>
<td>213</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>226</td>
<td>212</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety</td>
<td>226</td>
<td>208</td>
<td>92%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines management</td>
<td>220</td>
<td>202</td>
<td>92%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>226</td>
<td>207</td>
<td>92%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>226</td>
<td>205</td>
<td>91%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia</td>
<td>197</td>
<td>176</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent level 1&amp;2</td>
<td>226</td>
<td>197</td>
<td>87%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Calculating drug doses</td>
<td>218</td>
<td>189</td>
<td>87%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Hand hygiene (clinical)</td>
<td>226</td>
<td>193</td>
<td>85%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control level 2</td>
<td>226</td>
<td>191</td>
<td>85%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health records management</td>
<td>226</td>
<td>183</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>News</td>
<td>175</td>
<td>140</td>
<td>80%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; handling level 2</td>
<td>224</td>
<td>158</td>
<td>71%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>ILS (adults)</td>
<td>169</td>
<td>110</td>
<td>65%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 01</td>
<td>213</td>
<td>137</td>
<td>64%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 02</td>
<td>213</td>
<td>129</td>
<td>61%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>151</td>
<td>91</td>
<td>60%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk management (board and senior management)</td>
<td>45</td>
<td>27</td>
<td>60%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Understanding end of life</td>
<td>226</td>
<td>129</td>
<td>57%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>BLS (adults)</td>
<td>44</td>
<td>24</td>
<td>55%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, trips and falls level 2</td>
<td>224</td>
<td>82</td>
<td>37%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

At the Cumberland Infirmary medicine department, the 95% target was met for four of the 26 mandatory training modules for which qualified nursing staff were eligible. Moving and handling level 1 clinical (3 yearly) had a 100% completion rate, although there was only one staff member eligible for this training.

Apart from the four modules that met the 95% training completion target, a further six modules had completion rates above 90%.

Ward managers stated that, where there were identified shortfalls in mandatory training, staff were booked to attend the relevant session. Ward managers kept an internal, ward-level list of key mandatory training dates.

Many ward staff completed e-learning mandatory training modules at home to minimise time off the ward.
A breakdown of compliance for mandatory training courses as at March 2018 for medical staff in the medicine department at the Cumberland Infirmary is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand hygiene (non-clinical)</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Infection control level 1</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Moving &amp; handling level 1 non clinical (3 yearly)</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>NG tubes</td>
<td>19</td>
<td>15</td>
<td>79%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Information governance</td>
<td>35</td>
<td>26</td>
<td>74%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Slips, trips and falls level 1</td>
<td>35</td>
<td>25</td>
<td>71%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Risk management</td>
<td>35</td>
<td>24</td>
<td>69%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Hand hygiene (clinical)</td>
<td>33</td>
<td>22</td>
<td>67%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Duty of candour</td>
<td>35</td>
<td>23</td>
<td>66%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Calculating drug doses</td>
<td>32</td>
<td>21</td>
<td>66%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>32</td>
<td>21</td>
<td>66%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Medicines management</td>
<td>32</td>
<td>21</td>
<td>66%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Dementia</td>
<td>33</td>
<td>21</td>
<td>64%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Moving &amp; handling level 1 clinical (3 yearly)</td>
<td>33</td>
<td>21</td>
<td>64%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Fire safety</td>
<td>35</td>
<td>22</td>
<td>63%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Prevent level 1&amp;2</td>
<td>35</td>
<td>21</td>
<td>60%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>News</td>
<td>27</td>
<td>16</td>
<td>59%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Trust doctor’s patient safety programme</td>
<td>33</td>
<td>19</td>
<td>58%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>35</td>
<td>19</td>
<td>54%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Health and safety</td>
<td>35</td>
<td>19</td>
<td>54%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Health records management</td>
<td>35</td>
<td>19</td>
<td>54%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Blood safety 01</td>
<td>10</td>
<td>5</td>
<td>50%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>BLS (adults)</td>
<td>25</td>
<td>11</td>
<td>44%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Infection control level 2</td>
<td>33</td>
<td>14</td>
<td>42%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Blood safety 03</td>
<td>2</td>
<td>0</td>
<td>0%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>1</td>
<td>0</td>
<td>0%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>ILS (adults)</td>
<td>2</td>
<td>0</td>
<td>0%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Prevention of suicide</td>
<td>1</td>
<td>0</td>
<td>0%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

At the Cumberland Infirmary medicine department, the 95% target was met for three of the 28 mandatory training modules for which medical staff were eligible. Although three modules had a 100% training completion rate, the number of staff members eligible for this training were low, only two staff members for each of the three modules were required to complete this training.

Four modules had a 0% completion rate, although this relates to only one to two staff members that did not complete the training.
The medical care division were restructuring its regular medical teaching by moving from Fridays to Tuesdays to capture more junior doctors. We were advised this included a hot topics board, more advanced clinical simulation and problem solving, including complex prescribing.

**Safeguarding**

**Safeguarding training completion rates**

The trust set a target of 95% for completion of safeguarding training.

**Trust level**

A breakdown of compliance for safeguarding training courses from as at March 2018 at trust level for **qualified nursing staff** in medicine is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults level 1</td>
<td>303</td>
<td>264</td>
<td>87%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>294</td>
<td>258</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 3 (core)</td>
<td>9</td>
<td>8</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In medicine the 95% target was not met for any of the safeguarding training modules for which qualified nursing staff were eligible. Safeguarding children level 3 (core) had a completion rate of 89% although this relates to only one staff member not completing the training.

A breakdown of compliance for safeguarding training courses from as at March 2018 at trust level for **medical staff** in medicine is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 1</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>45</td>
<td>20</td>
<td>44%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>43</td>
<td>19</td>
<td>44%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In medicine the 95% target was met for one of the three safeguarding training modules for which medical staff were eligible. Safeguarding children level 1 had a 100% completion rate, although staff numbers eligible for this training were low with only two staff members required to complete this training.

The trust set a target of 95% for completion of safeguarding training. We were not assured that safeguarding training was delivered in accordance with Adult Safeguarding Levels And Competencies For Healthcare, Intercollegiate guidance (2016)’. Training data submitted by the trust prior to inspection, showed that all staff appear to be completing level one adults safeguard training. This includes managers investigating safeguarding alerts. Intercollegiate guidance (2016) recommends level two training for clinical staff and level three for staff responsible for the
review of alerts. We reviewed the trusts adults safeguard policy and saw that all clinical staff working with adults should complete level two adults safeguarding training. Staff are instructed to inform their line managers when raising alerts, but the policy does not provide guidance for line managers to support any further action and no additional training is provided.

Cumberland Infirmary medicine department

A breakdown of compliance for safeguarding training courses as at March 2018 for qualified nursing staff in the medicine department at the Cumberland Infirmary is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 2</td>
<td>217</td>
<td>194</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 3 (core)</td>
<td>9</td>
<td>8</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>226</td>
<td>196</td>
<td>87%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

At the Cumberland Infirmary medicine department, the 95% target was not met for any of the safeguarding training modules for which qualified nursing staff were eligible. Safeguarding children level 3 (core) had a completion rate of 89% although this relates to only one staff member not completing the training.

A breakdown of compliance for safeguarding training courses as at March 2018 for medical staff in the medicine department at the Cumberland Infirmary is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 1</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>33</td>
<td>17</td>
<td>52%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>35</td>
<td>18</td>
<td>51%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

At the Cumberland Infirmary medicine department, the 95% target was met for one of the three safeguarding training modules for which medical staff were eligible. Safeguarding children level 1 had a 100% completion rate, although staff numbers eligible for this training were low with only two staff members required to complete this training.

The trust had an executive lead and a designated safeguarding lead across the organisation and senior divisional staff were involved in safeguarding board meetings.

We observed safeguarding policies and procedures on display in designated staff areas of wards. This information included process guidance, where to seek specialist advice, and key contact details for escalation and further advice.

All staff we spoke with were aware who their safeguarding lead was, how to contact them and when it was appropriate to raise a safeguarding concern. Staff explained that training was delivered through electronic learning and some staff told us they could complete electronic
We were not assured that safeguarding training was delivered in accordance with Adult Safeguarding Levels and Competencies for healthcare, Intercollegiate guidance (2016). Training data submitted by the trust prior to inspection showed that managers investigating safeguarding alerts received safeguarding adults training level two. Intercollegiate guidance recommends level three for staff responsible for the review of alerts.

**Cleanliness, infection control and hygiene**

The division followed the trust infection control procedures and infection, prevention and control (IPC) staff provided a seven-day service with on-site presence and telephone advice.

The trust healthcare associated infection (HCAI) prevention and control strategy was underpinned by national guidelines and IPC policies, to manage and monitor infection essential for patient and staff safety.

All areas we inspected were visibly clean and we saw infection prevention control compliance figures for individual wards displayed on the walls. Wards we visited displayed the number of and date of last case of Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C. diff).

The wards displayed clear instructions and signage to encourage staff and visitors to wash their hands on entering the ward. The signage was repeated throughout the ward environments, and there were numerous washbasins for handwashing. Wards provided wall mounted gel and soap for ease of use.

Regular monthly audits of hygiene and handwashing was undertaken on all wards, typically by the wards themselves, but also by the infection control staff. We found that hygiene and handwashing audits were consistently good. There was a rolling programme of hand washing reminders and education at induction for all new starters.

We observed staff carrying out hand washing prior to and after patient contact. However, over a few minutes observation on one ward (with 100% hand hygiene compliance) we observed a junior doctor, a nurse, an occupational therapist and a domestic enter a cubicle without using hand sanitiser. Staff adhered to the “bare below the elbow” protocol.

Staff told us that they had sufficient access to personal protective equipment (PPE), such as disposable gloves and gowns, was available to staff. Staff used PPE appropriately.

Rooms were available on all wards for the isolation of patients, with signage in place to advise anyone before entering an isolation room. We saw across several wards extensive deep cleaning processes in place including air purification processes.

All clinical and non-clinical areas had cleaning rotas, and all equipment that we checked was visibly clean. All clean utility areas and treatment rooms were visibly clean and tidy. We observed that clinical waste and sharps were disposed of appropriately.
Junior Medical staff were trained in appropriate insertion and management of peripheral vascular devices (cannula) prior to commencement of employment within the trust and attended refresher sessions when an update was required. For all other staff, including nurses, who require cannulation training, NCUH provided e-learning followed by practical face to face training. Staff were expected to attend an update every three year.

Since the last inspection the trust had implemented an improvement plan which included a review of the e-learning package and targeted educational sessions within clinical areas to reinforce compliance with the trust policy. In addition to this, we found that post infection reviews and discussions took place to disseminated information of all attributed bacteraemia cases within the organisation. A cannulation meeting (to drive the improvement plan) was maintained to raise continuity.

The trust had an Adult Cannulation policy and Aseptic Non-Touch Technique (ANTT) policy on the intranet which staff must comply with. Cannula audits were carried out monthly on all wards and departments.

The first cannula prevalence audit was completed in July 2017 and compared to the December 2017 audit, with the aim of demonstrating improvement since the initiatives were implemented. Some aspects of the repeat audit had shown an improvement; however, further improvement is required.

We reviewed the improvement plan dated June 2018 in relation to urinary catheter insertion rates and associated infections and saw the average number of patients at NCUH who are recorded as having a new patient harm from a catheter associated UTI was 2%, which was higher than the national average of 1%. The trust outlined plans to reduce the number of patients with a urinary catheter within the improvement plan.

Environment and equipment

The divisional wards were situated in the main building at the Cumberland Infirmary. There had been investment to improve internal facilities, and there had been a reconfiguration in ward layout. The heart centre was situated in a separate area, adjacent to the main entrance of the hospital. Reiver House, the chemotherapy day unit at Cumberland Infirmary, was in a relatively new building within the hospital grounds.

All equipment inspected had been electrical safety tested. The trust had systems in place for recording the service and maintenance of equipment identified through compliance stickers.

Staff confirmed there was adequate equipment to meet the needs of patients, e.g. moving and handling equipment and equipment for bariatric patients.

All patients had designated bed space, which included a personal locker, table, call bell, and access to gender-specific toileting and bathing facilities.

We checked the resuscitation trolleys on all the wards we visited and these contained correct stock. We saw that each resuscitation trolley had a log attached to it for staff to complete when they had undertaken daily and weekly checks. We found all checks completed accordingly. Not all trolleys were fitted with a tamper-proof tag.
The endoscopy unit had purchased new equipment in 2016 and had access to on site disinfection facilities. The unit was not JAG accredited but was actively working towards this accreditation. (JAG is the Joint Advisory which provides formal recognition of competence to deliver services against recognised standards).

**Assessing and responding to patient risk**

We saw patient observations (blood pressure, pulse, temperature, respirations) were recorded on the new electronic system on two wards. Staff told us that the system required WiFi signal to load the patient record and record it successfully. All staff we spoke with told us that there were ongoing problems with the WiFi signal and it was not always possible to use the electronic system. However, we saw concerns about deteriorating patients had been escalated in accordance with guidance and the national early warning score (NEWS) system.

E-observations were piloted on Maple A ward at the Cumberland Infirmary in July 2017. During the pilot, both issues and suggestions were collated from the staff who were using the system. Subsequently, between January and July 2018, the system was rolled out across 24 areas taking a phased approach. Looking at NEWS audits before implementation of e-observations in these areas, 18 out of 24 miscalculated the NEWS score in one or more of the patients being audited. Post-implementation, all areas now have 100% correct NEWS scores as demonstrated through their audits except for four areas that have not yet been audited.

In July 2018, the IT department carried out an audit of WiFi coverage across the Cumberland Infirmary. It found that WiFi coverage was well above required levels, however the department wanted to encourage and remind staff to report any issues with WiFi and e-Observations straight away to the IT Service Desk or the out-of-hours on-call IT team. This reminder was well-publicised to all staff.

During our inspection we saw that deteriorating patients had evidence of appropriate escalation and intervention recorded. We observed red stickers on medical and nursing notes where high risk was identified.

However, the NEWS patient escalation audit undertaken by the trust (April 2018) highlighted that out of a total of 22 beds, over 10 wards that had a NEWS score of five or more two out of 10 wards had a 100% compliance rate to the question ‘Was a sticker used?’ with five out of 10 wards having a 0% compliance rate. The average compliance rate for the Cumberland Infirmary was 45%.

In answer to the question ‘was there an assessment/plan documented?’ we found that seven out of 11 wards had a 100% compliance rate one having a 0% compliance rate. The average compliance rate was 88%.

The heart unit provided specialist coronary care interventions for patients requiring primary angioplasty, elective angiograms, percutaneous coronary intervention (PCI), and treatment for acute coronary syndromes. In the event of clinical concern or a request for a senior review out-of-hours, staff could send electrocardiograms directly to the cardiologist on call for remote review and guidance. Should a patient require assessment for cardiac surgery, staff stabilised the patient on site prior to escorted transfer to specialist centres in the region.
We were informed by staff that the trust no longer employed resuscitation officer. Staff felt that this increased patient risk. However, no evidence of risk was observed during the inspection.

The sepsis care pathway flowchart provided guidance in treating severe sepsis, management plan documentation, critical care considerations and observation monitoring. Patients who triggered a sepsis care bundle were monitored through audit, to check whether treatment and anti-biotics were given appropriately. We saw the sepsis pathway being followed during the inspection and saw that there was a sepsis escalation plan in place for patients requiring immediate review.

The sepsis audit for the Cumberland Infirmary showed that for Q1 (quarter) 17/18 83% of patients were screened; Q2 17/18 showed 88% of patients were screened; and in Q3 17/18 there were 85% of patients screened. This was an improvement on Q4 16/17 were only 59% had been screened appropriately. We saw that for the Cumberland Infirmary Q1 17/18 66% of patients treated within one hour; Q2 17/18 showed 70% of patients; and in Q3 17/18 there were 75% of patients were treated within one hour. This was an improvement on Q4 16/17 were only 50% patients were treated within one hour.

Overall, we saw that although sepsis screening and the number of patients receiving treatment within one hour had greatly improved, there was room for further improvement.

Risks associated with falls, pressure ulcers, venous thromboembolism (VTE), catheter and urinary infections were assessed monthly using the NHS safety thermometer.

At the time of our inspection, stroke patients were thrombolysed in the emergency department and then transferred to the Coronary Care Unit (CCU) for initial monitoring.

**Nurse staffing**

The trust has reported their staffing numbers below as at March 2018 and April 2018 for medicine by site:

<table>
<thead>
<tr>
<th>Location</th>
<th>Mar-18</th>
<th></th>
<th>Apr-18</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
<td>Fill rate</td>
<td>Actual WTE staff</td>
</tr>
<tr>
<td>Cumberland Infirmary</td>
<td>278.0</td>
<td>333.8</td>
<td>83.3%</td>
<td>273.1</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>122.2</td>
<td>161.8</td>
<td>75.5%</td>
<td>119.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>400.2</strong></td>
<td><strong>495.6</strong></td>
<td><strong>80.8%</strong></td>
<td><strong>392.9</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) –P16)

Nurse staffing was managed by each Clinical Care Group and uses both an e-roster tool along with the SafeCare module which managed a range of parameters which were in line with the most recent NHSI publication (Safe, sustainable and productive staffing - An improvement resource for adult inpatient in acute care).

We were informed that the trust utilised SafeCare to enable coordination of staffing levels and skill mix to the actual patient demand. SafeCare provided visibility which enables acuity based daily

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staffing processes to improve productivity and safeguard patient safety. SafeCare triangulated information from the health roster and acuity levels from real-time to calculate the ward staffing levels needed to provide the optimum care hours per patient per day and enabled the redeployment of staff to facilitate this.

The trust acknowledged that the collection of acuity and dependency data helped senior nurses and operation teams to get an organisation-wide view of staffing levels and staffing needs. This enabled proactive and informed decision making, to redeploy staff to areas of high demand to provide a safe establishment based on patient acuity/dependency levels.

Census data was pulled through via ‘Health Roster’ for staffing levels and ‘Real-time’ for patient acuity. This was a change for adult wards to the original process of staff inputting acuity data two times a day directly in to the SafeCare tool. The trust audit advised that morning data entry must take place between 06:30 and 08:00 ideally at 07:00 handover. Night data entry must take place between 18:30 and 20:00, ideally at the 19:00 handover.

The audit report represented data collected for acuity levels across inpatient areas for the trust in quarter 1, 2018 by using data from ‘Real-time’. Data was scored using the ‘Shelford Safer Nurse Tool for Acuity’.

The audit highlighted that in April 14% (66) of patients of 463 did not have acuity scores recorded. When reviewing the data for non-recording of acuity it was identified the longest period since the acuity had been recorded for an individual patient was 21 days, this was found to be the same across five wards. There was no data to support the reason for this failure to record the acuity.

In May 14% (60) patients of 420 did not have acuity scores recorded. The longest period since acuity had been reviewed for an individual patient was 90 days; however, there were five wards who had not reviewed scores for over 21 days and this was repeated across five wards.

In June 17% (74) patients of 436 did not have acuity scores recorded. The longest period since acuity had been reviewed for an individual patient was eight weeks and this was evident on two wards.

It was further highlighted that the interface between Real-time and SafeCare had been unreliable and the trust were informed by Allocate that this was a technical problem which was being resolved in the next upgrade of the system which would be monitored by the E-Roster Clinical Lead.

Recommendations from the audit emphasised that support was to be offered to all wards with low participation in acuity scoring, education and continue to support SafeCare users was to be provided and SafeCare relaunch to commence when issues were resolved between the Real-time and SafeCare interfaces. This was expected at the end of July 2018.

We were informed that red flags were used to highlight concerns and were logged on the system to be viewed by line managers and Matrons to identify problems are and implement actions to resolve the issues.

We saw the trust’s comprehensive escalation policy which clearly identified the role and responsibility for all staff, management team and executive team.
The trust work to three levels of escalation; level one required no action as planned rosters were achieved without gaps, skill mix and qualified nurse to patient ratio achieved. Level two escalation meant that the fill rate was below 80% but two qualified staff were on duty. The response required for level two escalation was to initially review patient acuity and dependency. Nonetheless, the ward may manage to provide the correct level of care and no further action would be required. If additional ‘red flags’ were identified then staffing must be increased based on professional judgement. Level three escalation would occur when a ward had less than two qualified nurses; the shift fill rate was below 80% and there were patients with an increased level of acuity. The trust state that the required response to a level three escalation would be to provide an additional qualified nurse or decide to close beds. Patient dependency and acuity would be reviewed by the ward manager and Matron.

We saw that the trust had implemented standard operating procedure for the utilisation of nursing staff out of hours (OOH). This SOP is to guide the reallocation of existing nursing staff for defined periods of time when safe staffing levels cannot be met from within the allocated resource across our wards. This paper outlines the principals for the movement of staff being cognisant of the NMC Code of Practice, Rule 13 Preserve Safety. During times of exceptional and unexpected staffing shortfalls the absolute minimum standard required on any ward documented as two registered nurses.

The SOP stated that staff based on wards may be requested to relocate to ensure skills mix and safe staffing levels are maintained across all patient areas. Wherever possible these moves should have been identified and agreed by Matrons in the operational staffing plan by 17:00. However, this plan may require review out of hours should circumstances change; this revised plan was made by the site coordinator.

We were advised that all staff were given training on acuity and dependency scoring, which was tested on an ad-hoc basis by senior nurses and matrons to ensure the accuracy of the data entered. At the morning matrons meeting, if a ward appeared to have higher or lower acuity and dependency data than would be expected the matron went to the ward and reviewed the data with the ward sister.

We saw matrons and senior staff use the tool to make regular reallocation of nursing resources every morning and several times throughout the day and therefore ensure the data is as contemporaneous as possible. However, we also saw that patient acuity was not regularly updated or updated following patient ward moves.

We asked ward staff when they updated the electronic system. Responses varied from “daily” to “when we get a chance”. A staff member told us they updated the system every day but could not identify or log onto the system when we asked them to demonstrate how it was used. Some members of staff told us they used Real Time, which was one of the electronic systems used to capture staff and patient numbers.

Ward sisters stated they escalated staffing risks to their matrons, who then escalated to the chief matron. Some sisters told us they completed a risk assessment each time they encountered staffing concerns. Other staff told us they would add an electronic flag to the system and others said they didn’t report the risk as SafeCare captured staffing shortfalls. However, we identified that SafeCare was not regularly updated when staff were moved to another ward.
All staff told us that the relevant matrons walked the floors and visited the wards. We were advised that the experienced matrons knew which wards were experiencing the greatest pressures.

We observed that nurse staffing numbers appeared on the service’s risk register. All wards that we visited had registered nurse vacancies.

We observed the site co-ordinator in the late evening, assessing and responding to patient risk and deploying staff appropriately.

We were advised that the SBAR methodology (Situation, Background, Assessment, Recommendation) was used to assess which staff transfer to another ward. It was felt that although not perfect, there was a real benefit for the on-call team when they are not clinicians. By using SafeCare, the e-roster, assessing acuity, supported with clinical decision making and what nurses are available, decisions were made regarding staff movement between wards.

A high proportion of medical wards were under staffed both at night and through the day. Several ward sisters noted that their staffing levels were not safe. This was due to staff being moved to meet demand on other wards. We saw that actual nursing fill rates were lower than planned. However, healthcare assistant actual fill rates were higher than planned. This was evident on the majority of wards visited during inspection. Nursing staff sickness was also prevalent across wards with several wards having teams that were described as “burnt out.”

There was evidence of health care assistants being used to support gaps in nurse care. On the discharge lounge, it was reported that there was occasionally only one staff member on the unit for the whole day. We were advised of this by numerous members of staff.

We saw on all wards that we visited that planned and actual registered nursing numbers were displayed, alongside health care assistant numbers. The skill mix of healthcare assistant and nurse staffing was raised as an issue with some wards, such as dementia wards, requiring more specialist skills.

Where shifts could not be covered by existing staff, ward managers escalated concerns to their matrons. Escalation processes provided several options to help support wards. These included moving nursing resource from better staffed areas, sourcing bank staff, and utilising nurse specialists. Several wards noted that additional staff was not always available once concerns had been escalated to the matrons. Wards also noted that despite having patients with complex needs including those requiring one to one support, behavioural problems including aggressive tendencies, additional staff support was not available. We were informed that there had been occasions when patients assessed as requiring one to one care, would lose the one to one support if the nurse was required elsewhere. We were advised this had occurred on two occasions (separate wards) just prior to the inspection. We were also advised that removing the one to one support occurred against the assessed patient risk. We did not see evidence of a risk assessment prior to the removal of the support.

We asked the matron responsible for the respiratory ward, how safe numbers of staffing was maintained to meet the needs of patients with non-invasive ventilation (NIV). The British Thoracic society recommended a minimum staffing ratio of one nurse to two patients, within the first 24hrs. The matron was not sure if there were any patients requiring NIV at the time of inspection. We
advised the matron to check immediately, due to the strict guidance in place to support these patients. We saw there were no NIV patients on the ward, at the time of inspection. We saw that the NIV policy stated that staffing ratios increased for the care of NIV patients.

**Vacancy rates**

From April 2017 to March 2018, the trust reported a vacancy rate of 25.9% in medicine. This was higher than the trust target of 5%.

A breakdown by site is shown below:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total vacancies (WTE)</th>
<th>Total number of staff establishment (WTE)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>1,010.8</td>
<td>3,983.9</td>
<td>25.4%</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>395.6</td>
<td>1,439.7</td>
<td>27.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,406.4</strong></td>
<td><strong>5,423.6</strong></td>
<td><strong>25.9%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

From May 2017 to April 2018, the trust reported a turnover rate of 11.5% in medicine. This was lower than the trust target of 13%. Cumberland Infirmary had a turnover rate of 53.8%, much higher than the trust target although this equates to only 1.3 WTE staff members leaving the trust.

A breakdown per site can be seen in the table below:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total leavers (WTE)</th>
<th>Average number of staff establishment (WTE)</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Cumberland Hospital</td>
<td>11.3</td>
<td>2.4</td>
<td>53.8%</td>
</tr>
<tr>
<td>Cumberland Infirmary</td>
<td>1.3</td>
<td>107.4</td>
<td>10.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12.6</strong></td>
<td><strong>109.8</strong></td>
<td><strong>11.5%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Matrons and ward sisters, we spoke with acknowledged the high turnover rate and told us that on-going advertisements were in place.

We did not see evidence of any learning from staff exit interviews or any trends identified by the trust, when staff left the trust.

**Sickness rates**

From May 2017 to May 2018, the trust reported a sickness rate of 4.9% in medicine. This was higher than the trust target of 4%.
A breakdown per site can be seen in the table below:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total absence days</th>
<th>Total WTE days available</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>4,275.9</td>
<td>88,256.2</td>
<td>4.8%</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>1,797.7</td>
<td>34,483.0</td>
<td>5.2%</td>
</tr>
<tr>
<td>Total</td>
<td>6,073.6</td>
<td>122,739.2</td>
<td>4.9%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

We did not see evidence of any learning following sickness review meetings. Staff we spoke with told us that ‘staff exhaustion’ was common place.

Bank and agency staff usage

From April 2017 to March 2018, the trust reported that 27.1% of qualified nursing shifts in medicine were filled by bank staff.

The trust was unable to provide comparable data for agency and shifts left unfilled, due to system restrictions.

The breakdown by site is shown in the table below.

<table>
<thead>
<tr>
<th>Site</th>
<th>Bank shifts</th>
<th>Total shifts</th>
<th>Bank shifts as a proportion of total shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>1,172</td>
<td>4,274</td>
<td>27.4%</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>465</td>
<td>1,761</td>
<td>26.4%</td>
</tr>
<tr>
<td>Total</td>
<td>1,637</td>
<td>6,035</td>
<td>27.1%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Ward staff told us that an internal nursing bank was used. Occasionally staff were sought from an external nursing agency, when no internal staff were available.

Medical staffing

The trust has reported their staffing numbers below as at March 2018 and April 2018 for medicine.

<table>
<thead>
<tr>
<th>Location</th>
<th>Mar-18</th>
<th></th>
<th>Apr-18</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
<td>Fill rate</td>
<td>Actual WTE staff</td>
</tr>
<tr>
<td>Cumberland Infirmary</td>
<td>87.5</td>
<td>112.0</td>
<td>78.1%</td>
<td>87.1</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>4.0</td>
<td>25.5</td>
<td>15.7%</td>
<td>4.0</td>
</tr>
<tr>
<td>Total</td>
<td>91.5</td>
<td>137.5</td>
<td>66.5%</td>
<td>91.1</td>
</tr>
</tbody>
</table>
Data has shown that trust wide the medical staffing cover was poor and locum cover was significant. Staff told us that weekends were the worst affected and we saw that fill rates for March 2018 was 66.5% and 66.7% for April 2018. We were informed that consultants worked cross site. Where substantive posts remained vacant the division had secured long-term locum contracts to support stability within the service.

The heart centre was supported by the consultant cardiologist of the week rota and covered by the general medical rota out-of-hours. The consultant cardiologist remained on call from home and available to attend in the event of any overnight emergencies.

Medical rota shortfalls were managed and reinforced by advanced clinical practitioners on a 24/7 basis. The division had also implemented the ‘hospital at night’ programme to support clinical presence on site during night hours, and the Cumberland Infirmary had a proactive critical care outreach team (CCOT) who worked 24/7.

Junior medical grades at the Cumberland Infirmary considered their senior colleagues were supportive, available, approachable, and willing to spend time with them when required. Junior doctors told us that they were expected to cover rota gaps and work additional hours when required to support the service.

Vacancy rates

From April 2017 to March 2018 the trust reported a vacancy rate of 22.8% in medicine. This was higher than the trust target of 20%. Cumberland Infirmary reported a vacancy rate of 18.8% lower than the trust target of 20%.

A breakdown per site can be seen below:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total vacancies (WTE)</th>
<th>Total number of staff establishment (WTE)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>251.7</td>
<td>1,336.9</td>
<td>18.8%</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>81.6</td>
<td>128.0</td>
<td>63.8%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>333.3</strong></td>
<td><strong>1,464.9</strong></td>
<td><strong>22.8%</strong></td>
</tr>
</tbody>
</table>

Turnover rates

From May 2017 to April 2018, the trust reported a turnover rate of 28.2% in medicine. This was higher than the trust target of 13%.

A breakdown per site is shown in the table below:
### Site name
<table>
<thead>
<tr>
<th>Total leavers (WTE)</th>
<th>Average number of staff establishment (WTE)</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>17.9</td>
<td>60.9</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>1.0</td>
<td>6.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>18.9</strong></td>
<td><strong>67.1</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

### Sickness rates

From May 2017 to May 2018, the trust reported a sickness rate of 2% in medicine. This was lower than the trust target of 4%.

A breakdown per site can be seen in the table below:

### Site name
<table>
<thead>
<tr>
<th>Total absence days</th>
<th>Total WTE days available</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>564.1</td>
<td>22,108.7</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>0.0</td>
<td>1,916.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>564</strong></td>
<td><strong>24,025</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

### Bank and locum staff usage

The trust was unable to provide this data broken down by site or core service, due to system restrictions under the previous recording method.

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

### Staffing skill mix

In January 2018, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.

**Staffing skill mix for the 99 whole time equivalent staff working in medicine at North Cumbria University Hospitals NHS Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>35%</td>
<td>43%</td>
</tr>
<tr>
<td>Middle career</td>
<td>4%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group</td>
<td>19%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior</td>
<td>42%</td>
<td>22%</td>
</tr>
</tbody>
</table>
Records

We reviewed 23 sets of patient records. Records were up-to-date with evidence of on-going review, diagnosis and management plans and patient involvement. All records contained assessments for venous thromboembolism (VTE) risk, nutritional risk, fall risk, and a full nursing assessment. We saw evidence of discussion of patient care at multidisciplinary meetings, with the patient and with families.

During the record review we saw evidence of escalation of deteriorating patients. We saw patients at higher risk of deteriorating had a red sticker on their file to indicate a high NEWS score (5>).

Staff within the medicine division recorded relevant clinical patient information in paper records and many core documents were completed on the electronic patient record. Staff stored these safely in portable locked cabinets or in areas manned by staff.

The division had developed several care bundles and specialist care pathway documentation following best practice guidelines, such as sepsis and chronic obstructive respiratory disease.

Medicines

We reviewed 15 patient clinical records specifically in relation to the management of medications and spoke with one patient and two members of staff.

In general, medicines, including intravenous fluids, were stored securely and access was restricted to authorised staff. However, on Maple A we found that emergency trolleys containing intravenous fluids were not secured as per the trusts medicines policy. This meant there was a risk that they could be accessed by an unauthorised person.

The trust policy did not state staff should record minimum and maximum temperatures for medicines refrigerators, and staff we spoke to were not aware of this requirement. Therefore, we could not be assured medicines requiring cold storage had been stored at the recommended temperature and were safe to use.
Pharmacy technicians and pharmacists checked (reconciled) patients’ medicines on admission to hospital, and we saw this generally occurred in a timely manner.

Controlled drugs were managed appropriately in relation to storage and administration, however at Carlisle Infirmary we found staff were not adhering to trust policy in relation to recording of balance adjustments.

In all charts we looked at we found prescriptions which did not comply with the trust prescribing policy. For example, we found prescriptions with no dose which continued to be given by staff, no indication or review date on antibiotics and no maximum dose specified on when required prescriptions. Ambiguous prescriptions can lead to medicine administration errors by nursing staff.

A prescribing audit was carried out once a year by pre-registration pharmacists, the last audit being carried out in August 2017. Whilst this audit did identify some of the issues we found on inspection we could not see evidence of actions taken to improve this.

We also found two patients who had missed medicines for anti-coagulation and blood pressure with no omission code documented on the chart. Staff confirmed they had missed these medicines but could not explain why.

On one ward we were told that only one nurse routinely worked a shift. This meant that to gain second signatures for intravenous medicines and controlled drugs, the nurse had to leave the ward. Therefore, there was a chance there would be no nursing cover should patients require it. We were also told that nurses who were performing the second check on these occasions did not accompany the nurse back to the ward to witness administration. This therefore increased the risk of this medicine being administered to the wrong individual. This is not in line with trust policy or nursing and midwifery council (NMC) code of practice.

Antibiotic stewardship appeared thorough. We saw prescribing, changing from intravenous administration to oral, and stopping prescriptions were overseen by the pharmacists, including dedicated antibiotic pharmacists, consultants, and consultant microbiologists.

**Incidents**

**Never Events**

Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each Never Event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event.

From June 2017 to May 2018, the trust reported one incident classified as a never event for medicine. The incident took place on 6 October 2017 at Cumberland Infirmary, and was classed as a medication incident meeting serious incident (SI) criterion. The incident was reported on 9 October 2017. The incident involved a patient who was administered 60ml enteral syringe containing oramorph solution via subcutaneous route in abdomen instead of through the percutaneous endoscopic gastrostomy tube (PEG).

*Source: NHS Improvement - STEIS (01/05/2017 - 30/04/2018)*
We reviewed the root cause analysis for this incident and saw that a pre-investigation risk assessment had been carried out, background, context and relevant policies and guidance identified, chronology and detection of the incident outlined. The investigation examined care and service delivery, equipment and individual responsibilities and training.

This resulted in an identification of root causes, lessons learned and recommendations. Management discussed outcomes at divisional meetings and managers shared learning and cascaded key information to their staff at safety huddles, ward meetings, through the patient safety newsletter, on the intranet, and with direct staff communications.

The division reported incidents through the trust electronic reporting system and graded incidents according to risk rating and severity of harm in accordance with their incident management policy (including the management of serious incidents), which was published in in February 2016.

All staff spoken to knew of the Duty of Candour (DoC) requirements and of the trust’s ‘being open’ policy.

The division held monthly mortality and morbidity review meetings. The meeting considered case summaries, reviewed outcomes and identified key lessons.

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 19 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from June 2017 to May 2018.

<table>
<thead>
<tr>
<th>Type of Incident</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>6</td>
</tr>
<tr>
<td>Surgical/invasive procedure incident meeting SI criteria</td>
<td>4</td>
</tr>
<tr>
<td>Abuse/alleged abuse of adult patient by staff</td>
<td>2</td>
</tr>
<tr>
<td>Diagnostic incident including delay meeting SI criteria</td>
<td>2</td>
</tr>
<tr>
<td>Medication incident meeting SI criteria</td>
<td>2</td>
</tr>
<tr>
<td>Pressure ulcer meeting SI criteria</td>
<td>1</td>
</tr>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>1</td>
</tr>
<tr>
<td>Sub-optimal care of the deteriorating patient meeting SI criteria</td>
<td>1</td>
</tr>
</tbody>
</table>

Of these, the most common types of incident reported were:

- Treatment delay meeting SI criteria with six (32% of total incidents).
- Surgical/invasive procedure incident meeting SI criteria with four (21% of total incidents).
• Abuse/alleged abuse of adult patient by staff with two (11% of total incidents).
• Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with two (11% of total incidents).

Note: the incidents above include the one never event discussed in the previous section

Site specific information can be found below:

• Cumberland Infirmary: 15 incidents.
• West Cumberland Hospital: four incidents.

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within ten days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 17 new pressure ulcers, 29 falls with harm and 41 new urinary tract infections in patients with a catheter from April 2017 to April 2018 for medical services.

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

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at North Cumbria University Hospitals NHS Trust
Medicine reported 17 new pressure ulcers. Over the period numbers varied month on month with no pressure ulcers reported in April, June, August, November 2017 and April 2018. The highest numbers reported were during May (four), July 2017 (three) and in March 2018 (three). During September and October 2017 one pressure ulcer per month was reported. In the winter months from December 2017 March 2018, between one to three pressure ulcers were reported consecutively.

In April 2017 the highest number of seven falls were reported, numbers decreased to two in May although increased again to four in June while decreasing month on month from three in July to no falls reported in September 2017. Three falls were again reported in October and no falls in November 2017. During the winter months of December 2017, four falls were reported, numbers decreased to one fall reported in January 2018, although increased once more to four falls reported in February 2018. In March and April 2018 no falls were reported. The overall trend, although there were variances month on month, showed a decrease in the number of falls reported.

A high number of 41 urinary tract infections (UTIs) were reported. Except for April 2018, from one to six UTIs were reported month on month. In April 2017 five UTIs were reported, numbers decreased to three in May, although increased again to six per month in June and July 2017. From August 2017 to January 2018, numbers stabilised with one to two ulcers reported per month. In February six UTIs were again reported after which numbers decreased to four in March and none in April 2018.

Source: Safety thermometer - Safety Thermometer

Is the service effective?

Evidence-based care and treatment

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

The division was actively involved in local and national audit programmes collating evidence to monitor and improve care and treatment. The division compiled an annual clinical audit report of activity that specified a range of completed, planned, and ongoing evidence-based reviews.
In accordance with NICE quality standards, the division was involved in data collection activity for numerous national audits such as chronic obstructive pulmonary disease (COPD), cardiac rhythm management devices (CRM), diabetes, acute coronary syndromes, and the falls and fragility fracture audit programme (including hip fractures).

The division at Cumberland Infirmary had developed several evidence-based, condition-specific care pathways to standardise and improve patient care and service flow, for example, ambulatory care services, hot clinics, frailty pathways, and extended scope of the medical procedures unit.

The division had adapted guidance for sepsis screening and management.

All endoscopic procedures were carried out in accordance with recognised best practice and professional guidelines. The unit was working towards JAG (Joint Advisory Group) accreditation.

The division had a designated audit lead, and business units were active in the trust clinical audit group.

**Nutrition and hydration**

We saw that the division had recognised the importance of good nutrition and hydration as an essential part of patient care and monitored nutritional documentation compliance by auditing nutritional screening, risk assessments, and care plans.

We reviewed 19 records during inspection against malnutrition and hydration. We observed all patients had had malnutrition universal screening tool (MUST) risk assessment (equating to 100% compliance) and found 100% compliance in fluid chart completion. Staff implemented care plans for those patients who required support and assistance with eating and drinking.

Staff told us they accessed support from dietetics and speech and language therapy service (SaLT) specifically allocated to their ward to support those patients who required additional input to maintain their nutritional status.

Patients had protected meal times. Staff allowed family members to attend during meal times where patients required help or support in eating or drinking.

We received positive comments from patients regarding food quality and menu choice. Of the 41 patients we spoke to, most confirmed that the food choice and quality was good. There were various menu options for individual dietary requirement such as halal, coeliac, and vegetarian options.

We observed nursing staff assisting and supporting patients with eating and drinking. This included feeding, and supporting with drinks.

**Pain relief**

The trust took part in the National Cancer Patient Experience Survey (NCPES) 2016. Patients were asked if hospital staff definitely did everything to help control pain. On a scale of zero (very
poor) to 10 (very good). Respondents gave an average rating of 89% against a national average of 84%.

We found all patients had access to prescribed analgesia. We found analgesia prescribed on a regular basis and on an as required basis.

We observed staff monitored pain and assess the effectiveness of pain relief using a number of techniques such as direct questioning, by observation, anticipatory ahead of procedures and with reference to observations and pain assessment tools such as the zero to three pain scoring tool.

Patients informed us staff asked them if they had any discomfort or if they required any pain relief. The division accessed the trust pain team if required.

The division took part in the trust wide pain management audit which was submitted to the medicines optimisation committee. Medicines optimisation committee meeting minutes did not highlight any concerns.

**Patient outcomes**

**Relative risk of readmission**

**Trust level**

From January 2017 to December 2017, patients at the trust had a slightly higher than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

**Elective re-admissions**

- Patients in clinical oncology (previously radiotherapy) had a slightly higher than expected risk of readmission for elective admissions
- Patients in gastroenterology had a similar than expected risk of readmission for elective admissions
- Patients in clinical haematology had a higher than expected risk of readmission for elective admissions

**Non-Elective re-admissions**

- Patients in general medicine and cardiology had a lower than expected risk of readmission for non-elective admissions
- Patients in geriatric medicine had a much lower than expected risk of readmission for non-elective admissions

**Elective Admissions – Trust Level**
From January 2017 to December 2017, patients at Cumberland Infirmary had a similar than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

**Elective readmissions**

- Patients in clinical oncology (previously radiotherapy) had a slightly lower than expected risk of readmission for elective admissions
- Patients in gastroenterology had a slightly higher than expected risk of readmission for elective admissions
- Patients in clinical haematology had a much higher than expected risk of readmission for elective admissions

**Non-elective readmissions**

- Patients in general medicine had a lower than expected risk of readmission for non-elective admissions
- Patients in geriatric medicine and cardiology had a much lower than expected risk of readmission for non-elective admissions

**Elective Admissions - Cumberland Infirmary**
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

**Non-Elective Admissions - Cumberland Infirmary**

![Bar chart showing observed to expected emergency readmissions for Clinical Oncology, Gastroenterology, and Clinical Haematology.]

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

**Sentinel Stroke National Audit Programme (SSNAP)**

**Cumberland Infirmary**

Cumberland Infirmary took part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved an overall SSNAP level of grade C from August to November 2017.

The team-centred total key indicator level remained unchanged at level C in April to July 2017 and August to November 2017. The stroke unit and thrombolysis were both downgraded from level C to level D. Speech and language therapy was upgraded from level E to level D, while standards by discharge was upgraded from level C to level B. The remaining indicators remained unchanged between the two periods.

The patient-centred total key indicator level remained unchanged at level C in April to July 2017 and August to November 2017. The stroke unit and thrombolysis were both downgraded from level C to level D. Scanning and standards by discharge were both upgraded from level C to grade B.

**Team centred performance**

<table>
<thead>
<tr>
<th>Team centred performance</th>
<th>Jan-Mar 16</th>
<th>Apr-Jul 16</th>
<th>Aug-Nov 16</th>
<th>Dec 17</th>
<th>Apr 17-Jul 17</th>
<th>Aug 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: Scanning</td>
<td>C</td>
<td>B↑</td>
<td>B</td>
<td>B</td>
<td>C↓</td>
<td>C</td>
</tr>
<tr>
<td>Domain 2: Stroke unit</td>
<td>E↓</td>
<td>D↑</td>
<td>D</td>
<td>D</td>
<td>C↑</td>
<td>D↓</td>
</tr>
</tbody>
</table>
### Domain 3: Thrombolysis
- Domain 3: Thrombolysis
- Domain 4: Specialist assessments
- Domain 5: Occupational therapy
- Domain 6: Physiotherapy
- Domain 7: Speech and language therapy
- Domain 8: Multidisciplinary team working
- Domain 9: Standards by discharge
- Domain 10: Discharge processes

#### Patient centred performance

**Patient centred performance**

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 2: Stroke unit</td>
<td>B↑</td>
<td>D↑</td>
<td>C↑</td>
<td>D↑</td>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td>Domain 3: Thrombolysis</td>
<td>D↓</td>
<td>D</td>
<td>D</td>
<td>D</td>
<td>C↑</td>
<td>D↓</td>
</tr>
<tr>
<td>Domain 4: Specialist assessments</td>
<td>E↓</td>
<td>D↑</td>
<td>C↑</td>
<td>D↓</td>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td>Domain 5: Occupational therapy</td>
<td>A↑</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 6: Physiotherapy</td>
<td>A</td>
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<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 7: Speech and language therapy</td>
<td>E↓</td>
<td>E</td>
<td>C↑↑</td>
<td>E↓↓</td>
<td>D↑</td>
<td>D</td>
</tr>
<tr>
<td>Domain 8: Multidisciplinary team working</td>
<td>C</td>
<td>C</td>
<td>B↑</td>
<td>C↓</td>
<td>B↑</td>
<td>B</td>
</tr>
<tr>
<td>Domain 9: Standards by discharge</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>C↓</td>
<td>C</td>
<td>B↑</td>
</tr>
<tr>
<td>Domain 10: Discharge processes</td>
<td>A↑</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>C↓↓</td>
</tr>
<tr>
<td>Patient-centred Total Key Indicator Level</td>
<td>D↓</td>
<td>C↑</td>
<td>B↑</td>
<td>C↓</td>
<td>C</td>
<td>C</td>
</tr>
</tbody>
</table>

#### Overall scores

**Overall Scores**

<table>
<thead>
<tr>
<th>Overall Scores</th>
<th>Jan-Mar 16</th>
<th>Apr-Jul 16</th>
<th>Aug-Nov 16</th>
<th>Dec 16 - Mar 17</th>
<th>Apr 17 - Jul 17</th>
<th>Aug 17 - Nov 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSNAP level</td>
<td>D</td>
<td>C↑</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Case ascertainment band</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Audit compliance band</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>A</td>
</tr>
<tr>
<td>Combined Total Key Indicator level</td>
<td>D↓</td>
<td>C↑</td>
<td>B↑</td>
<td>C↓</td>
<td>C</td>
<td>C</td>
</tr>
</tbody>
</table>

**Overall scores**
Heart Failure Audit

The trust did not take part in this audit.

(Source: NICOR - Heart Failure Audit (01/04/2014 - 31/03/2015))

National Diabetes Inpatient Audit

The National Diabetes Inpatient Audit (NaDIA) measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital whatever the cause, and aims to support quality improvement.

The audit attributes a quartile to each metric which represents how each value compares to the England distribution for that audit year; quartile 1 means that the result is in the lowest 25 per cent, whereas quartile 4 means that the result is in the highest 25 per cent for that audit year.

The 2017 National Diabetes Inpatient Audit identified 59 in patients with diabetes at Cumberland Infirmary, 93.4% of patients with diabetes reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which places this site in quartile 4. Performance improved in 2017 compared to 2016 performance. In 2016 81.9% of patients were satisfied or very satisfied with overall in hospital care and the trust was placed in quartile 2 nationally.

Myocardial Ischaemia National Audit Project (MINAP)

All hospitals in England that treat heart attack patients submit data to MINAP by hospital site (as opposed to trust).

From April 2015 to March 2016, 31.9% of nSTEMI patients were admitted to a cardiac unit or ward at Cumberland Infirmary and 94.6% were seen by a cardiologist compared to an England average of 55.8% and 96.2% respectively.

The proportion of nSTEMI patients who had angiography at Cumberland Infirmary was 97.3% compared to an England average of 83.6%.

From April 2015 to March 2016, 55.5% of nSTEMI patients were admitted to a cardiac unit or ward were seen by a cardiologist compared to an England average of 55.8% and 96.2% respectively.
At Cumberland Infirmary percentages for patients seen by a cardiologist improved between 2014/15 and 2015/16 from 90.2% to 94.6% in 2015/16. The proportion of patients admitted to a cardiac unit or ward increased from 27.6% to 31.9%, while patients receiving an angiogram before discharge decreased from 98.6% to 97.3%.

(Source: National Institute for Cardiovascular Outcomes Research (NICOR))

### Lung Cancer Audit

The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 86.8%, which did not meet the audit minimum standard of 90%. The 2016 figure was 71.8%

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 17.5%. This is within the expected range. The 2016 figure was not significantly different to the national level. The audit national standard of 17%* was met for this metric.

The proportion of fit patients with advanced (NSCLC) receiving Systemic Anti-Cancer Treatment was 52.7%. This is within the expected range. The 2016 figure was not significantly different to the national level. The national audit standard of 65%* was not met for this metric.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 65.5%. This is within the expected range. The 2016 figure was not significantly different to the national level. The national audit standard of 70%* was not met for this metric.

The one-year relative survival rate for the trust in 2017 is 33.9%. This is within the expected range. The 2016 figure was not significantly different to the national level.

* Audit standard based on NICE guideline

(Source: National Lung Cancer Audit)
National Audit of Inpatient Falls 2017

The national aspirational standard is 100% for all measures, the trust failed to meet this standard for all indicators.

The crude proportion of patients who had a vision assessment (if applicable) was 5%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 17%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 32%.

The crude proportion of patients with a call bell in reach (if applicable) was 83%.

(Source: Royal College of Physicians)

Competent staff

Appraisal rates

Trust wide appraisal rates

From April 2017 to March 2018, 93% of staff within medicine at the trust received an appraisal compared to a trust target of 95% for nursing staff and 90% or higher for medical staff.

Nursing staff did not meet the trust target with a completion rate of 93%, while medical staff met the trust with a completion rate of 97%. Medical staff within gastroenterology had the lowest completion rate of 50%, although this relates to only one of the two staff members not receiving an appraisal.

It should however be noted that in the 2017 staff survey, quality of appraisals was within the worst 25% of trusts nationally.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required</th>
<th>Appraisals complete</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>316</td>
<td>293</td>
<td>93%</td>
</tr>
<tr>
<td>Medical and dental staff</td>
<td>36</td>
<td>35</td>
<td>97%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>352</td>
<td>328</td>
<td>93%</td>
</tr>
</tbody>
</table>

Cumberland Infirmary appraisal rates

From April 2017 to March 2018, 93% of staff within medicine care at the trust received an appraisal compared to a trust target of 95% for nursing staff and 90% or higher for medical staff. Nursing staff at Cumberland Infirmary did not meet the trust target with a completion rate of 92%, while medical staff met the trust with a completion rate of 97%. Medical staff within gastroenterology had the lowest completion rate of 50%, although this relates to only one of the two staff members not receiving an appraisal.
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</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>235</td>
<td>216</td>
<td>92%</td>
</tr>
<tr>
<td>Medical and dental staff</td>
<td>35</td>
<td>34</td>
<td>97%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>270</strong></td>
<td><strong>250</strong></td>
<td><strong>93%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

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

Ward managers discussed formal learning and training needs with individual staff members at one to one sessions and during appraisal. Informally, staff identified their own areas of interest and proposed study for consideration at a local level.

Junior medical staff maintained close links with the Deanery as part of their clinical placements and post rotations. The junior medical staff stated that the division was extremely supportive of their learning, training, and developmental needs.

Staff received formal engagement sessions with their ward supervisor or academic lead. These took the format of one to one meetings, clinical supervision sessions, attachment to specialist practitioners, mentoring and observation, reflective practice, and revalidation.

Nursing staff told us that they had received information and support from the trust about Nursing and Midwifery Council (NMC) revalidation. Many wards had developed clinical competencies for their specific area.

Junior nursing and medical staff were supported by their senior colleagues, who they described as approachable and willing to share. Many junior staff were involved in audit and improvement projects and were invited to attend senior staff meetings.

**Multidisciplinary working**

We observed well-attended, informal, and structured multidisciplinary team meetings throughout our visit. These meetings considered patient condition, clinical care, and discharge planning. We also observed informal discussions between professional colleagues at safety huddles and ward meetings.

Formal documented input from the multidisciplinary team collective was recorded in the medical records. The entries highlighted involvement in care and treatment planning, discharge processes, and social considerations.
The division had representation at the multi-agency steering group. The group were refreshing discharge procedures including adult social care colleagues.

We observed physical therapies being provided by the multidisciplinary team on the divisional wards at Cumberland Infirmary. This included ward based activities, group exercises and educational sessions however staff confirmed some clinical areas did not lend themselves to long term rehabilitation programmes.

We also observed informal discussions between professional colleagues at safety huddles and ward meetings.

There were clear internal referral pathways to therapy and psychiatric services. All wards had developed strong links with community colleagues when implementing discharge plans and care packages.

We observed multidisciplinary team board rounds being led by medics, nurses and therapists. The stroke team were part of the North-West Network multidisciplinary collaboration model for stroke care.

**Seven-day services**

The trust monitored its current working scheme against NHS Services, Seven Days a Week Clinical Standards. The division provided evidence to address the four priority clinical standards namely time to first consultant review, diagnostics, interventions and on-going review.

We found that there was consultant presence 8-10pm 7 days per week in acute medicine.

On-call consultants covered weekends and nights. Other medical out-of-hours cover was provided by one agency registrar, and two foundation year two doctors.

Endoscopy services at Cumberland Infirmary worked on a weekend waiting list initiative and aimed to deliver seven days working with increased resource in the near future.

The Cumberland Infirmary critical care outreach service was available to the division at all times. All ward staff said they had access to mental health and psychiatry support 24hrs per day, seven days per week.

‘Reach-Out’ was a new delirium service with two staff grade six nurses and support workers. The service operated seven days per week and had several key elements; prevention, effective screening, support, treatment, liaising with other services to support discharge and education.

Health professionals worked with patients who are at risk of developing delirium. Reach-Out provided education and practical support to other hospital staff aimed to improve awareness and recognition of delirium.

Access to physiotherapists and occupational therapy service is good with on call night services and a seven-day service. Physiotherapists worked both Saturday and Sunday on the ward with occupational therapists providing services on a Sunday.
The dietitians and speech and language therapy (SaLT) service was available from Monday to Friday only.

The ambulatory care ward provided seven days services between 9am to 8pm.

**Health promotion**

Divisional leads in conjunction with the leadership team had progressed staff surveys looking at health and wellbeing and seeking opinion from staff. This had generated physical activity schemes, physiotherapy services, mental health initiatives and the trust had appointed a health and wellbeing coordinator.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

**Mental Capacity Act and Deprivation of Liberty training completion**

**Trust level**

The trust reported that as at March 2018 Mental Capacity Act (MCA) training was completed by 89% of staff in medicine compared to the trust target of 95%.

Note: Mental Capacity Act training includes both level 1 and level 2.

A breakdown per staff group is shown in the table below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental staff</td>
<td>75</td>
<td>49</td>
<td>65%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>369</td>
<td>344</td>
<td>93%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>444</strong></td>
<td><strong>393</strong></td>
<td><strong>89%</strong></td>
<td><strong>95%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

Nursing staff fell just short of the trust target with 93% of staff having completed the training.

Over the same period deprivation of liberty safeguards training was completed by 78% of staff within medicine compared to the trust target of 95%.

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental staff</td>
<td>27</td>
<td>19</td>
<td>70%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>66</td>
<td>54</td>
<td>82%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>93</strong></td>
<td><strong>73</strong></td>
<td><strong>78%</strong></td>
<td><strong>95%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

**Cumberland Infirmary**

The trust reported that as at March 2018 Mental Capacity Act (MCA) training was completed by 90% of staff at Cumberland Infirmary in medicine compared to the trust target of 95%.
A breakdown per staff group is shown in the table below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental staff</td>
<td>63</td>
<td>44</td>
<td>70%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>284</td>
<td>268</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>347</td>
<td>312</td>
<td>90%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

Nursing staff fell just short of the trust target with 93% of staff having completed the training.

Over the same period deprivation of liberty safeguards training was completed by 77% of staff at Cumberland Infirmary within medicine compared to the trust target of 95%.

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental staff</td>
<td>25</td>
<td>17</td>
<td>68%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>58</td>
<td>47</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>83</td>
<td>64</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Trust Provider Information Request P14/P49)

We visited three medical wards at the Cumberland Infirmary specifically to look at the care of patients with mental health diagnosis. We found that most of nursing staff did not have a clear understanding of the Mental Capacity Act or the Mental Health Act. One staff member we spoke with told us that they completed a Deprivation of Liberty Safeguards application for all patients who lacked capacity. Other staff members told us they had completed applications for patients who required a drip or nasal gastric tubes.

We spoke with four nurses and two members of the delirium team at the Cumberland Infirmary. None of the nurses we spoke with were aware of fluctuating capacity and none had ever carried out a capacity assessment as they believed that this could only be done by doctors.

Two further patients had been admitted with confusion however capacity assessments had not been completed for either and the other patient was unable to communicate verbally so a capacity assessment had not been completed. It was not clear if the last patient was able to communicate as there was no communication care plan in place to assist staff and visitors.

Staff in the emergency assessment unit had a good knowledge of the Mental Capacity Act and were also aware of the Mental Health Act and the fundamental rules in relation to the Act.

We looked at the care records of two patients on the emergency assessment unit at the Cumberland Infirmary and found that staff had carried out a capacity assessment on one of the patients and although they had considered submitting an application under the Deprivation of Liberty Safeguards, they had not done this as they did not feel it necessary at that time.
The second patient had been detained under section three of the Mental Health Act and therefore was not able to leave the ward. Staff on the ward were aware what this detention meant and knew that the patient should not leave the ward. Staff we spoke with told us that if the patient tried to leave the ward they would make efforts to persuade the patient to stay but would not physically try to stop them. Staff were aware where they could get help if this was needed.

We spoke with the ward manager regarding the second patient and found that the ward manager was clear on their responsibilities and made sure staff were aware what they should do in relation to treatment.

We found the patient’s care record to be completed accurately with details of the detention and what treatment had been permitted in the patient’s best interest. We also found a copy of an application to the Court of Protection to enable doctors to perform a surgical procedure on the patient. This was necessary because the patient was detained and was refusing to have treatment. If granted, this would allow doctors to carry out the treatment without the patient’s authority.

**Is the service caring?**

**Compassionate care**

**Friends and Family test performance**

The Friends and Family test response rate for medicine at the trust was 29% which was better than the England average of 25% from April 2017 to March 2018.

**Friends and family Test – Response rate between 01/04/2017 to 31/03/2018 by site.**

![Friends and family Test - Wards (% recommend)]
The division used the ‘two minutes of your time’ survey which was completed monthly across divisional wards at Cumberland Infirmary. The survey covered six core questions relating to patient experience and quality of care. All wards at Cumberland Infirmary reported positive results, which were reflected in patient ratings, which averaged 9 out of 10.

The division took part in the National Cancer Patient Experience Survey (NCPES) 2016 receiving 409 responses. Patients were asked to rate their care on a scale of zero (very poor) to 10 (very good). Respondents gave an average rating of 8.3. Seventy-four percent of respondents said that they were involved as much as they wanted to be in decisions about their care and treatment. Eighty-eight percent said that overall, they were always treated with dignity and respect while they were in hospital.

We saw that divisional wards advertised ‘you said, we did’ actions on noticeboards at ward entrances to report on changes made following patient feedback on care.

We spent time observing care interactions between staff and patients. These were polite and compassionate. However, patients commented that the ward appeared short staffed. Nonetheless, patients described feeling safe on the wards and said that, when they needed a member of staff, they responded promptly to the call bell.

Privacy and dignity was maintained and we observed staff informing patients of any care delivery and seeking their consent before proceeding. Staff confirmed that, when they assessed patient needs, they always considered personal preferences, cultural, social, and religious needs.

The majority of the wards we visited had set visiting times to ensure meal times were protected. Staff authorised visiting outside of these hours to assist in individual circumstances.
Staff displayed and shared positive feedback on noticeboards which stated, “excellent nursing” and “thanks for care and support”, a family card thanked doctors and nurses for their “love, kindness and care”. Another said, “dedicated care to the patient and support offered to the family”.

During a discussion with a patient we were told that “patients were looked after very well and the staff were hardworking and caring”.

**Emotional support**

Family members were actively encouraged to get involved in any aspect of care they felt able, with consent of the patient.

Patients stated that they were given time to speak with nurses and doctors about their care and that information was explained clearly. Staff assessed patients and used clinical judgment to identify those who may require additional support in understanding care and treatment.

Senior clinical staff were available to answer questions or concerns from patients and family members. We were advised that relatives could book appointments to meet with medical and nursing staff.

We observed nurses and therapy staff actively engaging in rehabilitative activities with patients and family members.

Patients told us “ward staff treat and look after me really well”. They have been “really understanding and supportive regarding my planned amputation”, and “staff put up with a lot with patients who are demanding aggressive or shouting”.

**Understanding and involvement of patients and those close to them**

We observed emotional support being provided by nurses and indirect care being provided by housekeeping and domestic staff.

All patient care plans commented on individual patient social, emotional, and spiritual needs and, where relevant, this was integrated into the care plan.

Staff acknowledged that being in hospital can be distressing and frightening for a number of patients. Staff spent time understanding individual concerns and environmental triggers which could exacerbate emotional stability and wellbeing. Staff informed us that patients also received emotional support from chaplaincy and bereavement services, support groups, charity workers, and volunteer staff.

Staff offered patients and relatives private areas if they wanted time away from their bed area to discuss personal matters.

**Is the service responsive?**

**Service delivery to meet the needs of local people**
The division supported the trust in planning services to meet the needs of the people of Cumbria in conjunction with the local clinical commissioning group (CCG). Divisional management staff attended meetings with local CCG representatives to feed into the local health network and identify service improvements to meet the needs of local people.

It was acknowledged by the divisional management team, that developing future services would better position it to respond to the demands upon it, namely the needs of its population, geography, local infrastructure, and recruitment issues.

The trust employed one stroke physician who took part in a Telestroke system integrating staff from six trusts to mount an acute stroke service. A transient ischaemic attack (TIA) clinic was held every morning and then ward work. The hospital was covered by a stroke physician 9am to 5pm Monday to Friday. The stroke ward had 32 beds which were not ring fenced, however, we found that stroke patients were rarely moved elsewhere.

The division had access to escalation beds at Cumberland Infirmary (primarily for winter pressures or surges in demand) attached to various existing medical wards. When divisional managers opened the beds, these tended to be staffed by existing ward based staff. These beds were not in use at the time of the inspection.

The division had appointed a number of specialist nurses and developed a number of specialist clinics.

Heart failure nurse specialists were in post to support this cohort of patients requiring specialist cardiology care.

In September 2015, the division opened a hybrid medical procedures unit at to support divisional services. The aim was to reduce unnecessary patient admissions and support patient ease of access to day services. The unit worked with 13 specialisms across the organisation.

The chemotherapy unit at Reiver House had specialist chemotherapy nurses and clinical leads for guidance and advice on haematological and oncological conditions.

Meeting people’s individual needs
The divisional managers confirmed that, when planning services, the needs of all patients, irrespective of age, disability, gender, race, religion, or belief were considered.

During the inspection we observed various dementia initiatives in place to improve care. These included dementia care bundles, John’s campaign, Forget-me-not and the butterfly scheme which discreetly identified dementia patients.

We were advised that patients with a learning disability were catered for dependant on need. For example, a patient earlier in the year was very anxious in a ward of other people. As a result, it was arranged, with patient and family involvement to move into an individual cubicle.

Staff stated that they could access support from the learning disability and most patients had a ‘This is me’ passport. The passport detailed personal preferences, likes/dislikes, anxiety triggers, and interventions which were helpful in supporting them during difficult periods.
Staff informed us that they had ease of access/referral into psychiatric services for those patients requiring this care, when needing MCA/DoLS guidance.

All wards displayed information for patients and carers on a variety of topics such as trust information, quality standards, disease/condition specific information, ward/staff contact details, a who’s who of staff on the ward, and general useful signposting on where to get further information such as Patient Advice and Liaison Services (PALS), and complaints.

Staff explained that translation services were available and found the process easy to use. The trust had chaplains who provided access to major faiths within their communities. Staff accommodated faith preferences, and this was facilitated by the chaplaincy service or at the bedside.

Staff we spoke with explained that they could access bariatric equipment via equipment storage when this was required. This included access to special beds, wheelchairs and chairs.

Letters to patients were provided in a larger font for patients with impaired sight. We found that text and telephone calls were used to remind patients about appointments and elective admissions.

The trust was working with the Learning Disability lead to implement ‘easy read’ leaflets for patient appointments and admissions. In addition to this, the trust was considering how they ensured learning disability patients were offered reasonable adjustments for appointments, such as, being offered appointments at the beginning of clinics and extended clinic slots to support patients’ complex needs.

**Average length of stay**

**Trust Level**

From February 2017 to January 2018 the average length of stay for medical elective patients at the trust was 2.1 days, which is much lower than the England average of 5.8 days.

For medical non-elective patients, the average length of stay was 5.9 days, which is lower than the England average of 6.4 days.

**Average length of stay for elective specialties:**

- Average length of stay for elective patients in cardiology and gastroenterology is lower than the England average.
- Average length of stay for elective patients in nephrology is much lower than the England average.

**Elective Average Length of Stay – Trust Level**

<table>
<thead>
<tr>
<th>This trust</th>
<th>England Average</th>
</tr>
</thead>
</table>
Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine, cardiology and geriatric medicine is similar to the England average.

Non-Elective Average Length of Stay – Trust Level

Cumberland Infirmary

- From February 2017 to January 2018 the average length of stay for medical elective patients at Cumberland Infirmary was 2.0 days, which is lower than England average of 5.8 days. For medical non-elective patients, the average length of stay was 5.7 days, which is similar to the England average of 6.4 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in cardiology and gastroenterology is lower than the England average.
- Average length of stay for elective patients in nephrology is much lower than the England average.

Elective Average Length of Stay - Cumberland Infirmary
Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine, cardiology and geriatric medicine is similar to the England average.

Non-Elective Average Length of Stay - Cumberland Infirmary

Access and flow

Referral to treatment (percentage within 18 weeks) - admitted performance

Referral to treatment (RTT) times followed a stable trend over the period April 2017 to March 2018. Trust performance was on average 3% better than the England average for eight of the twelve months. In August and September 2017, trust rates were 8% and 4% respectively lower than the England average. During the winter months of November 2017 and January 2018 trust rates were 3% and 5% respectively lower than the England average.

(Source: NHS England)
Referral to treatment (percentage within 18 weeks) – by specialty

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric medicine</td>
<td>100%</td>
<td>97.5%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>100%</td>
<td>93.1%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>95.5%</td>
<td>94.1%</td>
</tr>
<tr>
<td>Neurology</td>
<td>0%</td>
<td>91.5%</td>
</tr>
</tbody>
</table>

Three specialties, general medicine, rheumatology and thoracic medicine were above the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric medicine</td>
<td>100%</td>
<td>97.5%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>100%</td>
<td>93.1%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>95.5%</td>
<td>94.1%</td>
</tr>
</tbody>
</table>

One specialty, neurology was below the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurology</td>
<td>0%</td>
<td>91.5%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

The trust provided us with sight of medical outliers (medical patients being cared for on non-medical wards) bed occupancy data at Cumberland Infirmary. Between January 2018 and June 2018, the number of patients classified as being medical outliers ranged was 2,209.

Staff on the non-medical wards confirmed that medical outliers remained under the care of their admitting medical team and that these patients were reviewed regularly. Staff confirmed that these patients were discussed at bed meetings, to facilitate return to their base ward and vacate the surgical bed.

Wards with medical outliers were paired with specific teams to look after medical patients. Consultants did early rounds Monday to Friday based on early morning emails with patient lists. Junior doctors from the base ward undertake the daily tasks. We were informed that new admissions or listed complex patients were reviewed, but not all patients.

From May 2017 to April 2018, there were 1,750 patients moving wards at night across the trust. Ward moves at night followed an overall increasing trend over the period, from 82 in May 2017 to 154 in April 2018. There were on average of 146 ward moves per month. From August to December 2017 however numbers escalated and an average of 176 ward moves per month were reported. Numbers decreased from 176 in December 2017 to 112 in February 2018, while increasing again to 174 in March 2018, after which numbers decreased to 154 in April 2018.
The trust held local and cross-site bed meeting teleconferences during the day to address access and flow issues. Division senior nursing staff, matrons, and business managers attended to record bed occupancy and availability, discharges, and pending admissions.

All wards held daily board rounds and staff worked with pharmacy colleagues to obtain patient medications to take home in a timely manner.

There had been no mixed sex breaches in the division in the previous 12 months.

There was an electronic system of appointing social workers to individual cases. Staff have found delays in finding a social worker and inefficiencies with several different social workers visiting the wards at the same time to see different patients. Staff told us that the old system of a ward based social worker was better.

We spoke with the integrated discharge team (IDT) and found that different types of multidisciplinary team meetings were needed to achieve successful discharge of complex patients, using the discharge screening tool (DST). Each meeting, involving family, social worker, occupational therapist, physiotherapist, nursing staff and doctor, could take 90 minutes to two hours to complete. The discharge screening tool used by the IDT was not anticipatory and came into operation when the patient was medically fit, which might involve a wait of two weeks or more. Some patients can spend time in the on-site residential home where the trust has purchased for 15 step-down beds. There is no medical input into this home. Patients who spend this time in other community hospitals would have the benefit of General Practitioner (GP) ward rounds each morning.

Community beds were being re-planned. These developments were not synchronised and there was an anticipated period time when there will be a marked reduction in community beds. We were not made aware of any major issues relating to delayed transfers of care (DTOC) outliers. We were informed that an increasing number of patients were admitted to the Cumberland Infirmary from Scotland. We were informed that during the week prior to inspection, there were five on the ward, a fifth of the patients. We were advised that home discharge packages for Scottish patients are extremely difficult to arrange and may take months. One of the only successful ways is to arrange an agreed transfer to a Scottish community hospital from which the home discharge package is prepared.

We were informed that there were Frailty Assessment clinics offered at the Cumberland Infirmary between Monday and Friday from 09:00 to 16.00. Direct referrals were accepted from GPs, the emergency department and specialist wards.

There were transient ischemic attack (TIA) clinics offered at the Cumberland Infirmary between Monday and Friday from 09:00 to 12:00. Direct referrals were accepted from GPs, and the emergency department.

There are no rapid access or hot clinics in gastroenterology, renal or endocrinology. There were also no rapid access or hot clinics in dermatology or oncology.

**Patient moving wards per admission**

Information provided by the trust stated that data is captured on the daily Situation Reports (Sit
Reps) but the system does not have the ability to extract data to provide a longer-term overview.

(Source: Trust Routine Provider Information Request – Ward moves)

**Patient moving wards at night**

The trust is unable to provide data broken down to ward level or per core service and data is provided across all core services at site level.

From May 2017 to April 2018, there were 1,750 patients moving wards at night across the trust. Ward moves at night followed an overall increasing trend over the period, from 82 in May 2017 to 154 in April 2018. There were on average of 146 ward moves per month. From August to December 2017 however numbers escalated and an average of 176 ward moves per month were reported. Numbers decreased from 176 in December 2017 to 112 in February 2018, while increasing again to 174 in March 2018, after which numbers decreased to 154 in April 2018.

(Source: Trust Routine Provider Information Request – Moves at night)

**Learning from complaints and concerns**

**Summary of complaints**

**Trust level**

From April 2017 to March 2018 there were 66 complaints about medical care. The trust took an average of 31 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be, responded to and closed within 30 working days. We found that 100% compliance for complaints responded to within 30 working days in February 2018.

Medical staff received the highest number of complaints of 51 (77%) followed by nursing staff with 12 complaints (18%). The most complaint about service area was elderly care (frailty unit) with 13 (20%) complaints, respiratory received the second highest number of seven (11%) complaints.

The trust did not allocate a site to two complaints received.

A breakdown of complaints per subject is shown in the table below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment / care - inpatient</td>
<td>42</td>
<td>64%</td>
</tr>
<tr>
<td>Treatment / care - outpatient</td>
<td>15</td>
<td>23%</td>
</tr>
<tr>
<td>Attitude of staff</td>
<td>4</td>
<td>6%</td>
</tr>
<tr>
<td>Appointment issues</td>
<td>3</td>
<td>5%</td>
</tr>
<tr>
<td>Information &amp; communication</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>Lost property and expenses</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Grand total</strong></td>
<td>66</td>
<td></td>
</tr>
</tbody>
</table>
Cumberland Infirmary

Cumberland Infirmary received 47 complaints, of these 32 (68%) were about inpatient treatment and care. Twenty-two (47%) of complaints were partially upheld, 14 (30%) refuted, nine (19%) upheld and two (4%) were transferred to serious incidents.

A breakdown of complaints per subject is shown in the table below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment / care - inpatient</td>
<td>32</td>
<td>68%</td>
</tr>
<tr>
<td>Treatment / care - outpatient</td>
<td>8</td>
<td>17%</td>
</tr>
<tr>
<td>Attitude of staff</td>
<td>3</td>
<td>6%</td>
</tr>
<tr>
<td>Appointment issues</td>
<td>2</td>
<td>4%</td>
</tr>
<tr>
<td>Information &amp; communication</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>Lost property and expenses</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Grand total</strong></td>
<td>47</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

We saw that the trust had a complaint policy and staff were aware of it. Staff discussed feedback from complaints and lessons learnt at ward meetings. We were advised that minor complaints were dealt with at ward level by the ward manager and identified issues were generally resolved at the time.

The wards we visited displayed leaflets and posters outlining the complaints procedure and escalation processes and how to access further support from Patient Advice and liaison Services.

Number of compliments made to the trust

The trust was unable to provide data broken down per core service.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

The medical care division had a clear management structure defining lines of responsibility and accountability. The division was led by an associate medical director, an associate chief operating officer and a divisional chief matron. The management team covered all sites. The division management structure was further underpinned by two general managers, business managers, divisional human resources business partner, governance facilitator and clinical directors for the service specialisms namely acute medicine, cardiology and respiratory, elderly care, rehabilitation and stroke, gastroenterology, renal, dermatology, oncology and allied health professionals.

The divisional leads understood the current challenges and pressures impacting on service delivery and patient care.
We reviewed divisional operational board monthly meeting minutes for January and February 2018. These meetings were well attended by the divisional leadership across both sites. The agenda covered strategic, operational, divisional and business unit items. The Chair updated action plans after the meeting and these were revisited as a standing agenda item at subsequent meetings.

Divisional leadership recognised their cross-site responsibilities and encouraged staff to engage with colleagues on other trust sites to build team networks. Some roles provided staff with the opportunity to work cross-site and liaise with the wider divisional team.

Ward staff confirmed that clinical leaders were visible, approachable and part of the team. Staff did not view the senior management team in the same way stating they were not as visible as they could be. Staff also stated that they were not familiar with some members of the senior management team.

We observed the site co-ordinator in the late evening, working calmly and decisively during a difficult period. We saw the co-ordinator assessing and responding to patient risk and deploying staff promptly and appropriately.

Staff felt that communication from the divisional leaders could be further improved.

**Vision and strategy**

The vision and strategic goals for the division mirrored the aims and objectives of the trust. The trust’s aim was to ‘ensure we provide high quality, safe and effective services for all our patients’. Divisional managers had developed a business plan which identified strategic priorities for the division aligned to trust principles and values. The divisional strategy had short, medium and long-term projections corresponding with performance improvement, clinical strategy, partnership working and engagement.

These included financial recovery plans, constitutional targets to meet patient outcomes, delivery of the trust quality improvement plan (QIP), sustainability by partner collaboration with multi-agencies, the Cumbria Clinical Commissioning Group (CCG), Cumbria Partnership NHS Foundation Trust, Cumbria County Council, North West Ambulance Service, NHS England and neighbouring NHS Foundation Trusts), exploring opportunities offered by the *Five Year Forward View* and improving staff engagement.

The divisional business unit plan further detailed key strategic priorities relevant to all areas such as workforce planning and improving patient flow to specific objectives under relevant business specialisms such as stroke services, older person’s services, cardiology, haemodialysis and ambulatory care.

Divisional managers completed a service review in 2016 to analyse on-going service delivery across key specialisms namely renal, cardiology, respiratory, gastroenterology, older person’s services, stroke and dermatology. This review looked at current service configuration, activity trend, quality and workforce issues, financial position, future clinical model proposals, sustainability issues and organisational options.
Culture

Staff at all levels spoke passionately about their work, and about the quality of care delivered. Staff spoke openly about some of the staffing difficulties faced on the wards but described their commitment to deliver the best possible care at all times.

We observed staff working together on the wards and a sense of ‘pulling together’ to get the job done. We saw with staff from a variety of specialisms and grades of staff working together effectively.

Staff morale was variable and staff expressed concern for colleagues working in particularly demanding wards due to staffing difficulties. Staff considered these issues to be national and generally described their managers as supportive and hard working. Recruitment efforts were recognised and teams were aware of progress being made where possible to fill vacancies.

All staff we spoke with told us their immediate line managers and clinical leaders were professional, supportive and helpful. Nursing and junior medical staff described their senior peers to be supportive, approachable and willing to spend time with them when necessary.

At listening events and focus groups prior to the inspection we heard divisional staff describe the culture as having improved but they stated they felt there was room for further improvement in terms of inclusion and communication.

Staff considered the amount and speed of change in the organisation, whilst they recognised this as necessary, felt it added to existing pressures and did not bring about the immediate perceived benefits.

Governance

The division had clear governance channels into the wider organisational management structure. The medical division governance was clinician driven with multi-specialism input.

We reviewed monthly divisional governance, safety and quality board meeting minutes for January and February 2018. The agenda items covered relevant matters such as incidents, risk register, clinical audit, medication issues and policy review. When governance folders were checked on the three of the medical care wards, we found that information was out-of-date, incomplete.

Several weaknesses in governance and performance exist within the trust with respect to medicines use, as stated on the medicines optimisation strategy 2014 to 2019. There had been some recent and early signs of improvement but further significant change and action is required to deliver the level of care that patients need. The trust recognised that a fundamental requirement will be to have a safe and effective system for managing medicines to ensure that all patients received the medicines that they need, when they need them and irrespective of location within the Trust. The strategy outlines the seven strategic challenges required over the next five years to ensure delivery of the safe and effective use of medicines.

We saw that the divisional clinical audit reporting arrangements flow from the monthly dashboard into the emergency care and medicine operational board, to the safety and quality committee before presentation at the trust board.
The division actively contributed to the trust quality improvement plan which drew together organisational objectives and improvement plans.

The division were involved in reviewing procedures caught within the National Safety Standards for Invasive Procedures (NatSSIPs) agenda. The team had identified local invasive practices by business unit based on core NatSSIPs and were reviewing procedures locally to standardise practice, referred to as LocSSIPs. Division leads were working with the NatSSIPs Steering Group to prioritise specific procedures for development.

**Management of risk, issues and performance**

We were provided with sight of the divisional risk register dated 19 June 2018. Divisional managers confirmed the risk register was a live document with on-going review, actions taken and progress. However, we were advised that numerous items had remained on the risk register for several years.

The registers contained a risk descriptor, risk controls, control assurances, risk grading and reviewed progress against each. The on-going risks listed in the June 2018 register included a number of trust wide matters.

We found those risks which attracted a rating of 12 or more included nurse staffing cover and impact, slip, trips and falls, failure to consistently meet cancer targets, no substantive middle grade doctor in haematology-oncology, lack of consultant oncologist capacity, patient flow as well as education and training of the workforce.

Whilst detailed in terms of risk description, the register appeared unreliable, duplicating many common themes and lacking detail in terms of actions taken and progress over the period of time since the risk was identified. There were several examples of wards not knowing what the risk register was. Additionally, ward managers were unable to voice what risks were on it.

There was internal clinical audit activity and monitoring of performance and quality within the division. Senior staff recorded local and national measures and outcomes which fed into divisional activity.

**Information management**

Staff we spoke with raised no concerns about being able to access patient information or investigation results in a timely manner. However, we were advised that there were frequent difficulties recording and retrieving patient observations due to fluctuating WiFi signal on the ward. This was thought to cause many delays when checking and monitoring change in a patients’ observations.

We were notified, post inspection, that a recent WiFi upgrade has significantly improved coverage and performance and on 31 July, the e-observations software was upgraded to NEWS2 and monitoring data has showed that staff were using the system and all issues were being reported. The trust had 12 issues logged to date, all of which were resolved. An action plan was in place in order to ensure there was ongoing monitoring of WiFi performance and any issues reported to the service desk.
Staff informed us that discharge-planning considerations commenced on admission with input from the discharge team. We found that general practitioners (GPs) were informed of patient discharge in writing and always made themselves available in the event of any GP telephone queries.

Community services and ongoing care needs were identified by staff prior to the patient’s discharge and involved the patient, his or her family, and the service providers in the discharge planning.

Staff on specialist units gave patients and their families discharge booklets which provided medical information, treatment details, contact information, and signposting for further support and guidance.

**Engagement**

Divisional staff actively engaged with patients, family members and the local population to gather their opinions and obtain feedback regarding current services.

Patients and their families provided views and feedback on their experiences of using the service in the family and friends test, through the ‘two minutes of your time’ survey, ‘face-to-face and real-time surveys. Patients could also leave feedback on comment cards and via the trust website.

Wards displayed information for patients and their families on ways in which they could provide commentary about their experiences in a more confidential setting such as accessing patient advice and liaison services (PALS).

The division had good links with numerous volunteer organisations, charities and national support groups. The divisional stroke services supported a local stroke group network. The chemotherapy lead had forged strong links with MacMillan services supporting local projects and initiatives to improve care for this cohort.

The division supported the organisation and wider health community agenda with the consultation surrounding the future of healthcare services across the region.

The leadership team arranged staff forums and drop-in sessions. The trust chief executive held cross-site roadshows with previous topics covering staff support, staff morale and generating cost savings. Some staff commented how they were not able to attend due to the local of the forums, staff shortages and clinical duties.

The division provided staff with information via the trust intranet, email, and cascades from senior staff meetings. The division supported the development of the ‘glimpses of brilliance’ (GOB) boards on wards where staff could share and celebrate positive outcomes, patient feedback and work-related successes.

Staff had developed good links with external professional colleagues, support organisations and volunteer groups.
Staff commented how their line managers and clinical support network showed understanding, empathy and kindness during the difficult time. Manager supported staff returning to work following a leave of absence.

Friends and family test score: staff showed that 57 staff recommend this trust as a place to work. There were 251 responses out of 4,100 staff who work at this trust.

The NHS staff survey outcomes for 2017 showed a 54.4% return rate for the trust. The survey was made up of 88 questions separated under five themes. We found that compared to 2016, out of 88 questions the trust had 13 questions showed outcomes which were significantly better, 72 showed no change and three areas were significantly worse.

The top three findings from the NHS staff survey outcomes for 2017 compared to other acute trusts were the ‘percentage of staff appraised’, the ‘percentage of staff working extra hours’ and the ‘percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months’.

The lowest three findings from the NHS staff survey outcomes for 2017 compared to other acute trusts were ‘quality of appraisals’, ‘support from immediate managers’ and ‘percentage of staff reporting good communication between senior management and staff’.

**Learning, continuous improvement and innovation**

- The trust provided us with detail of divisional innovations within the last two years. They reported a joint project with the University of Cumbria to develop and appoint allied nurse practitioners (occupational therapists) to support the nursing compliment across the division.
- ‘Reach-Out’ was a new delirium service which operated seven days per week and had several key elements; prevention, effective screening, support, treatment, liaising with other services to support discharge and education.
- The stroke team were part of the North-West network which provided telemedicine (Telestroke) services across the region.
- The Cumberland Infirmary has been one of nine disablement service centres (DSCs) (Murrison Centre) across England selected to provide enhanced services to veterans who lost a limb because of their service in the armed forces.
- The endobronchial ultrasound service implemented and successfully moved to core biopsy improving diagnostic rates.
- The ambulatory lung biopsy vent improved the lung cancer pathway
- The trust had recruited sleep specialist nurses to provide continuous positive airway pressure (CPAP) service and in due course plan to introduce an in-house sleep diagnostic service.
- We were advised that the new exhaled nitric oxide analysers purchased were improving asthma care.
- A subspecialist interstitial lung disease clinic has been developed (with same day gas transfer testing, and embedded specialist nurse with palliative care skillset).
- Local safety standards for invasive procedures (LocSSIPs) had been introduced and embedded in cardio catheterisation lab.
- The trust was top in the UK for patient reported experience measures survey for kidney care.
- We were informed that the home therapists were shortlisted for a national award.
- The peritoneal dialysis nursing team at the trust were nominated for a Burdett Award (The Burdett trust for nursing).
- The trust host and participate in Regional Upper GI Endoscopy training
- A hyper-acute stroke unit business case was approved and the implementation process has commenced.
- We were informed that the frailty service had received a HSJ nomination.
- There were joint appointments agreed with the University of Central Lancashire and professor of medicine, senior lecturers and clinical fellows.
- We were advised of secondment of community heart failure nurses to acute and developing single services.
- A business case for a Cancer Centre within a large North-East hospital had been approved
- The trust was providing scientific immunology at a large North-East hospital.
- We saw that pathology services within the trust had received ISO (15189) Accreditation.
- A consultant of the week had been implemented to provide clear direction to staff and patients across the directorate.
- A new sleep apnoea service had been introduced and the introduction of sleep specialist nurses were due to be appointed at the hospital in the future.
- Additional respiratory nurses to be introduced the support the ward based pleural service. The COPD care bundle had been updated and a new asthma bundle created. This included the purchase of new exhaled nitric oxide analysers to use improve asthma care
- The introduction of specialist interstitial lung disease clinic developed (with same day gas transfer testing, and embedded specialist nurse with palliative care skillset) and now participating in regional MDT work.
- A cardiologist lead for the directorate agreed and improved cardiologist cover for the hospital. Heart failure nurses appointed.
- The trust had recently purchased new dialysis machines and the renal department commenced expansion within this service.
- We were informed that the trust has purchased a fibro scan and that staff training had completed
- During the inspection were informed of approval to progress to a seven-day endoscopy service in the near future.
- The trust had appointed advanced care practitioners.
The trust provides both emergency and elective surgical intervention at two sites Cumberland Infirmary and West Cumbria Hospital. Surgical service is split into a number of specialities as listed below:

- General surgery (lower GI, upper GI, breast)
- Urology
- Theatres & anaesthetics
- Critical care & High dependence unit
- Trauma & orthopaedics
- Rheumatology
- Head & neck (ENT, oral surgery, orthodontics)
- Ophthalmology
- Vascular
- Radiology

Trauma is carried out at Cumberland Infirmary with the one list of minor trauma procedures carried out weekly at West Cumberland Hospital.

Emergency surgery is provided primarily at Cumberland Infirmary and a clinical pathway is in place for patients presenting at West Cumberland Hospital requiring emergency surgical intervention.

The trust has seven surgical wards with 157 inpatient beds.

(Source: Routine Provider Information Request (Acute RPIR) – Info about service)

The trust had 25,605 surgical admissions from January to December 2017. Emergency admissions accounted for 7,388 (29%), 15,122 (59%) were day case, and the remaining 3,095 (12%) were elective.

(Source: Hospital Episode Statistics)

Following a comprehensive inspection in 2016, the trust was required to complete the following actions:

- Ensure the perioperative improvement plan is thoroughly embedded and debrief sessions are undertaken;
- Improve compliance against 18 week RTT standards for oral surgery, trauma and orthopaedics, urology and ophthalmology;
- Improve rate of short notice cancellations for non-clinical reasons, specifically ENT, orthopaedic and general surgery; and
- Must ensure patients whose operations are cancelled are treated within 28 days.
During this inspection we visited all surgical wards, the surgical assessment unit, and the day surgery unit. We observed care being given and surgical procedures being undertaken in theatres and recovery areas. We spoke with 32 patients and relatives and 26 members of staff. We observed care and treatment and looked at 18 care records.

**Is the service safe?**

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

**Mandatory training**

The trust set a target of 95% for completion of mandatory training.

**Trust level**

A breakdown of compliance for mandatory training courses as at March 2018 at trust level for qualified nursing staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving &amp; handling level 1 non clinical (3 yearly)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, trips and falls level 1</td>
<td>362</td>
<td>354</td>
<td>98%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk management</td>
<td>362</td>
<td>350</td>
<td>97%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>361</td>
<td>342</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Duty of candour</td>
<td>362</td>
<td>341</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>362</td>
<td>340</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety</td>
<td>362</td>
<td>340</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>362</td>
<td>340</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>362</td>
<td>337</td>
<td>93%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent level 1&amp;2</td>
<td>362</td>
<td>327</td>
<td>90%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia</td>
<td>335</td>
<td>302</td>
<td>90%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines management</td>
<td>350</td>
<td>308</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control level 2</td>
<td>362</td>
<td>308</td>
<td>85%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Calculating drug doses</td>
<td>347</td>
<td>290</td>
<td>84%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health records management</td>
<td>362</td>
<td>301</td>
<td>83%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Hand hygiene (clinical)</td>
<td>362</td>
<td>287</td>
<td>79%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>BLS (adults)</td>
<td>72</td>
<td>56</td>
<td>78%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; handling level 2</td>
<td>361</td>
<td>278</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>News</td>
<td>312</td>
<td>213</td>
<td>68%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 04</td>
<td>14</td>
<td>9</td>
<td>64%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>ILS (adults)</td>
<td>268</td>
<td>168</td>
<td>63%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 01</td>
<td>327</td>
<td>200</td>
<td>61%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
In surgery the 95% target was met for four of the 28 mandatory training modules for which qualified nursing staff were eligible. Blood safety 04 had a completion rate of 64%, although this equates to only five staff members that did complete the training. Apart from the four training modules that met the 95% trust target a further seven modules had completion rates of 90% and above. Moving & handling level 1 non clinical (3 yearly) had a 100% completion rate, although only one staff member was eligible for this training.

A breakdown of compliance for mandatory training courses from as at March 2018 at trust level for medical staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand hygiene (non clinical)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>NG tubes</td>
<td>65</td>
<td>58</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>147</td>
<td>130</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Duty of candour</td>
<td>147</td>
<td>123</td>
<td>84%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prompt</td>
<td>12</td>
<td>10</td>
<td>83%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, trips and falls level 1</td>
<td>147</td>
<td>121</td>
<td>82%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk management</td>
<td>147</td>
<td>120</td>
<td>82%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>147</td>
<td>117</td>
<td>80%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Hand hygiene (clinical)</td>
<td>146</td>
<td>115</td>
<td>79%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>147</td>
<td>113</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; handling level 1 clinical (3 yearly)</td>
<td>147</td>
<td>112</td>
<td>76%</td>
<td>95%</td>
<td>No</td>
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<tr>
<td>Health and safety</td>
<td>147</td>
<td>111</td>
<td>76%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent level 1&amp;2</td>
<td>147</td>
<td>110</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>147</td>
<td>109</td>
<td>74%</td>
<td>95%</td>
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<td>Trust doctors patient safety programme</td>
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<td>74%</td>
<td>95%</td>
<td>No</td>
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<tr>
<td>Dementia</td>
<td>124</td>
<td>89</td>
<td>72%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Calculating drug doses</td>
<td>138</td>
<td>97</td>
<td>70%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control level 2</td>
<td>147</td>
<td>100</td>
<td>68%</td>
<td>95%</td>
<td>No</td>
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<tr>
<td>Medicines management</td>
<td>139</td>
<td>93</td>
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<td>95%</td>
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</tr>
<tr>
<td>ALS (adults)</td>
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<td>95%</td>
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<tr>
<td>BLS (paediatrics)</td>
<td>29</td>
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<td>95%</td>
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<tr>
<td>BLS (adults)</td>
<td>92</td>
<td>59</td>
<td>64%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health records management</td>
<td>147</td>
<td>90</td>
<td>61%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>News</td>
<td>109</td>
<td>66</td>
<td>61%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Module</td>
<td>Required</td>
<td>Completed</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Target met Yes/No</td>
</tr>
<tr>
<td>--------</td>
<td>----------</td>
<td>-----------</td>
<td>----------------</td>
<td>--------------</td>
<td>-------------------</td>
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<tr>
<td>Moving &amp; handling level 1 (non clinical)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, trips and falls level 1</td>
<td>268</td>
<td>261</td>
<td>97%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk management</td>
<td>268</td>
<td>257</td>
<td>96%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>267</td>
<td>250</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Duty of candour</td>
<td>268</td>
<td>249</td>
<td>93%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety</td>
<td>268</td>
<td>249</td>
<td>93%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>268</td>
<td>249</td>
<td>93%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>268</td>
<td>248</td>
<td>93%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>268</td>
<td>245</td>
<td>91%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia</td>
<td>255</td>
<td>226</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent level 1&amp;2</td>
<td>268</td>
<td>236</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines management</td>
<td>256</td>
<td>219</td>
<td>86%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health records management</td>
<td>268</td>
<td>220</td>
<td>82%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control level 2</td>
<td>268</td>
<td>219</td>
<td>82%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Calculating drug doses</td>
<td>253</td>
<td>205</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>BLS (adults)</td>
<td>58</td>
<td>46</td>
<td>79%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Hand hygiene (clinical)</td>
<td>268</td>
<td>210</td>
<td>78%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; handling level 2</td>
<td>267</td>
<td>208</td>
<td>78%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>News</td>
<td>219</td>
<td>140</td>
<td>64%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>ILS (adults)</td>
<td>191</td>
<td>114</td>
<td>60%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 01</td>
<td>248</td>
<td>147</td>
<td>59%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 02</td>
<td>241</td>
<td>129</td>
<td>54%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>ILS (paediatrics)</td>
<td>102</td>
<td>52</td>
<td>51%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>111</td>
<td>54</td>
<td>49%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Understanding end of life</td>
<td>267</td>
<td>119</td>
<td>45%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk management (board and senior management)</td>
<td>40</td>
<td>17</td>
<td>43%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In surgery the 95% target was met for one of the 28 mandatory training modules for which medical staff were eligible. ALS (adults) had a completion rate of 67% and ILS (adults) had a completion rate of 40%, this equates to only one and three staff members respectively that did not complete the training. Hand hygiene (non clinical) had a 100% completion rate, although only one staff member was eligible for this training.

**Cumberland Infirmary**

A breakdown of compliance for mandatory training courses as at March 2018 for qualified nursing staff in the surgery department at Cumberland Infirmary is shown below:
At Cumberland Infirmary the 95% target was met for one of the 27 mandatory training modules for which medical staff were eligible. ALS (adults) had a completion rate of 50% and Prompt a completion rate 88%, this equates to only one staff member that did not complete the training for both modules.

A breakdown of compliance for mandatory training courses as at March 2018 for medical staff in the surgery department at Cumberland Infirmary is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand hygiene (non clinical)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>113</td>
<td>102</td>
<td>90%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NG tubes</td>
<td>46</td>
<td>41</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prompt</td>
<td>8</td>
<td>7</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Duty of candour</td>
<td>113</td>
<td>93</td>
<td>82%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, trips and falls level 1</td>
<td>113</td>
<td>91</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk management</td>
<td>113</td>
<td>90</td>
<td>80%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>113</td>
<td>88</td>
<td>78%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>113</td>
<td>86</td>
<td>76%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; handling level 1 clinical (3 yearly)</td>
<td>113</td>
<td>86</td>
<td>76%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Hand hygiene (clinical)</td>
<td>112</td>
<td>84</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>113</td>
<td>84</td>
<td>74%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety</td>
<td>113</td>
<td>84</td>
<td>74%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent level 1&amp;2</td>
<td>113</td>
<td>83</td>
<td>73%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Trust doctors patient safety programme</td>
<td>112</td>
<td>81</td>
<td>72%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia</td>
<td>97</td>
<td>67</td>
<td>69%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Calculating drug doses</td>
<td>105</td>
<td>71</td>
<td>68%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control level 2</td>
<td>113</td>
<td>76</td>
<td>67%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>News</td>
<td>82</td>
<td>55</td>
<td>67%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines management</td>
<td>105</td>
<td>69</td>
<td>66%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>BLS (paediatrics)</td>
<td>23</td>
<td>15</td>
<td>65%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health records management</td>
<td>113</td>
<td>71</td>
<td>63%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>BLS (adults)</td>
<td>76</td>
<td>46</td>
<td>61%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>ALS (adults)</td>
<td>2</td>
<td>1</td>
<td>50%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 01</td>
<td>94</td>
<td>45</td>
<td>48%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>13</td>
<td>5</td>
<td>38%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 02</td>
<td>11</td>
<td>4</td>
<td>36%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Cumberland Infirmary the 95% target was met for one of the 27 mandatory training modules for which medical staff were eligible. ALS (adults) had a completion rate of 50% and Prompt a completion rate 88%, this equates to only one staff member that did not complete the training for both modules.
Apart from the one training module that met the 95% trust target a further one module had a completion rate of 90%.

Hand hygiene (non clinical) had a 100% completion rate, although only one staff member was eligible for this training.

(Source: Routine Provider Information Request (RPIR) – P40)

Senior managers explained that staff shortages had contributed to the lower than expected compliance and it would take time for staff to catch up with their mandatory training. At ward level ward managers told us their staff were either booked to receive training or had been encouraged to complete as soon as practicable. Staff we spoke with confirmed that training completion was discussed at annual appraisals and throughout the year.

The divisional senior management team had initiated action to increase the levels of compliance for mandatory training. This included reimbursing staff for undertaking training during their own time and linking the completion of mandatory training to salary progression.

### Safeguarding

The trust set a target of 95% for completion of safeguarding training.

#### Trust level

A breakdown of compliance for safeguarding training courses as at March 2018 at trust level for qualified nursing staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 3</td>
<td>14</td>
<td>13</td>
<td>93%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>(specialist)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>313</td>
<td>281</td>
<td>90%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>362</td>
<td>315</td>
<td>87%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>35</td>
<td>30</td>
<td>86%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>(core)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In surgery the 95% target was met for none of the five safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses as at March 2018 at trust level for medical staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 2</td>
<td>128</td>
<td>93</td>
<td>73%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>147</td>
<td>103</td>
<td>70%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
In surgery the 95% target was met for none of the three safeguarding training modules for which medical staff were eligible.

Cumberland Infirmary

A breakdown of compliance for safeguarding training courses as at March 2018 for qualified nursing staff in the surgery department at Cumberland Infirmary is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 3 (core)</td>
<td>13</td>
<td>12</td>
<td>92%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>255</td>
<td>225</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>268</td>
<td>231</td>
<td>86%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Cumberland Infirmary the 95% target was met for none of the three safeguarding training modules for which qualified nursing staff were eligible. Safeguarding children level 3 (core) had a completion rate of 92%, this equates to only one staff member not completing this training.

A breakdown of compliance for safeguarding training courses from as at March 2018 for medical staff in the surgery department at Cumberland Infirmary is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults level 1</td>
<td>113</td>
<td>81</td>
<td>72%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>101</td>
<td>71</td>
<td>70%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 3 (core)</td>
<td>12</td>
<td>7</td>
<td>58%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Cumberland Infirmary the 95% target was met for none of the three safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – P40)

We were not assured that safeguarding training was delivered in accordance with ‘Adult Safeguarding Levels and Competencies for Healthcare, Intercollegiate guidance (2016)’. This recommends level two training for clinical staff and level three for staff responsible for the review of alerts.

Training data submitted by the trust prior to inspection, showed that all staff appear to be completing level one adults safeguard training. This included managers investigating safeguarding alerts.

The trust’s adults safeguarding policy stated that all clinical staff working with adults should complete level two adults safeguarding training. Staff were instructed to inform their line.
managers when raising alerts, but the policy did not provide guidance for line managers to support any further action and no additional training was provided.

The divisional senior management team had initiated action to increase the levels of compliance for safeguarding training. This included reimbursing staff for undertaking training during their own time and linking the completion of training to salary progression.

The trust had systems and processes in place to protect patients from abuse and staff were aware of safeguarding and how to get help so that safeguarding was everyone’s responsibility. We saw that the trust had an up to date safeguarding policy that staff accessed on the trust’s intranet.

The trust had a lead nurse for adult and children safeguarding. The safeguarding sub-group reported to the safety and quality committee which reported to the board.

Staff were able to describe circumstances when they would make a safeguarding referral with the help of the central team. Staff at ward level described good support from the psychiatric team for patients with mental health needs.

**Cleanliness, infection control and hygiene**

We found ward areas were visibly clean and tidy and the trust had systems and processes in place to monitor and eliminate the risk of infection. Clinical equipment was visibly clean and labelled providing assurance of cleanliness.

However, the theatre environment was an exception to this. We observed that corridors were cluttered, adhesive remained on walls from previously attached posters, equipment appeared not to be well cleaned and patient sensitive information had been discarded in one theatre.

We reported this to the theatre manager and re-inspected these areas two days later; action had been taken immediately to address these issues and gave reassurance that the environment was now fit for purpose. The trust provided an action plan to immediately address the issues identified and maintain infection control and cleanliness.

The trust cleaning services policy included a set of standards and frequencies against which the trust monitored and assessed the effectiveness of cleaning services across the trust. Compliance was assessed against the NPSA national specifications for cleanliness.

Environmental audits were completed on a weekly basis. The latest audits gave compliance results for nursing (92%), domestic (100%) and estates (100%) areas – a combined total of 97% compliance. The latest audits (June 2018) of standard procedures showed 100% compliance for the day surgery unit and 93% for recovery. Hand hygiene audits showed 100% compliance within all surgical areas and action plans were discussed and monitored through ward meetings.

We saw staff washing their hands, using hand gel between patients and staff and complying with ‘bare below the elbows’ policies. Isolation rooms were available on all wards for the isolation of patients; signage was in place to advise anyone prior to entering an isolation room.

Personal protective equipment (PPE) and hand sanitising gel was available throughout wards and departments. We saw that infection prevention and control information was visible on all
wards and that staff wore PPE and complied appropriately with the principles of infection control.

All patients were screened for healthcare acquired infections and the assessment of patients who were at risk of developing a healthcare infection were incorporated into nursing assessment documentation as part of the electronic patient record. All wards visited had isolation for the treatment of patients identified at risk of infection.

We saw there were alcohol hand gels available on entry into the ward and posters on hand washing and sinks were available with adequate supplies of soap and paper towels. We saw sluice and linen rooms on each ward were visibly clean and tidy and all commodes seen were clean.

**Environment and equipment**

All equipment inspected had been electrical safety tested. The trust had systems in place for recording the service and maintenance of equipment identified through compliance stickers.

We saw that resuscitation trolleys were checked daily and accessibly located in ward areas. We inspected resuscitation equipment in wards and surgical areas and confirmed daily checks had been undertaken. All sharps bins seen were properly assembled, stored off of the floor, not over full and signed and dated. Two wards (Beech C and Beech D) shared a clean utility room and staff told us this could be a challenge in terms of space at times.

Staff we spoke with reported that they had enough equipment to provide safe care to patients e.g. moving and handling equipment and equipment for bariatric patients. We saw staff making use of personal protective equipment, for instance, when barrier nursing a patient.

The trust told us that all equipment was subject to routine planned preventative maintenance as defined by the equipment manufacturer and we saw that equipment had been maintained and were safety checked.

**Assessing and responding to patient risk**

The surgical division had systems and processes in place to support staff in wards and theatres to assess and respond to patient risk. An example of this was the development of a standard operating procedure for the management of critical care patients who were nursed in recovery areas within theatres that ensured specialist critical care nurses were available.

Within the electronic patient record there were a series of prompts built in to support staff in managing risks posed to individual patients. For example, automatic drug alerts, dose alerts, allergy alerts, venous thromboembolism alerts and care bundles such as for pressure ulcers or falls.

Information gathered from the electronic patient record was used to help the trust assess and respond to patient risks. Staff, using the electronic patient record, recorded patient observations using the national early warning score (NEWS) system. In addition, we saw that each ward displayed posters about the risk of sepsis. All staff we spoke with were able to describe what they would do to treat and escalate sepsis. Staff also had access to an outreach team if NEWS scores
were abnormal and staff required additional help.

The trust had a sepsis policy in place to provide best practice guidance to all staff involved in the care of patients presenting with sepsis. The policy covered initial management of patients with sepsis and was based on recommended research based evidence. Emphasis was placed on actions within the first hour and reflected NICE guidance issued in July 2016.

The policy required all ill or deteriorating patients to be screened for sepsis, using bedside observations, clinical skills, blood tests (including lactate) and imaging where appropriate. All patients with an elevated NEWS score were considered for screening and escalation to senior medical staff. Further management, such as the use of the sepsis care bundle and antibiotics were implemented.

We saw that patient observations were recorded appropriately on the electronic system and concerns about deteriorating patients were escalated in accordance with guidance and the NEWS system. During our inspection we saw that deteriorating patients had evidence of appropriate escalation and intervention recorded.

Risks associated with falls, pressure ulcers, VTE, catheter and urinary infections were assessed on a monthly basis using the NHS safety thermometer.

In theatres staff used the World Health Organisation' (WHO) surgical safety checklist. This was supplemented by the perioperative improvement plan (POIP) to ensure all debrief sessions were undertaken as part of the checklist to reduce the risk of never events.

The trust had taken action to ensure the POIP was embedded and that all debrief sessions were undertaken as part of the WHO checklist to reduce the risk of never events. The perioperative improvement plan was shared on the trust intranet and was a live document continually monitored and updated. Within the division, the POIP was discussed at the safety and quality board and surgical away days and also at relevant directorate meetings. LocSSIP audits were carried out on a monthly basis, each audit reviewed 10 patient episodes and a draft summary report on audits conducted to date was awaiting final approval.

The national safety standards for invasive procedures (NatSSIPs) incorporated the contents of the WHO surgical safety checklist. These required the checklist to be completed for every patient undergoing a surgical procedure (including local anaesthesia).

We saw that audits of completion of the checklist were carried out for all theatres. Staff told us the audit also identified whether the sign-in, time-out and sign-out had been completed for each patient. The audits provided by the trust showed completion of the checklist had been ‘poor’ and had not been completed for every patient.

The audit identified areas of good practice (compliance with the safety checklist, excluding debrief, was good; ‘no’ responses were less than 1%) and areas for improvement (compliance with the audit; omissions in the safety process were not always escalated). The audit outcomes were to be presented to the board in August 2018. Observation of procedures during this inspection showed the WHO checklist was appropriately completed.
Nurse staffing

The trust has reported their staffing numbers below for the period as at March 2018 and April 2018.

<table>
<thead>
<tr>
<th>Location</th>
<th>Mar-18 Actual WTE staff</th>
<th>Mar-18 Planned WTE staff</th>
<th>Mar-18 Fill rate</th>
<th>Apr-18 Actual WTE staff</th>
<th>Apr-18 Planned WTE staff</th>
<th>Apr-18 Fill rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>219.3</td>
<td>226.8</td>
<td>96.7%</td>
<td>216.6</td>
<td>228.2</td>
<td>94.9%</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>91.5</td>
<td>102.9</td>
<td>88.9%</td>
<td>90.4</td>
<td>108.0</td>
<td>83.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>310.8</strong></td>
<td><strong>329.7</strong></td>
<td><strong>94.3%</strong></td>
<td><strong>307.0</strong></td>
<td><strong>336.2</strong></td>
<td><strong>91.3%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16)

Vacancy rates

From April 2017 to March 2018, the trust reported a vacancy rate of 10% in surgery. This was higher than the trust target of 5%.

A breakdown for each site is as follows:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total vacancies (WTE)</th>
<th>Total number of staff establishment (WTE)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>231.0</td>
<td>2,890.7</td>
<td>8.0%</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>187.6</td>
<td>1,291.1</td>
<td>15.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>419.5</strong></td>
<td><strong>4,181.7</strong></td>
<td><strong>10.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From May 2017 to April 2018, the trust reported a turnover rate of 7.3% in surgery. This was better than the trust target of 13%.

A breakdown for each site is as follows:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total leavers (WTE)</th>
<th>Average number of staff establishment (WTE)</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>8.1</td>
<td>104.3</td>
<td>7.8%</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>6.2</td>
<td>90.5</td>
<td>6.9%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14.3</strong></td>
<td><strong>194.8</strong></td>
<td><strong>7.3%</strong></td>
</tr>
</tbody>
</table>
### Sickness rates

Between April 2017 and April 2018, the trust reported a sickness rate of 5% in surgery. This was higher than the trust target of 4%.

A breakdown for each site is as follows:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total absence days</th>
<th>Total WTE days available</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>3,710.0</td>
<td>79,785.0</td>
<td>5.0%</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>1,550.4</td>
<td>33,028.0</td>
<td>5.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5,260.4</strong></td>
<td><strong>112,813.0</strong></td>
<td><strong>4.7%</strong></td>
</tr>
</tbody>
</table>

### Bank and agency staff usage

From April 2017 to March 2018, the trust reported a bank usage rate of 22% in surgery.

The trust was unable to provide comparable data for agency and shifts left unfilled, due to system restrictions.

At Cumberland Infirmary endoscopy (88%), day surgery (56%) and general theatres (50%) reported the highest agency staff use.

The breakdown for each site is as follows:

<table>
<thead>
<tr>
<th>Site</th>
<th>Bank shifts</th>
<th>Total shifts</th>
<th>Bank shifts as a proportion of total shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>361</td>
<td>1,906</td>
<td>19%</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>71</td>
<td>83</td>
<td>86%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>432</strong></td>
<td><strong>1,989</strong></td>
<td><strong>22%</strong></td>
</tr>
</tbody>
</table>

We saw nurse staffing figures were displayed in each ward and planned staffing numbers matched actual numbers in each ward we visited on this inspection.

However, practice within the trust was for matrons and the operational matron to undertake meetings on a daily basis to identify wards most at risk of running at less than optimal staff numbers. This occasionally resulted in staff being moved from surgical wards and areas to cover shortages on medical wards. Although, this resulted in reduced numbers of staff on surgical wards we were told this did not result in unsafe numbers or practice.

During particular periods of staff pressures matrons worked operationally on wards.
We spoke with the operational matron who confirmed that staffing levels were reviewed across the trust as a whole based on staffing numbers, the use of an acuity tool ((safer nursing care tool (SNCT)) and professional judgement. Some ward staff were uncomfortable with moving wards at short notice and were unsure how effectively decisions had been made, e.g. the use of the SNCT. We attended the bed meetings and saw that daily staffing levels were escalated and discussed by the operational matron and the matrons for the division. Staff were moved between wards to reach an acceptable staffing. Theatre staffing levels were planned according to the lists on a daily basis.

Staffing was on the division’s risk register because the senior management team recognised that, while it achieved safe staffing levels, the position was only maintained with daily close monitoring. The risk register identified that there was insufficient staff to meet the needs of patients across the trust. Within the division there were 24 whole time equivalent qualified vacancies across both sites and 0.8 healthcare assistant vacancies.

A number of actions had been identified to address staffing vacancies, e.g. recruitment plans for current vacancies, robust sickness monitoring, the use of bank nurses, overtime, daily board rounds prioritising care, monitoring of staff rotas. Longer term plans had also been developed, such as vacancies advertised and international recruitment, implementation of the e-roster, escalation processes in place through the matron, business manager and chief matron, daily situation reports (‘sitreps’ x4).

The trust had also implemented the ‘allocation safe care programme’ that reviewed nurse staffing against patient acuity and facilitated the appropriate movement of staff between wards. The trust used situation, background, action, result (SBAR) notes for handovers which reduced patient risk.

The trust had initiated a student nurse apprenticeship programme (‘grow your own’) which is a four year programme that enables healthcare assistants within the organisation to be seconded and trained.

**Medical staffing**

The trust reported staffing numbers for the period March 2018 and April 2018 as follows:

<table>
<thead>
<tr>
<th>Location</th>
<th>Mar-18</th>
<th></th>
<th></th>
<th>Apr-18</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
<td>Fill rate</td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
<td>Fill rate</td>
</tr>
<tr>
<td>Cumberland Infirmary</td>
<td>141.6</td>
<td>162.8</td>
<td>87.0%</td>
<td>141.6</td>
<td>167.0</td>
<td>84.8%</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>21.6</td>
<td>37.8</td>
<td>57.1%</td>
<td>22.6</td>
<td>36.8</td>
<td>61.4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>163.2</strong></td>
<td><strong>200.6</strong></td>
<td><strong>81.4%</strong></td>
<td><strong>164.2</strong></td>
<td><strong>203.8</strong></td>
<td><strong>80.6%</strong></td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) –P16)*
Vacancy rates
As from April 2017 to March 2018, the trust reported a vacancy rate of 14.7% in surgery. This was lower than the trust target of 20%

A breakdown for each site is as follows:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total vacancies (WTE)</th>
<th>Total number of staff establishment (WTE)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>221.5</td>
<td>2,005.4</td>
<td>11.0%</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>140.0</td>
<td>453.9</td>
<td>30.8%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>361.6</strong></td>
<td><strong>2,459.2</strong></td>
<td><strong>14.7%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates
From May 2017 to April 2018, the trust reported a turnover rate of 15.9% in surgery. This was above the trust target of 13%.

A breakdown for each site is as follows:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total leavers (WTE)</th>
<th>Average number of staff establishment (WTE)</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>19.2</td>
<td>103.3</td>
<td>18.6%</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>1.0</td>
<td>24.1</td>
<td>4.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>20.2</strong></td>
<td><strong>127.4</strong></td>
<td><strong>15.9%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates
From April 2017 to April 2018 the trust reported a sickness rate of 2% in surgery. This was better than the trust target of 4%.

A breakdown for each site is as follows:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total absence days</th>
<th>Total WTE days available</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>820</td>
<td>37,442</td>
<td>2%</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>258</td>
<td>8,977</td>
<td>3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,078</strong></td>
<td><strong>46,419</strong></td>
<td><strong>2%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage
The trust was unable to provide this data broken down by site or core service, due to system restrictions under the previous recording method.

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

**Staffing skill mix**

From January 2017 to January 2018, the proportion of consultant staff reported to be working at the trust was slightly higher than the England average and the proportion of junior (foundation year 1-2) staff was about the same.

**Staffing skill mix for the whole time equivalent staff working at North Cumbria University Hospitals NHS Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>52%</td>
<td>49%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>16%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>19%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>12%</td>
<td>11%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Medical cover was available on-site 24 hours a day and the division of surgery made use of a number of on call rotas. Consultants were supported at ward level by foundation year one doctors assigned to each ward. We spoke with consultants in the theatres and noted there were no concerns raised about medical cover.

Junior doctors were assigned to each ward and trust data showed the trust was above the England average for junior doctors. Junior doctors out of hours could call for consultant support. Predominantly this would be by phone with the option to attend site for emergency theatre, emergency procedures or diagnostic procedures. At weekends the rota was shared and the team of consultants gave telephone advice, ward rounds and emergency procedures out of hours.

Following an inspection in January 2018 the foundation school reported concerns about the adequacy of training and experience of foundation programme doctors in surgery and intends to remove recognition for training from August 2019. The division had developed an action plan to address these concerns which included providing a supportive environment for learning, improved induction, handover, re-organised ward cover and a regular teaching programme that
meets stipulated educational standards. Additionally, the introduction of the consultant surgeon of the week model and the reorganisation of ward and patient cover had been completed.

Post-operative ward rounds were completed daily. We were told medical outliers on a surgery ward awaiting a bed on a medicine ward were seen by consultants from medicine usually before midday each day.

The trust had introduced a composite workforce model through the recruitment of four trainee advanced clinical practitioners and three physician associates to support the medical workforce within surgery. Where locums were used, the booking team checked the suitability of the locum to work in the trust according to set criteria which included obtaining references. According to data submitted by the trust the anaesthetics team made most use of locums.

**Records**

The trust had introduced an electronic patient record supported by paper records for each patient as well as integrated patient assessment and bed management systems.

We reviewed 18 sets of nursing and medical records across wards and checked care plans and risk assessments in detail. These were completed accurately and updated regularly and included nutrition, fluid balance, turning charts and hydration charts and do not attempt cardiopulmonary resuscitation (DNACPR) forms. We were told discharge summaries were completed in a timely way and delayed discharges were not a concern.

Ward managers and staff confirmed that the quality of record keeping was emphasised within the trust and matrons and ward sisters carried out documentation audits on records in all wards, these were used to identify learning and improvement. We saw that records were consistent, fully completed and learning needs were addressed with relevant staff. Common issues were shared with all staff at ward meetings.

**Medicines**

We saw the trust had an up to date medicine policy that detailed the safe storage and management of medicines, including controlled drugs.

All medicines and intravenous fluids were stored behind keypad locked doors and the nurse in charge carried the keys to gain access to the locked controlled drugs cabinet and locked drugs fridge. On each ward we visited we randomly checked the controlled drugs medicines and medicines stored in the locked fridge and saw that the medicines concerned were in date and that the controlled drugs register showed the correct balance for that drug.

However, we found inconsistent practice across wards regarding the management of medicines. Although trust policy identified arrangements for monitoring medicines which required refrigeration, maximum and minimum temperatures were not recorded on wards. On some wards the same temperature had been recorded for each day without the thermometer being reset and recalibrated giving a potentially wrong reading.
CQC pharmacy colleagues identified (Maple D) further issues such as poor standards of prescription writing, storage, inadequate storage of oxygen cylinders, gaps in medication charts not annotated and changes to prescription checked without a pharmacist initials or date.

The trust ensured appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance. We saw all patients had been appropriately assessed for the risk of Venous Thromboembolism (blood clots) and appropriate prophylaxis had been prescribed where this was indicated.

**Incidents**

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From June 2017 to May 2018, the trust did not report any never events at Cumberland Infirmary for surgery.

*(Source: Strategic Executive Information System (STEIS))*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 14 serious incidents (SIs) from June 2017 to May 2018 in surgery which met the reporting criteria set by NHS England.

The most reported incident types were:

- Treatment delay meeting SI criteria with four incidents (29%)
- Sub-optimal care of the deteriorating patient meeting SI criteria with two incidents (14%)
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with two incidents (14%)
- Medical equipment/ devices/disposables incident meeting SI criteria with two incidents (14%)
Site specific information was as follows:

- Cumberland Infirmary: 11 Incidents
- West Cumberland Hospital: Three incidents

(Source: Strategic Executive Information System (STEIS))

Staff we spoke with knew how to report incidents and could describe lessons that had been learnt. For instance, we saw posters on the ward reminding staff of best practice for identifying sepsis and the administration of medicine.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with demonstrated an awareness of the duty and the importance of being open and honest when delivering care.

Staff described various ways in which learning was shared about incidents such as safety huddles, handovers, and during ward meetings. In addition, on the wards there were communication folders or monthly bulletins displayed, for staff to see and read. Some staff said they did not receive feedback on incidents they had reported, particularly staffing issues.

Matrons shared lessons learnt at ward level with the ward manager and sister within each ward. Matrons also met regularly with the ward leaders and the head of nursing for the surgery division to discuss learning from incidents. Mortality and morbidity was discussed at regular mortality sub-committee meetings.

Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide
immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 13 new pressure ulcers, 14 falls with harm and nine new catheter urinary tract infections from April 2017 to April 2018 for surgery.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at North Cumbria University Hospitals NHS Trust**

1. **Total Pressure ulcers (13)**

2. **Total Falls (14)**

3. **Total CUTIs (9)**

- 1 Pressure ulcers levels 2, 3 and 4
- 2 Falls with harm levels 3 to 6
- 3 Catheter acquired urinary tract infection level 3 only

From April 2017 to April 2018 surgery reported 13 pressure ulcers. From April to August 2017 two pressure ulcers were reported, one in April and one in June 2017. From September 2017 to January 2018 one to two pressure ulcers per month were reported consecutively. Pressure ulcers reported escalated sharply from none reported in February to five in March 2018. Pressure ulcers reported decreased with no pressure ulcers reported in April 2018.

No falls were reported from April to October 2017. In November 2017 three falls were reported, numbers escalated sharply with ten falls being reported in December 2017. One fall was reported in January 2018 and no falls from February to April 2018.
From April to July 2017 no CUTIs were reported. Two infections were reported in August and none in September and October 2017. During the winter months of November 2017 to February 2018, one to three infections per month were reported, reaching the highest number of three in December 2017. After February no CUTIs were reported up until April 2018.

(Source: NHS Digital)

Safety thermometer results were on display to the public on each ward. These included staffing levels, days since the occurrence of pressure ulcers, falls and CUTIs as well as medication errors, hand hygiene and cleaning audits. Compliance rates for the assessment of venous thromboembolism and the provision of patient information and the completion rates for mandatory training and appraisals were also displayed.

Is the service effective?

Evidence-based care and treatment

Trust policies and clinical pathways were based on guidance from the Royal College of Surgeons and the National Institute for Health and Care Excellence (NICE). New guidance was monitored through clinical governance meetings and we saw evidence of this through a review of clinical governance reports.

The division had care plans and pathways for a number of conditions including stroke, deep vein thrombosis (DVT), cellulitis, rapid access chest pain and sepsis based on the acute toolkit, screening tool and care protocols.

Staff accessed policies, procedures and other guidance through the trust intranet. We reviewed policies and found them to be in date with version control and a named author. Integrated pathways were in use for patients undergoing day surgery procedures including documentation to assess risk such as venous thromboembolism (VTE). Enhanced recovery pathways were in place, for example for patients undergoing elective joint replacement surgery.

Audits were undertaken for the completion and accuracy of care bundles, the use of NEWS, medication and documentation such as those which related to infection prevention and control. Results showed good levels of compliance. Ward sisters completed trust-wide nursing audit programmes and we saw results and action plans in ward files.

The division participated in a number of national audits including the national hip fracture database and the national bowel cancer audit programme. Staff records reflected training initiated and completed. Medical staff undertook clinical audits and these were discussed at clinical governance meetings.

Nursing staff completed a number of audits on patient experience and outcomes, these audits were completed internally and were completed by observation or review of documents. These audits included medicines administration, environment and hand hygiene.
Nutrition and hydration

We reviewed electronic and paper care plan documentation and risk assessments were fully completed and fluid, food and rounding charts were completed appropriately.

The electronic patient record enabled staff to identify patients at risk of malnutrition, weight loss or requiring extra assistance at mealtimes. Protected meal times were in place and we saw patients being supported to eat and drink. Drinks were readily available and were in easy reach of patients.

Most patients said food was good, menus were varied. The quality and quantity of food was monitored through patient led assessments of the care environment (PLACE) which show an overall satisfaction with food provided.

Policies were in place regarding fasting times and intravenous fluids in line with best practice. We saw records in notes for patients who received nutrition via nasogastric tubes, including the day and reason for insertion, the type of tube, measurement, aspirate pH and a confirmation that consent had been obtained.

Pain relief

We reviewed care plans related to pain management. Pain assessments were carried out and recorded in patient notes and the electronic patient record. Pain relief was provided as prescribed and there were systems in place to make sure that additional pain relief was accessed through medical staff, if required.

Patients we spoke with had no concerns about how their pain was controlled and staff checked that pain relief administered had been effective. We were assured about the assessment of pain for those patients who may not be able to communicate when in pain.

Staff used a pain-scoring tool to assess patient’s pain levels; staff recorded the assessment on paper and electronic records. We saw evidence of pain scores in patient documentation reviewed.

Patient outcomes

Relative risk of readmission

Elective admissions – trust level

From January 2017 to December 2017, all patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.

General surgery patients at the trust had a similar expected risk of readmission for elective admissions when compared to the England average.

Trauma & orthopaedics and urology patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity

Non-elective admissions – trust level

All patients at the trust had a slightly higher expected risk of readmission for non-elective admissions when compared to the England average.

General surgery patients at the trust had a higher expected risk of readmission for non-elective admissions when compared to the England average.

Trauma & orthopaedics patients at the trust had a lower expected risk of readmission for non-elective admissions when compared to the England average.

Urology patients at the trust had a similar expected risk of readmission for non-elective admissions when compared to the England average.

Elective admissions - Cumberland Infirmary

From January 2017 to December 2017, all patients at Cumberland Infirmary had a similar expected risk of readmission for elective admissions when compared to the England average.

General surgery patients at Cumberland Infirmary had a higher expected risk of readmission for elective admissions when compared to the England average.

Urology patients at Cumberland Infirmary had a similar expected risk of readmission for elective admissions when compared to the England average.

ENT patients at Cumberland Infirmary had a lower expected risk of readmission for elective admissions when compared to the England average.
Non-elective admissions - Cumberland Infirmary

All patients at Cumberland Infirmary had a slightly higher expected risk of readmission for non-elective admissions when compared to the England average.

General surgery patients at Cumberland Infirmary had a higher expected risk of readmission for non-elective admissions when compared to the England average.

Trauma & orthopaedics patients at Cumberland Infirmary had a lower expected risk of readmission for non-elective admissions when compared to the England average.

Urology patients at Cumberland Infirmary had a slightly lower expected risk of readmission for non-elective admissions when compared to the England average.

We discussed the higher than expected risk of readmission for general surgery for both elective and non-elective admissions when compared to the England average with the divisional management team.

The division’s senior management team were aware of the readmission rates and told us the issue was being addressed by a review to identify the causes of the elevated expected risks of readmissions and methodologies for bringing the risks of readmission in line with England averages.

National Hip Fracture Database – trust level
In the 2017 National Hip Fracture Database, the risk-adjusted 30-day mortality rate was 5.1% (England average 6.7%) which was within the expected range. The 2016 figure was 6.7%.

The proportion of patients having surgery on the day of or day after admission was 69.8% (England average 70.6%), which failed to meet the national standard of 85%. This was within the middle 50% of trusts. The 2016 figure was 68.9%.

The perioperative medical assessment rate was 93.4% (England average 88.7%), failed to meet the national standard of 100%. This was within the middle 50% of trusts. The 2016 figure was 94.4%

The proportion of patients not developing pressure ulcers was 96.7% (England average 95.6%), failed to meet the national standard of 100%. This was within the middle 50% of trusts. The 2016 figure was 97.4%.

The overall length of stay was 16.1 days, which falls within the top 25% of trusts. The 2016 figure was 17.1 days.

The case ascertainment rate was 93% in 2017, a slight improvement in comparison with 2016 the 2016 rate of 92%. Rates however were below the national aggregate of 95% and failed to meet the 100% aspirational standard.

(Source: National Hip Fracture Database 2017)

The trust had introduced a full time orthogeriatrician and the ‘consultant of the week’ working model which had improved co-ordination, review and consistency of care. The trust also participated in the Northern Region tissue viability collaborative which had increased focus and improvement methodology for the reduction of pressure ulcers.

The reduction in the 30 day mortality rate was attributed to the input from the ward based orthogeriatrician, a holistic orthopaedic and geriatrician approach, supported by specialist nurses and nurse practitioners.

Bowel Cancer Audit

In the 2017 Bowel Cancer Audit, 80.3% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national aggregate.

The risk-adjusted 90-day post-operative mortality rate was 0% (England average 3.2%) which was within the expected range. The 2016 figure was 5.4%.

The risk-adjusted 2-year post-operative mortality rate was 21.3% which was within the expected range. The 2016 figure was 20.9%.

The risk-adjusted 30-day unplanned readmission rate was 16.6% (England average 9.9%) which was within the expected range. The 2016 figure was not reported.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 52.6% which was within the expected range. The 2016 figure was 42.7%.
The 2017 case ascertainment rate of 69.8% was lower than the 2016 rate of 82.1% and national aggregate of 95.0%, although in comparison to other hospitals the trust had a fair (50%-80%) ascertainment rate.

(Source: National Bowel Cancer Audit)

National Vascular Registry

In the 2017 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 3% for abdominal aortic aneurysms which was within the expected range. The 2016 figure was 2.9%.

Within Carotid Endarterectomy, the median time from symptom to surgery was 14 days, equal to the audit aspirational standard of 14 days.

The 30-day risk-adjusted mortality and stroke rate was 0% (England average 2.2%) this was within the expected range.

The trust had a 100% case ascertainment rate, better than the national aspirational standard of 90%. Rates improved from 82% in 2016 to 100% in 2017.

(Source: National Vascular Registry)

Oesophago-Gastric Cancer National Audit

In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 9.9%, this was a positive outlier in comparison to other trusts. Patients diagnosed after an emergency admission are significantly less likely to be managed with curative intent. The audit recommends that overall rates over 15% could warrant investigation. The 2015 figure was 9.5%.

The trust was not eligible for the 90-day post-operative mortality rate.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 34.2%. This was significantly lower than the national aggregate.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres); the result can therefore be used as a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results.

The case ascertainment rate at the trust was between 81% to 90%, which was better than the national aggregate.

(Source: National Oesophago-Gastric Cancer Audit 2016)

National Emergency Laparotomy Audit - trust level

The National Emergency Laparotomy audit awards three ratings for each indicator. Green ratings
indicate performance of over 80%, amber ratings indicate performance between 50% and 80% and red ratings indicate performance under 50%.

In the 2016 National Emergency Laparotomy Audit (NELA), the trust achieved an amber rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 102 cases.

The trust achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 73 cases.

The trust achieved a green rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 53 cases.

The trust achieved an amber rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 37 cases.

The risk-adjusted 30-day mortality for the trust was within the expected range. This was based on 102 cases.

(Source: National Emergency Laparotomy Audit)

Patient Reported Outcome Measures

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.
In 2016/17 performance on groin hernias was generally worse than the England average. The proportion of patients in England that reported improvement was 45% compared to the trust proportion of 35%. At the trust, 25% of patients reported an improvement for EQ VAS compared to an England figure of 39%. The EQ-5D Index at the trust was 46% compared to the England figure of 50%.

For varicose veins, performance was generally better than the England average. The proportion of patients in England that reported improvement was 58% compared to the trust proportion of 61%. The Aberdeen varicose vein score for the trust was slightly lower than England scores, 80% compared to 81%. At trust level, 49% of patients reported an improvement for EQ VAS compared to an England figure of 40%. The EQ-5D Index at the trust was 54% compared to the England figure of 52%.

For hip replacements, performance was similar to the England average. The proportion of patients in England that reported improvement was 84% compared the trust proportion of 85%. The Oxford hip score for the trust was 98% similar to England average, of 96%. At trust level, 67% of patients reported an improvement for EQ VAS, the same as the England figure. The EQ-5D Index at the trust was 90% similar to the England average of 89%.

For knee replacements performance was similar to the England average. The proportion of patients in England that reported improvement was 77% compared the trust proportion of 78%. The Oxford knee score for the trust was the same as than England score, of 94%. At trust level the EQ VAS score was 55% similar to the England figure of 58%. The EQ-5D Index at the trust was by 84% similar to the England figure of 81%.

(Source: NHS Digital)

Competent staff

Appraisal rates - trust level

From April 2017 to March 2018, 93% of staff within surgery at the trust received an appraisal compared to a trust target of 95%.

Appraisal rates for medical staff were in line with the trust target, the speciality with the lowest completion rate was trauma and orthopaedic with a completion rate of 85%. All other specialities met or exceeded the trust target of 90% for medical staff.

Nursing staff had a 92% appraisal completion rate, lower than the trust target of 95%. Appraisal rates for nine of the 16 specialities did not meet the trust target, with endoscopy, oral surgery and vascular surgery having a completion rate of 0%. Apart from the specialities that had a completion rate of 0%, anaesthetics (25%), otolaryngology (50%) and urology (67%) had the lowest completion rates.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required</th>
<th>Appraisals completed</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>328</td>
<td>302</td>
<td>92%</td>
</tr>
<tr>
<td>Medical &amp; dental Staff</td>
<td>122</td>
<td>116</td>
<td>95%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>450</td>
<td>418</td>
<td>93%</td>
</tr>
</tbody>
</table>
Cumberland Infirmary

From April 2017 to March 2018, 91% of staff within surgery at the trust received an appraisal compared to a trust target of 95%.

Nursing staff at Cumberland Infirmary had an appraisal completion rate of 89%, lower than the trust target of 95%. Appraisal rates for ten of the 15 specialities did not meet the trust target, with anaesthetics, endoscopy, oral surgery and vascular surgery having a completion rate of 0%. Apart from the specialities that had a completion rate of 0%, otolaryngology (50%) and urology (67%), had the lowest completion rates.

Appraisal rates for medical staff were in line with the trust target, the speciality with the lowest completion rate was trauma and orthopaedic with a completion rate of 85%. All other specialities met or exceeded the trust target of 90% for medical staff.

<table>
<thead>
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<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>228</td>
<td>203</td>
<td>89%</td>
</tr>
<tr>
<td>Medical &amp; dental Staff</td>
<td>94</td>
<td>90</td>
<td>96%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>322</td>
<td>293</td>
<td>91%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

The senior management team had issued instructions that appraisals had to be completed by September 2018 to ensure staff within the division complied with trust targets for appraisal.

Multidisciplinary working

Staff we spoke with told us multidisciplinary team meetings were held each week where different specialities attended, for example radiologists, speech and language therapy and consultants.

Staff we spoke with told us there was one stop clinic which involved a dietician, speech and language therapy, for example.

Nursing and medical staff reported good multidisciplinary working and all surgical wards participated in multidisciplinary ward rounds. This resulted in a co-ordinated approach to treatment plans and decisions.

Specialist nurses were available to review patients in specialties, such as respiratory and diabetes, physiotherapy, speech and language, pharmacy, child and adolescent and adult mental health liaison. Specialists were also available to support staff groups with training and to participate in multidisciplinary meetings to discuss patient care and treatment.

Allied Health Professionals confirmed there was good multidisciplinary working and also offered training to nursing staff where appropriate. Dieticians completed daily reviews of those patients referred for their input.

Seven-day services
The trust monitored its working scheme against NHS Services, Seven Days a Week Clinical Standards. At the time of inspection, the surgical division met NHS England’s seven day services priority standards; i.e. time to first consultant review.

Consultants provided seven-day cover for surgical wards and the assessment unit. On-call consultants covered weekends and nights. Daily consultant ward rounds took place and we saw evidence of reviews at weekends and patients confirmed this.

There was availability of physiotherapy and occupational therapy staff Monday to Friday and physiotherapists covered weekends on a rota system to deliver interventions to identified patients on a priority of need basis.

Health promotion

Patients said staff gave them advice on smoking cessation, healthy eating, weight loss, wound care and infection prevention on all wards.

Patient leaflets were available throughout the hospital, prominently displayed on communication boards within wards and corridors and available for patients to take with them.

We did not see patient information leaflets in other languages than English but were assured they were available on request.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion - trust level

The trust reported that as at March 2018 Mental Capacity Act (MCA) training was completed by 86% of staff in surgical care compared to the trust target of 95%.

A breakdown by staff group can be seen below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental staff</td>
<td>287</td>
<td>218</td>
<td>76%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>410</td>
<td>384</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Over the same period Deprivation of Liberty Safeguards training was completed by 75% of staff within surgical care compared to the trust target of 95%.

A breakdown by staff group can be seen below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental staff</td>
<td>100</td>
<td>67</td>
<td>67%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>46</td>
<td>43</td>
<td>93%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
Cumberland Infirmary

Cumberland Infirmary reported that as at March 2018 Mental Capacity Act (MCA) training was completed by 85% of staff in surgical care compared to the trust target of 95%.

A breakdown by staff group can be seen below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental staff</td>
<td>219</td>
<td>163</td>
<td>74%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>311</td>
<td>288</td>
<td>93%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Over the same period Deprivation of Liberty Safeguards training was completed by 75% of staff within surgical care compared to the trust target of 95%.

A breakdown by staff group can be seen below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental staff</td>
<td>75</td>
<td>49</td>
<td>65%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>41</td>
<td>38</td>
<td>93%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Trust Provider Information Request P40 - Training)

Staff spoken with demonstrated an understanding of consent, mental capacity and ‘best interest’ decisions and accessed training through e-learning. Staff had accessible guidance and information and knew who to contact for advice and support, if needed.

During discussion staff had an understanding of how to assess capacity and when this should be done and by whom. Support was provided throughout the division by the delirium team.

We reviewed patient records and saw that Mental Capacity Act (MCA) assessments had been undertaken by the doctor responsible for the patient’s care. Nursing records with DoLS in place showed the appropriate paperwork had been completed. We observed staff providing explanations and obtaining consent prior to completing procedures.

Staff told us best interest meetings were held for patients who lacked capacity to make decisions for themselves.

Staff showed a good understanding of mental capacity and referred to it as being decision and time specific. Staff had a good understanding of DoLS and used both the emergency and standard authorisation appropriately.
Mental health colleagues also visited surgical wards at both Cumberland Infirmary and West Cumberland Hospital and found that staff in both locations had a good understanding of the Mental Capacity Act.

Staff at Cumberland Infirmary had a good knowledge of fluctuating capacity and had identified the need for a capacity assessment to be carried out when a patient became ill. Colleagues reviewed the care record of this patient and found a nurse had carried out a capacity assessment and another had submitted an application under the Deprivation of Liberty Safeguards (DoLS) as the patient was thought to be a risk to themselves. The application submitted had been for a period of seven days and contained full details of the reason for the application and the reason it was required for only a short time.

Evidence that a best interest decision had been made in relation to the patient’s ongoing treatment and for the use of bed rails was seen. There was a system in place to ensure that staff were able to monitor when applications were due to expire, allowing staff to make further applications if these were needed.

If patients were due to have surgery and it was felt they lacked capacity, they would have their operation delayed, or if this was not possible, a best interest decision would be made and recorded on patient care records. Staff were clear about what capacity assessments were and how they fitted in with day to day work. If they had concerns they knew who they could speak to.

Staff at both sites were aware that patients who had received a general anaesthetic would not have full capacity for 24 hours and advised patients of this.

Is the service caring?

Compassionate care

Friends and Family test performance

The Friends and Family Test response rate for surgery at North Cumbria University Hospitals NHS Trust was 28% which was the same as the England average from April 2017 to March 2018.

A breakdown of response rate by site can be viewed below.

Friends and family test response rate at North Cumbria University Hospitals NHS Trust, by site.
Friends and family test scores per site and ward is shown in the table below:

(Source: NHS England Friends and Family Test)

National data (NHS England, June 2018) showed 97% of respondents recommended surgical services.

Each ward displayed their friends and family test results as well as ‘two minutes of your time’ feedback. Comments on display on wards showed a variety of responses from patients, most of which were positive. Patients we spoke with told us that staff were friendly, supportive, compassionate and caring. They said their privacy and dignity was respected and maintained.

Staff we spoke with told us they spoke with patients in a way which they understood and maintained privacy and dignity on wards by using the bed curtains where required.

Friends and family test data (January to March 2018) we saw on wards showed that 93% were extremely likely or likely to recommend the department to friends and family on Beech D. The quarter four January 2018 and March 2018 friends and family test data for Maple B and D wards showed that 88% of respondents were extremely likely or likely to recommend the department to friends and family. Maple C friends and family test results showed that 98% of respondents were likely or extremely likely to recommend the department.
We saw staff responded promptly to call bells or requests for assistance and had enough time for patients and they introduced themselves. All patients seen looked clean and well cared for and able to move around, with staff assistance where necessary. Discussions between staff and patients were carried out in a caring and supportive way, staff provided reassurance and provided information appropriate for the patient.

**Emotional support**

There was a day room available on some wards we visited for patients and families to use.

The trust used a system to assist in identifying people living with dementia. The trust had a chaplaincy service available.

Staff we spoke with told us they had mandatory training on dementia. The wards provided a care bundle for people living with dementia and there was a carers pass for families visiting wards for people living with dementia.

The hospital had a multi-faith chaplaincy service and a bereavement service which staff accessed to support patients or carers who needed.

**Understanding and involvement of patients and those close to them**

The wards worked with different services and staff to organise and manage discharges. There was a discharge liaison team available to assist in discharge from wards.

From reviewing patient notes and observation of interactions staff had with patients we were assured staff had tried to understand patient needs or those close to them. We saw how staff attended to a patient who was shouting out, gave reassurance and spent time with the patient to calm them down.

Patients told us that they knew what was happening with their care and what their treatment plans were. Almost all patients said they had been kept informed and what was being done in a way they could understand so that they felt involved in their care.

All wards involved relatives in the care of patients where possible and with the permission of the patient. Although there were set visiting times, all wards were flexible and provided information regarding current care and treatment. Wards told us they were planning to pilot ‘open visiting’ times.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

We asked senior managers about planning the services and were told there was an annual trust business plan which included surgery. Managers described working with business managers, the clinical director and matrons to plan services.
There were systems in place to assist in the delivery of care to patients. For example, people living with dementia were identified to staff on electronic systems used to highlight additional support or care that may be required.

**Elective average length of stay – trust level**

From February 2017 to January 2018, the average length of stay for all elective patients at the trust was 2.9 days, which was lower compared to the England average of 3.9 days.

The average length of stay for trauma & orthopaedics elective patients at the trust was 3.1 days, which was lower compared to the England average of 3.9 days.

The average length of stay for general surgery elective patients at the trust was 3.4 days, which was similar compared to the England average of 3.9 days.

The average length of stay for urology elective patients at the trust was 1.9 days, which was lower compared to the England average of 2.5 days.

![Graph](image)

*Note: Top three specialties for specific trust based on count of activity.*

**Non-elective average length of stay – trust level**

The average length of stay for all non-elective patients at the trust was 4.1 days, which was slightly lower compared to the England average of 4.9 days.

The average length of stay for general surgery non-elective patients at the trust was 2.6 days, which was lower compared to the England average of 3.8 days.

The average length of stay for trauma & orthopaedics non-elective patients at the trust was 7.4 days, which was lower compared to the England average of 8.7 days.

The average length of stay for ENT non-elective patients at the trust was 2.2 days, which was the same as the England average.
Note: Top three specialties for specific trust based on count of activity.

Elective average length of stay - Cumberland Infirmary

From February 2017 to January 2018 the average length of stay for all elective patients at Cumberland Infirmary was 3.4 days, which was similar compared to the England average of 3.9 days.

The average length of stay for general surgery elective patients at Cumberland Infirmary was 3.9 days, which was the same the England average.

The average length of stay for trauma & orthopaedics elective patients at Cumberland Infirmary was 4.1 days, which was slightly higher compared to the England average of 3.9 days.

The average length of stay for urology elective patients at Cumberland Infirmary was 1.9 days, which was lower compared to the England average of 2.5 days.

Non-elective average length of stay - Cumberland Infirmary

The average length of stay for all non-elective patients at Cumberland Infirmary was 4.4 days, which is slightly lower compared to the England average of 4.9 days.

The average length of stay for general surgery non-elective patients at Cumberland Infirmary was 2.9 days, which is lower compared to the England average of 3.8 days.

The average length of stay for trauma & orthopaedics non-elective patients at Cumberland Infirmary was 7.5 days, which is lower compared to the England average of 8.7 days.

The average length of stay for ENT non-elective patients at Cumberland Infirmary was 2.2 days, which is the same as the England average.
Meeting people’s individual needs

There was a variety of patient information leaflets available in wards; however, there were no leaflets available in different languages. The wards had access to translation services.

The electronic assessment system had an area for communication where hearing problems, sign language and interpreter required were documented. Staff we spoke with told us these assessments were completed upon admission to the hospital. The electronic system on wards allowed staff to see whether patients had been referred to a social worker.

There was a seven day physiotherapy and occupational therapy service on the wards providing further care and support to patients.

Staff we spoke with told us they referred patients on to a variety of teams at the trust, for example the tissue viability team and the pain team. Staff referred patients to the adult psychiatry team if required and there was a mental health team available for support and advice. The trustwide delirium team also attended wards to provide support to patients with delirium. There was regular pharmacy attendance on the surgical wards.

Staff we spoke with told us they could contact the trust learning disability specialist nurses for support and advice. Surgical wards had physiotherapy services and occupational therapists to assist and support patients on the wards.

Patients living with dementia were identified to staff by a butterfly symbol to enable them to provide additional support. Staff told us they had mandatory training on dementia. The wards provided a care bundle for people living with dementia and there was a carers pass for families visiting wards for people living with dementia.

Patients we spoke with said that staff respected their privacy and dignity by closing curtains and doors as necessary.

Patients’ religious needs, dietary requirements, and hearing, sight or language difficulties were identified through structured assessments. Patients were provided with information leaflets on their surgical procedures.
Staff identified patients who had additional care needs at handovers and safety huddles, for example patients living with dementia, learning disabilities or mental health conditions.

Wards and departments were accessible for patients with limited mobility and people who use a wheelchair. Specialised equipment for bariatric patients was available in one of the bedrooms on the ward. Staff informed us that such a room existed in every ward in the new build hospital.

**Access and flow**

We asked the senior management about managing surgical ‘outliers’ on other wards and were told that this was rare. Senior management told us that medical outliers could have an impact on surgical elective work and performance in the directorate.

Staff we spoke with told us that discharges were organised and managed during daily and weekly ward meetings and multidisciplinary team meetings on the different wards and staff worked with the discharge liaison team. Maple D ward held a daily team meeting involving specialist nurses, physiotherapists, occupational therapists and doctors and staff we spoke with told us that discharge would be discussed during these daily meetings.

There were escalation beds open on some wards we visited. For example, Maple D had forty beds with four escalation beds during our inspection. A new role had been implemented in the surgery division for patient flow co-ordination within the last 12 months. The role was to assist in elective admission and emergency admissions.

The surgical flow co-ordinator attended bed meetings, worked with the bed managers, business managers and matrons across surgical services. Staff we spoke with told us elective cancellations were discussed at the theatre planning meeting.

The trust had supported a two year training programme of a nurse hysteroscopist which enabled the service to reduce the number of inpatient admissions and costs. There was a 50% increase in the clinics for hysteroscopy which enabled the trust to ensure referral to treatment and diagnosis and treatment plan cancer standards are achieved.

A reduction in patient breaches, treatment without an admission to hospital, reduced wait for diagnosis and treatment plans and less hospital visits had been achieved through the support and training for a specialist nurse and a specialist doctor colposcopist and through delivering the urodynamic service at both sites.

**Referral to treatment (percentage within 18 weeks) - admitted performance**

From April 2017 to March 2018 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was consistently worse than the England average. Trust rates were on average 17% lower than the England average. Over the period trust performance worsened from 53% of patients referred for treatment within 18 weeks in April 2017 to 33% in March 2018.
At the time of inspection (June 2018), the trust’s referral to treatment time (RTT) for admitted pathways for surgery had improved to 43%, although this was still below the England average of patients treated within 18 weeks (64%).

Referral to treatment (percentage within 18 weeks) – by specialty

A breakdown of referral to treatment rates for surgery by specialty is below. Of these, two specialties, urology and ENT, were above the England average and two specialties were below the England average.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>89%</td>
<td>77%</td>
</tr>
<tr>
<td>ENT</td>
<td>72%</td>
<td>64%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>39%</td>
<td>61%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>39%</td>
<td>71%</td>
</tr>
</tbody>
</table>

We discussed the RTTs with the senior management team. Improving RTTs had been set as a priority within the division and at the time of inspection, national data (NHS England, May 2018) showed referral to treatment times had improved for these specialities:

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>93%</td>
<td>87%</td>
</tr>
<tr>
<td>ENT</td>
<td>93%</td>
<td>86%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>58%</td>
<td>84%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>78%</td>
<td>89%</td>
</tr>
</tbody>
</table>

The trust was meeting the operational national standard of 92% for urology and ENT.

National data (NHS England, May 2018) also showed referral to treatment times for general surgery (88%) and oral surgery (91%) were both above England averages (84% and 84% respectively).

Cancelled operations
A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

Patients who had their operations cancelled and not treated within 28 days were higher than the England average in Q1 and Q2 2016/17. Percentages improved and were lower than the England average from Q3 2016/17 to Q2 2017/18. Percentages however increased again to higher than the England average in Q3 and Q4 2017/18.

**Percentage of patients whose operation was cancelled and were not treated within 28 days - North Cumbria University Hospitals NHS Trust**

![Graph showing percentage of patients whose operation was cancelled and were not treated within 28 days]

Over the two years, the percentage of cancelled operations at the trust was higher than the England average in Q1 and Q2 2016/17. From Q3 2016/17 to Q2 2017/18 percentages improved to below the England average although percentages increased again in Q3 and Q4 2017/18 to above the England average.

Cancelled operations as a percentage of elective admissions only includes short notice cancellations. Trust rates were consistently worse than the England average with the worst performance in Q3 and Q4 2017/18. Trust performance improved from Q2 to Q4 2017/18 although rates remained higher than the England averages.

At the time of inspection national data (May 2018) showed the trust cancelled 1.5% of elective operations against a national average of 1.3%.
Learning from complaints and concerns

Trust level

From April 2017 to March 2018 there were 102 complaints about surgical care. The trust took an average of 31 days to investigate and close complaints. This is not in line with their complaints policy, which states complaints, should be responded to and closed within 30 working days.

Medical staff received the most complaints, 76%, followed by nursing staff with 13%. The orthopaedic department received the most complaints, 33%, followed by general surgery with 28%.

One complaint (1%) was fully upheld, 22 (22%) complaints were upheld, 37 (36%) were partially upheld, two (2%) were reviewed to do a moderate root cause analysis, three (3%) were transferred to serious incidents and 37 (36%) of complaints were refuted.

A breakdown of complaints per subject is shown in the table below:

<table>
<thead>
<tr>
<th>Subjects</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment / care - inpatient</td>
<td>51</td>
<td>50%</td>
</tr>
<tr>
<td>Treatment / care - outpatient</td>
<td>25</td>
<td>25%</td>
</tr>
<tr>
<td>Attitude of staff</td>
<td>11</td>
<td>11%</td>
</tr>
<tr>
<td>Information &amp; communication</td>
<td>9</td>
<td>9%</td>
</tr>
<tr>
<td>Appointment issues</td>
<td>5</td>
<td>5%</td>
</tr>
<tr>
<td>Lost property and expenses</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>102</strong></td>
<td></td>
</tr>
</tbody>
</table>

Cumberland Infirmary

Cumberland Infirmary received 68 complaints. One complaint (1%) was fully upheld, 12 (18%) complaints were upheld, 28 (41%) were partially upheld, two (3%) were reviewed to do a moderate root cause analysis, one (1%) complaint was transferred to serious incidents and 24 (35%) of complaints were refuted.

A breakdown of complaints per subject is shown in the table below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment / care - inpatient</td>
<td>34</td>
<td>50%</td>
</tr>
<tr>
<td>Treatment / care - outpatient</td>
<td>16</td>
<td>24%</td>
</tr>
<tr>
<td>Information &amp; communication</td>
<td>9</td>
<td>13%</td>
</tr>
<tr>
<td>Attitude of staff</td>
<td>5</td>
<td>7%</td>
</tr>
<tr>
<td>Appointment issues</td>
<td>3</td>
<td>4%</td>
</tr>
<tr>
<td>Lost property and expenses</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>68</strong></td>
<td></td>
</tr>
</tbody>
</table>
No site was allocated for a further seven complaints received within surgical care.  
(Source: Routine Provider Information Request (RPIR) – Complaints tab)

We asked staff and managers on wards about complaints and were told that formal complaints were investigated by ward managers and feedback was provided to staff through team meetings or displayed as information on staff boards. Staff on wards confirmed that feedback from complaints would be provided to staff at staff meetings.

Wards had patient information leaflets available for the patient advice and liaison service.

Is the service well-led?

Leadership

The surgical division had a management structure in place with clear lines of responsibility and accountability. The division was managed by an overall senior leadership team which included an associate clinical director, associate chief operating officer and chief matron. Each ward visited had a ward sister in place, deputy ward sister and a matron. The team was supported by heads of service, business and service managers and matrons. The senior management team had a clear and comprehensive understanding of the current risks, challenges and pressures impacting on service delivery and patient care.

Staffing levels were planned so that ward sisters were given management time with other senior nurses in their teams. All ward sisters said they were supported well by the senior management team and that members of the board were visible and matrons regularly visited the wards. During this inspection we saw matrons regularly on wards; some matrons had undertaken clinical duties to cover staff shortages.

At ward level staff said they were well supported by their matrons who provided clear leadership. Ward sisters said they had constructive and positive relationships with matrons and that they visited wards on a daily basis.

Vision and strategy

We asked senior managers about the vision and strategy for the service and we were told that the surgery reconfiguration was the current strategy across the different hospital sites. This was designed to provide services on an elective and acute basis, reconfigured over the two sites. Cumberland Infirmary was the designated ‘hot’ site for surgery and West Cumberland Hospital was used for increased levels of elective procedures. Emergency pathways were in place and all emergency orthopaedic procedures were carried out at Cumberland Infirmary.

The senior management team acknowledged the difficulties in covering the anaesthetic rota at West Cumberland Hospital and informed us that recruitment had recently been made ensuring the rota would be covered within the next few weeks.

Culture
All staff we spoke with during the inspection told us there was good teamwork, openness and morale was generally good.

Staff told us the division had strong leadership and senior managers were visible and engaged with staff. We interviewed a number of staff on an individual basis and held group discussions on the wards when possible. Staff spoke positively about the service they provided for patients and high quality care was a priority. All staff were clear about their roles and responsibilities, patient-focused, and worked well together.

All staff felt they received appropriate support from management to allow them to perform their roles effectively. Although staff reported difficulties with moving to other wards at short notice, they accepted this was necessary for the safety of patients. They all told us they felt able to report these concerns but recognised this was caused by recruitment issues.

We observed senior doctors supporting junior doctors; junior doctors reported feeling very supported and able to ask for advice. However, the foundation school did not feel the training and experience of foundation programme doctors in surgery was adequate during an inspection in January 2018. The intention is to remove recognition for training from August 2019. The team was addressing concerns by providing a supportive environment for learning, improved induction, handover, re-organised ward cover and a regular teaching programme that meet stipulated educational standards.

Nursing staff reported a positive culture and good working relationships between staff groups.

Ward sisters told us that they had appropriate access to senior staff members. This included being able to access support and leadership courses to help them in leading their services.

**Governance**

We asked senior managers about governance arrangements and were told there was a weekly governance meeting for the surgical division. There was a structure of management and governance meetings in the surgical division. For example, there was a divisional meeting which provided information to a care group surgical meeting and then to the clinical management group meeting. Alongside these meetings there was a quality and safety meeting and a weekly referral to treatment performance meeting.

Wards held a daily huddle and staff we spoke with told us they would discuss discharge, safety, staffing and complaints.

Senior staff were motivated and enthusiastic about their roles and had clear direction with plans in relation to improving patient care. Ward managers, senior managers and clinical leads showed knowledge, skills, and experience. A clear responsibility and accountability framework had been established. Staff at all levels were clear about their roles and understood their level of accountability and responsibility.

**Management of risk, issues and performance**

We asked senior management about managing risks and were told that risks were identified through the electronic incident reporting system and risks were discussed at the weekly
governance meeting, then to the quality and safety meeting. The senior management team were able to describe the risks to the services, for example referral to treatment performance. There was a quarterly performance meeting for the surgical division.

The division had a risk register which was detailed and thorough in identifying, recording and managing risks, issues and mitigating actions. Governance meeting minutes showed risk registers were reviewed regularly.

The highest risks identified were the lack of critical care capacity at Cumberland Infirmary, the rate of cancellation of elective patients scheduled for post operative care on ICU, the rate of non-clinical transfers out of ICU due to lack of emergency beds, the removal of foundation doctors from surgery, the inability to recruit permanent anaesthetic staff to maintain a sustainable anaesthetic care model at West Cumberland Hospital and the failure to achieve the referral to treatment standards.

We discussed these with the senior management team who were well informed about the difficulties and had action plans in place to address the risks.

**Information management**

The accessible information standard (AIS) was introduced in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand.

We saw that all patient observations and information was recorded on the electronic patient record system accessible to staff through the input of a password. This gave immediate access to risk assessments, test results, risk assessments and treatment of all patients. The ensured patients who had a disability, impairment or sensory loss were given information that they were able to access and understand.

The electronic patient record enabled staff to ask people if they had any information or communication needs. These were clearly recorded and highlighted in the record and covered disabilities, impairment or sensory loss. We saw contact methods, formats (audio, braille, easy read or large print) and support needed (e.g. interpreter, lip-read, hearing aid) were detailed.

**Engagement**

**Public engagement**

People using the service were encouraged to give their opinion on the quality of service they received. And the surgery division carried out ‘two minutes of your time’ surveys to gather feedback on the services from patients. The teams had a weekly team meeting where positive and negative feedback was discussed. The senior management team told us there had been a surgical away day with staff where improvement work was discussed.

Staff were clear about their roles and responsibilities, patient focused and worked well together to engage patients and families.
Leaflets about the friends and family test, and the Patient Advice and Liaison Service were available on all ward and reception areas. Internet feedback was gathered along with complaint trends and outcomes.

Ward sisters were visible on the ward, which provided patients opportunity to express their views and opinions.

Discussions with patients and families regarding decision making was recorded in patient notes. We saw thank you cards and letters displayed at the entrances to wards.

**Staff engagement**

The national NHS staff survey (2017) showed the trust scored 3.62 (out of five) for an overall indicator of staff engagement. This is below average (3.79) when compared with other trusts of a similar type.

We were told that management engaged with staff well and we saw senior managers communicate to staff through the trust intranet, e-bulletins, team briefs and safety huddles. Each ward held staff meetings when possible where issues, particularly service configuration and staffing, were discussed.

All staff were able to voice their opinions and speak with the ward sister, receive feedback and discuss any concerns. Staff we spoke to said they felt appreciated by the ward sister and more senior managers and listened to when they raised concerns.

**Learning, continuous improvement and innovation**

The division had developed a number of initiatives to improve and enhance care and treatment:

- Emergency surgical assessment unit had participated in ‘Engagement for Improvement Wave 6’, a 26 week process which looked at the environment and fluid balance compliance which is being audited weekly;
- A rapid process improvement workshop had been held with a multidisciplinary approach looking at the patient’s journey from referral to discharge. A number of small changes have been made to improve processes to help improve patient experience;
- As part of a quality improvement project on the surgical ward, a senior nurse provided education around VTE re-assessment which saw a 25% increase in compliance;
- The introduction of a surgical flow co-ordinator, an experienced surgical nurse, has improved flow;
- Introduced a virtual fracture clinic;
- Introduced a golden patient protocol where two trauma patients are identified and reviewed by the anaesthetist the night before the list;
- Nurse practitioner telephone review clinics in place of follow up clinics;
- Trans nasal oesophagoscopy (a flexible oesophagoscopy under local anaesthetic in outpatients) replacing a general anaesthetic procedure for many patients. This is safer, cheaper and much quicker. It also enabled examination in patients who are unfit for an anaesthetic;
• In the process of starting a new laser procedure for a specific swallowing disorder (cricopharyngeal spasm) that will allow a wider range of patients to be treated and thus help reduce the incidence of (potentially fatal) chest infections in these often elderly patients;
• ‘Healing Arts’ group (chaired by the clinical director for head and neck) which runs projects that connect arts to health;
• Introduction of ‘Positive Steps to Safety Newsletter’ which allowed the sharing of key learning from incidents and used to promote positive learning from incidents;
• Engaged with the Cumbria learning and improvement collaborative to embed a culture of learning by training staff to undertake quality improvement work utilising tools to equip teams.
We spoke with three women and looked at three patient records.

We spoke with 18 staff including:

- Three junior doctors
- One consultant
- One associate director of midwifery
- Three reception staff
- Three midwife managers
- Five midwives
- Two health care assistants

**Facts and data about this service**

The trust provides consultant led maternity care and midwifery led units at both Cumberland Infirmary Hospital and West Cumberland Hospital. This includes a day assessment centre, antenatal and postnatal inpatient beds, maternity theatre, delivery suite and a number of outpatient clinics on each site.

Services available on both sites include:

- Elective and emergency caesarean sections
- Epidural service
- Bereavement service
- Scanning, diabetic clinics and early pregnancy assessment clinics

At West Cumberland Hospital there is a foetal telemedicine clinic with the Royal Victoria Infirmary at Newcastle. Antenatal clinics are also undertaken in the community which covers the remote rural areas of North Cumbria.

The trust provides a birthing centre at Penrith and there is an active maternity voices partnership.

(Source: Trust Provider Information Request (RPIR) AC1 Context - description of all acute services)

The trust has 41 maternity beds. There are 23 maternity beds at Cumberland Infirmary Hospital, all of which are on the Aspen maternity ward. There are 17 maternity beds at West Cumberland Hospital, six of which are on the delivery suite and 11 are on Honister ward. There is one maternity bed at the Penrith birthing centre.

(Source: Trust Provider Information Request (RPIR) P2 Sites)

From January 2017 to December 2017 there were 2,763 deliveries at the trust, 1537 of which were carried out at Cumberland Infirmary.

A comparison of the number of deliveries at the trust and the national totals during this period is shown below.
Number of babies delivered at North Cumbria University Hospitals NHS Trust – comparison with other trusts in England

(Source: Hospital Episode Statistics)

A profile of all deliveries and gestation periods from January 2017 to December 2017 can be seen in the tables below.

Profile of all deliveries (January 2017 to December 2017)

<table>
<thead>
<tr>
<th></th>
<th>North Cumbria University Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Single or multiple births</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>2,371</td>
<td>98.8%</td>
</tr>
<tr>
<td>Multiple</td>
<td>32</td>
<td>1.2%</td>
</tr>
<tr>
<td>Mother’s age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 20</td>
<td>108</td>
<td>3.9%</td>
</tr>
<tr>
<td>20-34</td>
<td>2,238</td>
<td>81.0%</td>
</tr>
<tr>
<td>35-39</td>
<td>352</td>
<td>12.7%</td>
</tr>
<tr>
<td>40+</td>
<td>65</td>
<td>2.4%</td>
</tr>
<tr>
<td>Total number of deliveries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>2,763</td>
<td></td>
</tr>
</tbody>
</table>

Note: A single birth includes any delivery where there is no indication of a multiple birth.

Gestation periods (January 2017 to December 2017)

<table>
<thead>
<tr>
<th></th>
<th>North Cumbria University Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Gestation period</td>
<td></td>
<td></td>
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<tr>
<td>Category</td>
<td>Percentage</td>
<td></td>
</tr>
<tr>
<td>---------------------------</td>
<td>------------</td>
<td></td>
</tr>
<tr>
<td>Under 24 weeks</td>
<td>0.1%</td>
<td></td>
</tr>
<tr>
<td>Pre term 24-36 weeks</td>
<td>7.9%</td>
<td></td>
</tr>
<tr>
<td>Term 37-42 weeks</td>
<td>91.8%</td>
<td></td>
</tr>
<tr>
<td>Post Term &gt;42 weeks</td>
<td>0.2%</td>
<td></td>
</tr>
</tbody>
</table>

**Total number of deliveries with a valid gestation period recorded**

| Total                  | 492,201   |

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

The number of deliveries at the trust by quarter for the last two years can be seen in the graph below.

**Number of deliveries at North Cumbria University Hospitals NHS Trust by quarter**

There was a reduction in the number of deliveries for each quarter in 2017 compared to the equivalent quarter in 2016. However, the quarterly trend in 2017 follows the same trend when compared to 2016.

(Source: HES - Deliveries (January 2016 - December 2017))

**Is the service safe?**

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

**Mandatory training**

**Mandatory training completion rates**
The trust set a target of 95% for completion of mandatory training.

**Trust level**

Nursing and midwifery staff in maternity services had an overall mandatory training compliance rate of 81.1% for April 2017 to March 2018 which was below the trust target. A breakdown of completion of mandatory training courses for nursing and midwifery staff in maternity services is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced life support (adults)</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Basic life support (adults)</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia</td>
<td>14</td>
<td>14</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, trips and falls level 1</td>
<td>174</td>
<td>171</td>
<td>98%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk management</td>
<td>174</td>
<td>169</td>
<td>97%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>174</td>
<td>166</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Duty of candour</td>
<td>174</td>
<td>164</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Intensive life support (paediatrics)</td>
<td>16</td>
<td>15</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>174</td>
<td>158</td>
<td>91%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>174</td>
<td>155</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines management</td>
<td>174</td>
<td>155</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent level 1 and 2</td>
<td>174</td>
<td>155</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Calculating drug doses</td>
<td>174</td>
<td>153</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety</td>
<td>174</td>
<td>153</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 04</td>
<td>16</td>
<td>14</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>174</td>
<td>149</td>
<td>86%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Hand hygiene (clinical)</td>
<td>174</td>
<td>147</td>
<td>84%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>PROMPT</td>
<td>144</td>
<td>121</td>
<td>84%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health records management</td>
<td>174</td>
<td>140</td>
<td>80%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control level 2</td>
<td>174</td>
<td>135</td>
<td>78%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and handling level 2</td>
<td>174</td>
<td>124</td>
<td>71%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NEWS</td>
<td>10</td>
<td>7</td>
<td>70%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Maternity professionals issues day</td>
<td>144</td>
<td>100</td>
<td>69%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 02</td>
<td>174</td>
<td>109</td>
<td>63%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 01</td>
<td>158</td>
<td>98</td>
<td>62%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>162</td>
<td>99</td>
<td>61%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, trips and falls level 2</td>
<td>15</td>
<td>8</td>
<td>53%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Understanding end of life</td>
<td>174</td>
<td>92</td>
<td>53%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk management (board and senior management)</td>
<td>39</td>
<td>16</td>
<td>41%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevention of suicide</td>
<td>16</td>
<td>5</td>
<td>31%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The maternity service met the trust’s mandatory training target in six out of the 30 modules for which nursing and midwifery staff were eligible, however for two of these modules only a small number of staff were eligible to complete the training (nine eligible staff for adults advanced life support and five staff for adults basic life support). A further three training modules had a completion rate of over 90%, which was just below the trust target.

For four of the modules the compliance rate was less than 60%, however for two of these modules only a small number of staff were eligible to complete the training (15 eligible staff for slips, trips and falls level 2 and 16 eligible staff for prevention of suicide).
All medical staff in maternity services were reported as based at Cumberland Infirmary Hospital.

**Cumberland Infirmary Hospital**

Nursing and midwifery staff in maternity services at Cumberland Infirmary Hospital had an overall mandatory training compliance rate of 83.1% for April 2017 to March 2018 which was below the trust target. A breakdown of completion of mandatory training courses for nursing and midwifery staff in maternity services at Cumberland Infirmary Hospital is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic life support (adults)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Advanced life support (adults)</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia</td>
<td>10</td>
<td>10</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk management</td>
<td>84</td>
<td>83</td>
<td>99%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, trips and falls level 1</td>
<td>84</td>
<td>83</td>
<td>99%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Duty of candour</td>
<td>84</td>
<td>82</td>
<td>98%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>84</td>
<td>82</td>
<td>94%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines management</td>
<td>84</td>
<td>79</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Maternity professionals issues day</td>
<td>74</td>
<td>68</td>
<td>92%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>84</td>
<td>77</td>
<td>92%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>PROMPT</td>
<td>74</td>
<td>67</td>
<td>91%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Calculating drug doses</td>
<td>84</td>
<td>76</td>
<td>90%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent level 1 and 2</td>
<td>84</td>
<td>76</td>
<td>90%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>84</td>
<td>73</td>
<td>87%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety</td>
<td>84</td>
<td>72</td>
<td>86%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>84</td>
<td>71</td>
<td>85%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Hand hygiene (clinical)</td>
<td>84</td>
<td>68</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and handling level 2</td>
<td>84</td>
<td>68</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health records management</td>
<td>84</td>
<td>65</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control level 2</td>
<td>84</td>
<td>60</td>
<td>71%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NEWS</td>
<td>10</td>
<td>7</td>
<td>70%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>77</td>
<td>53</td>
<td>69%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 01</td>
<td>84</td>
<td>55</td>
<td>65%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 02</td>
<td>84</td>
<td>55</td>
<td>65%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Understanding end of life</td>
<td>84</td>
<td>44</td>
<td>52%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, trips and falls level 2</td>
<td>10</td>
<td>5</td>
<td>50%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk management (board and senior management)</td>
<td>27</td>
<td>10</td>
<td>37%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The maternity service met the mandatory training target in seven out of the 27 modules for which qualified nursing staff were eligible, however for three of these modules only a small number of staff were eligible to complete the training (one eligible staff for adults basic life support, nine eligible staff for adults advanced life support and 10 eligible staff for dementia). A further six training modules had a completion rate of 90% or more, which was just below the trust target.

For two of the modules the compliance rate was 50% or less, however for one of these modules only 10 staff were eligible to complete the training (slips, trips and falls level 2).
Medical staff in maternity services at Cumberland Infirmary Hospital had an overall mandatory training compliance rate of 69.8% for April 2017 to March 2018 which was below the trust target. A breakdown of completion of mandatory training courses for medical staff in maternity services at Cumberland Infirmary Hospital is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duty of candour</td>
<td>8</td>
<td>7</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>8</td>
<td>7</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Information governance</td>
<td>8</td>
<td>7</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Basic life support (adults)</td>
<td>5</td>
<td>4</td>
<td>80%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>NG Tubes</td>
<td>5</td>
<td>4</td>
<td>80%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Dementia</td>
<td>8</td>
<td>6</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Fire safety</td>
<td>8</td>
<td>6</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Hand hygiene (clinical)</td>
<td>8</td>
<td>6</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Health and safety</td>
<td>8</td>
<td>6</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Health records management</td>
<td>8</td>
<td>6</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>8</td>
<td>6</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Risk management</td>
<td>8</td>
<td>6</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Slips, trips and falls level 1</td>
<td>8</td>
<td>6</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Trust doctors patient safety programme</td>
<td>6</td>
<td>4</td>
<td>67%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Infection control level 2</td>
<td>8</td>
<td>5</td>
<td>63%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Medicines management</td>
<td>8</td>
<td>5</td>
<td>63%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Clinical moving and handling level 1 (3 yearly)</td>
<td>8</td>
<td>5</td>
<td>63%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Prevent Level 1 and 2</td>
<td>8</td>
<td>5</td>
<td>63%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Calculating drug doses</td>
<td>8</td>
<td>4</td>
<td>50%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>NEWS</td>
<td>8</td>
<td>4</td>
<td>50%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Blood safety 01</td>
<td>7</td>
<td>2</td>
<td>29%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

The maternity service at Cumberland Infirmary Hospital did not meet the mandatory target for any of the 21 modules for which medical staff were eligible. However, only a small number of staff were eligible for each module and in five modules only one eligible staff member had not completed the training and in a further eight modules two members of staff had not completed the training.

(Source: Routine Provider Information Request (RPIR) – P40)

The service had systems and processes in place to ensure that staff could access mandatory training and staff we spoke with confirmed they had enough time to complete mandatory training.

Staff told us mandatory training compliance was managed by a training lead midwife, responsible for all sites and the current rate was higher than that provided by the Trust. We spoke with staff about the compliance rates with mandatory training shown above and were assured that the compliance figures would improve as the year progressed and so patient safety was not at risk.

Staff we spoke with assured us all staff including midwives, health care assistants, managers and medical staff, were rostered to attend all elements of mandatory training. Courses were held regularly with e-learning modules and classroom based sessions. Those who did not attend received a reminder, copied to their team leader.
The lead consultant at West Cumberland Infirmary organised weekly education sessions for all staff. These were shared across sites using video link.

All maternity staff, including community midwives, completed skills training and emergency drills including birthing pool evacuation and obstetric emergencies.

**Safeguarding**

**Safeguarding training completion rates**

The trust set a target of 95% for completion of safeguarding training.

**Trust level**

Nursing and midwifery staff in maternity services had an overall safeguarding training compliance rate of 86.2% for April 2017 to March 2018 which was below the trust target. A breakdown of completion of safeguarding courses for nursing and midwifery staff in maternity services is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 2</td>
<td>14</td>
<td>13</td>
<td>93%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 3 (specialists)</td>
<td>160</td>
<td>145</td>
<td>91%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>174</td>
<td>142</td>
<td>82%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Maternity services did not meet the safeguarding training trust target for any of the three modules for which nursing and midwifery staff were eligible. However only one member of staff (out of 14) did not complete the safeguarding children level 2 training module, and over 90% of staff had completed two out of the three modules.

All medical staff in maternity services were reported as based at Cumberland Infirmary.

**Cumberland Infirmary**

Nursing and midwifery staff in maternity services at Cumberland Infirmary had an overall safeguarding training compliance rate of 85.7% for April 2017 to March 2018 which was below the trust target. A breakdown of completion of safeguarding courses for nursing and midwifery staff in maternity services at Cumberland Infirmary is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 3 (specialists)</td>
<td>74</td>
<td>68</td>
<td>92%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>10</td>
<td>9</td>
<td>90%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>84</td>
<td>67</td>
<td>80%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
Maternity services at Cumberland Infirmary did not meet the safeguarding training trust target for any of the three modules for which nursing and midwifery staff were eligible. However only one member of staff (out of 10) did not complete the safeguarding children level 2 training module, and 90% or more of staff had completed two out of the three modules.

Medical staff in maternity services at Cumberland Infirmary had an overall safeguarding training compliance rate of 68.8% for April 2017 to March 2018 which was below the trust target. A breakdown of completion of safeguarding courses for medical staff in maternity services at Cumberland Infirmary is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults level 1</td>
<td>8</td>
<td>6</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>8</td>
<td>5</td>
<td>63%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Maternity services at Cumberland Infirmary did not meet the safeguarding training trust target for either of the two modules for which medical staff were eligible, however there was only a small number of staff eligible for each training module.

(Source: Routine Provider Information Request (RPIR) – P40)

The midwives were moving onto online training for level three safeguarding and told us they understood this was the only route available to them for level three training. The community midwives carried out case reviews when they raised safeguarding issues, but we were told this practice did not take place in the ward areas. However, all midwives we spoke with in the ward areas told us they had spoken with staff at the safeguarding hub who provided support regarding any patients identified with safeguarding issues.

The trust had policies, systems and processes in place to protect children and adults from neglect or abuse. Staff we spoke with had undertaken safeguarding training so that safeguarding was everyone’s business. Staff we spoke with understood their responsibilities in identifying and reporting any safeguarding concerns.

Staff were able to give us examples of safeguarding referrals made including domestic abuse, child protection, and female genital mutilation (FGM). The lead consultant at West Cumberland Hospital was also the FGM lead for the whole service.

Midwives told us they undertook FGM and child sexual exploitation (CSE) training as part of their mandatory training. Staff told us they were not aware of any women who had presented with this. However, staff told us that any case would be shared with the community teams, GP, and health visitors.

There was a clear referral pathway via the community midwives if there were any identified safeguarding issues with expectant mothers, for example mothers who may have had children removed previously, those living with drug and alcohol abuse, and domestic violence.

Staff attended a regular core group meeting where all the professionals met to discuss the mothers and plan any further action that may be required. We looked at two cases with safeguarding issues and found that adequate risks had been assessed and recorded. If there was
any risk of the mother absconding due to safeguarding issues, the unit was part of a network and would put alerts out to warn other maternity units nationally. The midwives told us mothers were involved in any decisions about their care and staff would ensure any plans of action would be made clear.

Staff set an alert in the patient administration system in maternity and staff put a red divider in patient paper records to ensure all staff were aware of safeguarding issues for a mother. We saw red cards used in patient records to identify any patient with a reported safeguarding concern. We saw evidence to show the team identified babies at risk at birth due to social issues. Staff told us an alert would also show on any electronic record.

Once the mother was discharged home, staff would tick a box in the perinatal notes to alert any health visitors of risks such as safeguarding.

The midwives referred patients into the safeguarding HUB and received feedback when required from the social workers.

The trust had a range of specialist midwives for vulnerable women such as young parents, women suffering domestic abuse, women involved in abuse of drugs or alcohol, women living with learning disabilities, and maternity related conditions such as diabetes.

The chief Matron worked with women who wished to develop their birth plan in a way that was outside of best practice guidance. This work ensured that a woman’s wishes were heard and a safe plan was developed. Staff told us the specialist midwives for vulnerable women were involved in development of birth plans and worked closely with the mental health perinatal team.

Staff we spoke with were aware of the trust’s abduction policy and the infant tagging system. Midwives told us if a baby’s tag came off, and this had happened on occasions, sometimes several times a day, it would alarm and alerts would show on the midwife station computer screen. Staff felt this ensured they kept babies safe. However, staff we spoke with could not remember the abduction policy ever being formally tested with drills on site. We observed staff and visitors were compliant with ward security, using passes and challenging visitors.

**Cleanliness, infection control and hygiene**

We found that the environment was visibly clean and that systems and processes were in place to control infection and promote hygiene. We saw the results of monthly cleaning audits displayed in ward areas. Compliance was consistently measured at 100%.

We found cleaning rotas and checklists for all patient areas including delivery rooms, the birthing pool so staff were aware of what was expected of them. Domestics held cleaning rotas for public areas. However, staff could not show how they complied with the Health and Safety Executive guidance to run the hot water in the birthing pool for five minutes daily to reduce the risk of legionella.

Hand washing facilities and antibacterial gel dispensers were available at the entrance of the wards and on corridors. There was clear signage encouraging visitors and staff to wash their hands. We observed staff using personal protective equipment when required, and they adhered to ‘bare below the elbow’ guidance.
Women we spoke to said they had observed all disciplines of staff washing their hands and using hand gel.

Single rooms were available in all areas if a patient needed to be isolated.

We observed staff cleaned equipment after use and used assurance stickers to indicate it was clean and ready for use.

All wards displayed the results of hand hygiene audits. All the wards we visited achieved 100% throughout 2018.

We saw clinical waste and domestic waste was appropriately segregated and disposed of correctly in accordance with trust policy. Separate utility areas were designated for clean and dirty use. Separate bins for clinical and domestic waste were evident throughout all wards visited.

We saw posters offering women flu vaccinations.

Women were screened for Meticillin resistant staphylococcus aureus (MRSA) before undergoing elective caesarean sections as part of the pre-operative assessment.

**Environment and equipment**

We found the wards were accessible using a buzzer system, with good signage. All main entrances to the delivery suite and antenatal/postnatal ward were locked and admission was only possible via a telecom system. Staff and visitors gained entry and could only exit via a swipe card system.

However, during our inspection, we noticed the double doors between a shared gynaecology ward area and delivery suite had no security features or signs for delivery suite and staff told us gynaecology patients were known to have entered delivery suite by mistake. We raised this with staff during our inspection and asked if they felt there was a security risk. Staff and a senior manager told us they were aware of the problem but felt there was little they could do to change it. The ADM had raised their concerns with the estates department and security card readers had been ordered but not yet installed. Following our inspection, staff told us this had been escalated to the Director of Nursing. The inspection team returned to site and found a security swipe access point had been installed at this doorway, therefore, reducing the security risk.

Staff we spoke with reported having enough equipment that was ready and safe to be used.

Cardiotocography (CTG) equipment was available to enable staff to monitor the fetal heart rate in labour. The trust had a medical devices and equipment policy which set out how checks on equipment were done, how faults or damage were reported and what monitoring was in place.

Planned preventative maintenance was managed between estates and team leaders. Repairs needed earlier could be requested through the estates department. All the equipment we saw had visible evidence of electrical testing indicating safety checks.
The delivery suite was situated on the fourth floor and could be accessed via a lift or stairs.

The delivery suite had ten single labour, delivery, recovery and postnatal (LDRP) rooms. All the delivery rooms had en-suite facilities and a wet room, except for two rooms that shared a bathroom, lockable from either side. Delivery rooms close to the nurses’ station were used for women with higher risk scores and other rooms were used for women at lower risk. There was no separate midwifery led unit. However, staff told us two rooms had been identified to be converted for women wanting midwifery led care. There was no date set for this work to be done.

A birthing pool was available on the delivery suite and a safety net was stored in the room. Staff ran emergency pool evacuation simulation as part of their mandatory training.

There was an antenatal and postnatal ward with three four-bedded bays and a single room. Staff told us the single room was usually used to triage admissions and the bays could be used depending on the type of women admitted, but most often one bay was kept for antenatal women.

There were two dedicated obstetric theatres located just off the delivery suite, this enabled easy access. One theatre was in regular use for elective and emergency use and the second theatre was used rarely and for emergencies only. Theatres were cleaned and fully stocked every day.

Resuscitation trolleys were located on the main corridors in each of the areas we visited. We checked the resuscitation trolleys in all the clinical areas and found all stocks and supplies were checked in line with best practice in all clinical areas.

There were resuscitaires in LDRP rooms but not in the antenatal or postnatal ward area. This meant that staff had to access SCBU if a baby was in need of urgent resuscitation. SCBU was located through a security door so although it was very close, there was a physical barrier between a sick baby with staff providing care, and the equipment needed.

Community staff we spoke with explained that they carried weighing scales to monitor weight of mums and babies to ensure nutrition was taking place.

Assessing and responding to patient risk

Within the maternity service staff used the modified early obstetric warning score (MEOWS) and the national early warning score (NEWS) respectively to assess the health and wellbeing of women. These assessment tools enabled staff to identify if a patient’s clinical condition was changing. Women on the delivery suite and antenatal/postnatal ward were assessed using the MEOWS score. We reviewed three sets of records and found there was sufficient and regular information recorded for staff to assess women’s conditions and staff understood escalation protocols and interventions.

The Trust used the national sepsis tool to ensure early recognition and action regarding postnatal infection.

Staff used the World Health Organisation (WHO) safety checklist, modified for maternity, for all interventional procedures and staff told us the checklist would be started in the delivery room from the time of decision to proceed. We saw completed checklists and reviewed records of a woman who had been to theatre. All WHO checklists had been completed correctly.
We observed midwife handovers and medical staff communications and saw staff at all levels and grades took part fully in handovers of patient care from one shift to the next. Staff told us if anaesthetists were unable to attend medical handovers they would attend the ward before or afterwards. Staff gave updates on labouring women, transfers to and from other wards or theatre and details of women requiring additional care. We saw staff used a situation, background, action and result (SBAR) framework to transfer women between teams. This appeared to work well.

We saw evidence the unit used the ‘fresh eyes’ approach, a system that required two members of staff to review fetal heart tracings. This indicated a proactive approach in the management of obstetric risk as it reduced the risk of misinterpretation of the heart tracings. We also saw a second midwife attended a birth wherever possible.

Midwives completed risk assessments at booking to identify women with any medical, obstetric, psychological or lifestyle risk factors. This determined if an individual was high or low risk. High risk women were referred to consultant led antenatal clinics. Women referred by their GP or the emergency department attended the ward for assessment.

Medical staff told us clinical information was discussed formally between all levels of medical staff and recorded in handover notes.

Consultant obstetricians were available out of hours for emergency caesarean section and if a patient’s condition gave rise for concern.

The service had an agreement in place with the local ambulance service to attend babies born before arrival of a midwife at home. Community midwives told us they informed the ambulance service before attending any home birth in case an emergency arose.

**Midwifery and nurse staffing**

**Planned vs actual**

Staffing levels were recorded and displayed on noticeboards in ward areas. Most shifts were calculated to required seven midwives. However, there were regularly only six on day and night shifts. Lead midwives were supposed to be supernumerary on day shift but staff told us they regularly worked to make up the numbers. At night there were no other staff available so the team regularly worked one midwife short. Staff told us they were used to this and usually managed well but if a midwife was sick there was no way to contact managers for help. Staff told us they felt unsupported at night and requests for extra staff on busy shifts had been ignored on more than one occasion.

Staff were allocated by the lead midwife to specific areas such as delivery suite or the ward at the beginning of each shift. However, staff told us midwife staffing levels were static and did not risk assess daily. The service had used Birthrate Plus to manage and balance risk in 2016 but staffing had not reassessed since then. Staff told us this was mainly due to not being able to plan for the future.

There were two healthcare assistants (HCAs) on each shift, one on the antenatal and postnatal ward, and the other on delivery suite.
Vacancy rates

From April 2017 to March 2018, the trust reported an over-establishment of 4.1% with 63.4 more WTE staff in post than planned. The trust target for vacancy rate is 5%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From April 2017 to March 2018, the trust reported a turnover rate of 7.2% in maternity which was lower than the trust target of 13.0% for voluntary turnover (excluding corporate services, junior doctors and FTCs)

For Cumberland Infirmary Hospital the turnover rate was 6.4%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From May 2017 to May 2018, the trust reported a sickness rate of 5.2% in maternity which was above the trust target of 4.0%.

The sickness rate for Cumberland Infirmary Hospital was 5.9%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

From April 2017 to March 2018, the trust reported a bank usage rate of 8.6% in maternity.

The trust was unable to provide comparable data for agency and shifts left unfilled, due to system restrictions. However, staff told us the service did not use agency staff.

The breakdown for Cumberland infirmary is shown in the table below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Bank shifts</th>
<th>Total shifts</th>
<th>Bank shifts as a proportion of total shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary Hospital</td>
<td>12</td>
<td>759</td>
<td>1.6%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Midwife to birth ratio

From January 2017 to December 2017 the trust had a ratio of one midwife to every 23.7 births. This was similar to the England average of one midwife to every 25.5 births and similar to the trust’s previous performance (November 2015 to October 2016) of one midwife to every 24.4 births.

(Source: Electronic Staff Records – EST Data Warehouse)
The service performed better than national benchmark for midwifery staffing set out in the Royal College of Obstetricians and Gynaecologists guidance (Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour) with a ratio of 1:24 against the recommended 1:28. The service had previously used the Birthrate Plus® midwifery acuity tool, however, at the time of inspection the service was working towards the continuity of carer model advocated in Better Births (2017). This meant that the acuity tool would be more appropriate following the implementation of the new way of working.

Between July 2017 and June 2018, the service reported an average 1:1 care in labour rate of 81.9%, however, 15.9% of maternity records showed 1:1 care in labour was not recorded. The service identified 1.6% of women did not receive 1:1 care in labour.

Staff we spoke with told us, they were assured women received safe care through audit and friends and family survey results. We spoke with three women who said they had received one to one care in labour.

Medical staffing

The delivery suite had consultant cover 40 hours per week, this was in line with the safer childbirth (2007) recommendation. Consultants were available within 30 minutes when they were on call. We spoke with consultants and midwives who all confirmed this. However, some staff told us routine requests for doctors to see women on the antenatal and postnatal ward were not always answered quickly enough. On the day of our inspection, midwives told us women were kept waiting for 3 hours before being seen by a doctor.

Handovers took place twice a day and staff told us consultants on call made a structured call to the midwife in charge of the maternity units every evening at 10pm to receive information on women, their care and any specific needs.

The medical team were trialling a handover tool to help junior doctors be aware of the current acuity of women on the unit.

Anaesthetic cover was available 24 hours a day and included an epidural service, however there was not a dedicated anaesthetic team for the maternity unit. Anaesthetic cover was shared between the intensive care unit and maternity this meant that there may be a delay woman receiving an epidural. There was a trust shortage of anaesthetists but the trust had mitigated this risk by employing long term locums and existing staff worked flexibly to ensure all departments had adequate cover. The maternity service had not experienced any difficulties in accessing anaesthetists for their patients.

The consultant held clinics in Antenatal clinic, however, we were told that it was difficult to get medical consultant to support the diabetes clinic. There were specialist clinics available for women who had multiple pregnancies, mental health issues.
Staffing skill mix

In January 2018, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.

Staffing skill mix for the 24.5 whole time equivalent staff working in maternity at North Cumbria University Hospitals NHS Trust

```
<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>25%</td>
<td>41%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>30%</td>
<td>9%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>33%</td>
<td>45%</td>
</tr>
<tr>
<td>Junior*</td>
<td>12%</td>
<td>6%</td>
</tr>
</tbody>
</table>
```

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

We reviewed three sets of records and found them to be legible, detailed, signed, and safely stored. Records showed each woman had a named midwife responsible for their care. Individualised care plans for pregnancy and labour were documented and venous thromboembolism (VTE) risk assessments were completed.

Patient records were a mix of electronic and paper patient notes (for instance, inpatient notes and nursing care plans were paper based). Paper records were stored securely away from patient areas and maternity used an electronic record so data could be shared with community services.

Women carried their own hand-held records throughout their pregnancy. These were shared with community midwives and GPs. Results from antenatal tests were documented in these records. Antenatal risk assessments were completed at booking to identify any medical, obstetric, or psychological risk factors. Midwives we spoke with told us risk assessments were repeated at each antenatal visit. We saw evidence of this in records we reviewed.

Information relating to discharge was communicated using the SBAR tool to ensure timely communication on discharge from the maternity unit. Information was sent by post to women, GPs and health visitors. Community midwives could access the information electronically. Staff said if a woman had complex needs they would contact the relevant professional in addition.

All staff could access test results using the trust electronic system. Community staff had electronic access to test results at their hub offices.
Staff we spoke with told us and we saw senior midwives undertook a monthly spot check record audit of records. Any trends or good practice were disseminated to clinical areas.

The ‘fresh eyes’ approach was used to review CTG’s and we saw evidence of this in patient records.

**Medicines**

We checked the storage of medicines on the wards we visited. We found that medicines were stored securely in appropriately locked rooms and stocks were in date. Pharmacy staff checked storage and stocks of medicines weekly. A prescription pad was securely stored within the locked medicines cabinet.

We checked the storage and administration of controlled drugs, which require specific controls, in all clinical areas. We found controlled drugs were appropriately stored with access restricted to authorised staff. Records showed the administration of controlled drugs were subject to a second check. After administration, the stock balance was confirmed to be correct and the balance recorded. We checked records between March and July 2018 and found these had all been completed appropriately. Intravenous fluids were securely stored in all the clinical areas we visited.

Medicines that required refrigeration were stored appropriately in fridges. The drugs fridges were locked and there was a method in place to record daily fridge temperatures. All fridge minimum and maximum temperatures were checked and recorded daily. There were no gaps in recording. Staff we spoke with understood their responsibilities for raising concerns if the fridge temperature went out of range.

Ninety four percent of midwifery staff had completed medicines management training in the last 12 months.

We checked three prescription charts and found these to be comprehensive and completed to a high standard. Women received medicines promptly and any allergies were clearly recorded.

All midwives were practising under patient group directions (PGDs). (PGDs provide a legal framework that allows some registered health professionals to supply and/or administer specified medicine(s) to a predefined group of women without them having to see a doctor.) Records showed PDGs were in date and included exemptions.

In the medicine room on the labour suite there was grab box for post-partum haemorrhage (PPH) (on resus trolley – dates recorded when medicines taken out), two suturing boxes containing lignocaine, and five delivery boxes. These each contained medicines that required to be labelled when they were removed from the fridge. Four out of five delivery boxes contained dates on the two different medicines that were required to be labelled. However, in one box one medicine did not contain a date when the medicine was removed. We raised this with the lead midwife who assured us that this would be discarded. The other medicines were labelled correctly.

Community midwives stored their on-call drug box within the medicine room and would take this with them to home births. Two boxes (numbered box one and box three) were present which contained three medicines. We saw that none of the medicines contained dates when they were removed from the fridge. We spoke with a community midwife who told us that they had a diary in
the office where they documented when the medicines were taken out of the fridge. The midwife stated they put the date in the diary when the medicines were due to be changed or expired. Community midwives told us all home birth equipment, including medicines and medical gases, was stored on delivery suite and staff would collect the pack immediately before attending the woman at home. Community midwives did not carry or transport medical gases at any other times.

**Incidents**

The trust had a clear policy for the reporting of incidents, near misses and adverse events. Staff were encouraged to report incidents using the trusts electronic reporting system. The staff we spoke with described the process of incident reporting and understood their responsibilities to report safety incidents including near misses. Staff told us they received a copy of the closure of any incident they reported from the electronic reporting system.

Between May 2017 and June 2017 there were 621 incidents specifically categorised as obstetrics and reported to the National Reporting and Learning System (NRLS). Of these, 231 (37%) related to treatment and procedures and 130 (21%) were reported as concerns around staffing. Staff told us they completed details of actions taken to prevent a recurrence of an incident.

Staff we spoke with said incidents were discussed in weekly, cross-site core risk meetings. Feedback from incidents was shared in a number of ways including; a “safety message of the week”, case reviews, and face to face feedback. Safety and quality midwives relayed feedback and updates to staff.

The service held monthly perinatal mortality meetings where serious case reviews were discussed. These meetings were attended by gynaecology, obstetric and neonatal staff.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify women (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

Staff we spoke with understood and could describe duty of candour requirements and understood the importance of being open and honest with women. It was evident in the serious incident investigations we reviewed that the duty of candour had been applied.

There were escalation processes to activate plans during internal critical incidents such as shortfalls in staffing levels or bed shortages. However, some staff told us they had reported staff shortages, especially at night, and had been told there would be no additional staff made available.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From June 2017 to May 2018, the trust reported one incident which was classified as a never event for maternity. This was a retained foreign object post procedure and occurred in May 2018.
Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported nine serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from June 2017 to May 2018 including one never event.

The types of incident reported were:

- Maternity/obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant) with six (66.7% of total incidents)
- Maternity/obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant) with one (11.1% of total incidents)
- Maternity/obstetric incident meeting SI criteria: mother only with one (11.1% of total incidents)
- Surgical/invasive procedure incident meeting SI criteria with one (11.1% of total incidents)

There were five serious incidents reported at Cumberland Infirmary.

Staff gave an example of a recent serious incident involving post-natal sepsis and explained the lessons learned and shared and actions taken to help prevent a recurrence.
Safety thermometer

The Maternity Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care.

Measurement at the frontline is intended to focus attention on patient harms and their elimination. Data collection takes place one day each month – a suggested date for data collection is given but the service can change this. Data must be submitted within 10 days of suggested data collection date.

The graphs below identify the levels of harm free care for the maternity service.
The graphs show mixed results for the perception of harm free care for the service; however, women reported feeling safe 100% of the time between April 2016 and August 2018.

Is the service effective?

Evidence-based care and treatment

The trust had systems and processes in place to ensure that care was given by the service according to published national guidance such as that issued by National Institute for Health and Care Excellence (NICE) and Royal College of Obstetricians and Gynaecologists (RCOG). All staff we spoke with could access on the trust’s intranet, guidelines, policies and procedures relevant to their role.

On a review of clinical pathways and guidelines we found some maternity guidelines and procedures had an author and were within their review date. However, there were many maternity guidelines that were beyond their published review date. We found that of 20 maternity guidelines we reviewed, 17 were out of date, some by up to two years. We spoke with the midwife lead responsible for governance, along with the Head of Midwifery, to ensure that clinical guidelines were updated in accordance with NICE or RCOG guidelines. Staff told us guideline reviews were underway but there were various reasons for delays including lack of clinical input. There was no clear process or timeline for updating maternity guidelines and staff reported the Trust ratification process was responsible for some of the delays in publishing clinically agreed guidelines.

The service had an annual audit programme. Doctors and midwifes were involved in the audit programme. For instance, we saw audits on maternal and fetal monitoring in labour or indication for induction of labour. Actions from audits were discussed and monitored at joint core risk meetings and following presentations at education meetings.
Nutrition and hydration

We found the service met the needs of women having babies, babies and visitors, carers or relatives.

There was specialist midwife for infant feeding who worked across both sites, who led on the implementation and training associated with the implementing United Nations Children’s Fund (UNICEF) Baby Friendly Initiative standards. The specialist midwife also managed the breastfeeding peer supporters.

The trust had implemented United Nations Children’s Fund (UNICEF) Baby Friendly Initiative standards. The maternity unit in Carlisle was awarded stage two UNICEF baby friendly accreditation in October 2017.

Breastfeeding initiation rates for deliveries that took place in the hospital for June 2017 and May 2018 were reported between 52.2% and 69.9%.

The Maternity ward had a kitchen area where women had open access to hot drinks and cold water and a water fountain was situated in the ward waiting area.

Women told us they had a choice of meals and these took account of their individual preferences, including religious and cultural requirements.

Pain relief

To help women manage their pain we saw that the service could offer a range of options, both medical and non-medical. Women we spoke with did not report any issues with the management of their pain.

Women received information of the pain relief options available to them, this included Entonox (nitrous oxide and oxygen) piped directly to all delivery rooms, and pharmacological methods such as Pethidine and epidural.

For those women who wanted medical pain relief there was 24/7 anaesthetic cover available to the service for epidurals. Between June 2017 and May 2018 between 9.6% (April 2018) and 16.5% (December 2017) of women used epidural as a method of pain relief.

The service promoted normal birth as much as possible, there were birth balls available and the delivery suite had one birthing pool and had acquired funding for a further birthing pool.

The service did not actively promote alternative therapies such as aromatherapy and hypnobirthing, although staff we spoke with informed us that they had supported women using hypnobirthing techniques.

Community staff told us any required pain relief for a home birth would be prescribed by the GP but staff attending from the delivery suite would bring gas and air with them.
Patient outcomes

The service had systems and processes in place to monitor patient outcomes, such as case reviews, use of a maternity dashboard, maternity safety thermometers, and taking part in a programme of national and local audits, the results from all of which were used to improve the experience of women.

National Neonatal Audit Programme

Cumberland Infirmary Hospital

In the 2017 national neonatal audit Cumberland Infirmary Hospital performance in the two measures relevant to maternity services was as follows:

- **Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?**

There were 29 eligible cases identified for inclusion and 86.3% of mothers were given a complete or incomplete course of antenatal steroids.

This was within the expected range when compared to the national aggregate where 86.1% of mothers were given at least one dose of antenatal steroids.

The hospital met the audit’s recommended standard of 85% for this measure.

- **Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?**

Data for this metric was suppressed due to low numbers.

(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)

Standardised caesarean section rates and modes of delivery

From January 2017 to December 2017 the total number of caesarean sections, standardised caesarean section rates and emergency sections were all similar to expected.

<table>
<thead>
<tr>
<th>Standardised caesarean section rate (January 2017 to December 2017)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of caesarean</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Elective caesareans</td>
</tr>
<tr>
<td>Emergency caesareans</td>
</tr>
</tbody>
</table>
Between June 2017 and May 2018, the service reported the total caesarean section rate between 22% (July 2017) and 32.7% (November 2017) with the average being 27.5%. This was equal to the regional average of 27% and better than the England average of 28%.

Between June 2017 and May 2018, the service reported an elective caesarean section rate between 6.4% (March 2018) and 19% (November 2018). The average for this timescale was 12.7% which was better than the regional average of 13.3% and equal to the England average of 12.4%.

Between June 2017 and May 2018, the service reported an elective caesarean section rate between 12.2% (September 2017) and 20.9% (April 2018). The average for this timescale was 14.8% this was worse than the regional average of 13.6%, and better than the England average of 15.6%.

The proportion of deliveries by caesarean section at this trust was lower than the England average and the proportion of non-interventional deliveries was higher.

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

Between June 2017 and May 2018, the service reported an induction of labour rate between 26.3% (January 2018) and 45.3% (April 2018). Additional of those induced labours the service

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>North Cumbria University Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total caesarean sections¹</td>
<td>659</td>
<td>23.9%</td>
</tr>
<tr>
<td>Instrumental deliveries²</td>
<td>312</td>
<td>11.3%</td>
</tr>
<tr>
<td>Non-interventional deliveries³</td>
<td>1,789</td>
<td>64.7%</td>
</tr>
<tr>
<td>Other/unrecorded method of delivery</td>
<td>3</td>
<td>0.1%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>2,763</td>
<td>100%</td>
</tr>
</tbody>
</table>

¹Includes elective and emergency caesareans
²Includes forceps and ventouse (vacuum) deliveries
³Includes breech and normal (non-assisted) deliveries

Note: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries.

In relation to other modes of delivery from January 2017 to December 2017 the table below shows the proportions of deliveries recorded by method in comparison to the England average:

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>North Cumbria University Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total caesareans</td>
<td>23.9%</td>
<td>28.0%</td>
</tr>
<tr>
<td>Instrumental deliveries</td>
<td>64.7%</td>
<td>65.5%</td>
</tr>
<tr>
<td>Non-interventional deliveries</td>
<td>11.3%</td>
<td>16.7%</td>
</tr>
<tr>
<td>Other/unrecorded methods</td>
<td>0.1%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Total deliveries

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monitored the number of labours which resulted in an emergency caesarean section. The service reported between 14% (February 2018) and 28.6% (April 2018) against a target of 22%.

Between June 2017 and May 2018, the service reported the rate of 3rd and 4th degree vaginal tears between 0% (February 2018) and 3.6% (August 2017), this was better that the target of less than 5%, however, was worse than the regional average of 1.7%.

Between June 2017 and May 2018, the service reported a post-partum haemorrhage of 1500mls rate between 0.7% (August 2017) and 4.8% (March 2018), this was better than the regional average of 5%.

Between June 2017 and May 2018, the service reported a post-partum haemorrhage of 2000mls rate between 0% (June, August, December 2017, February, March, April 2018) and 2.1% (October 2017). The service had undertaken some improvement work around identifying estimated blood loss at delivery.

Maternity active outlier alerts

As of May 2018 the trust reported no active maternity outliers.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE UK Audit)

The trust took part in the 2017 MBRRACE audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 4.45.

This is up to 10% lower than the average for the comparator group rate of 4.73 and performance was rated as better than expected.

(Source: MBRRACE UK)

Competent staff

Appraisal rates

Trust level

From April 2017 to March 2018 97.3% of staff within maternity services at the trust received an appraisal compared to a trust target of 95.0%. A breakdown of staff appraisal completion is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required</th>
<th>Appraisals completed</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to doctors and nursing staff</td>
<td>38</td>
<td>38</td>
<td>100%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>4</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff (Qualified nurses)</td>
<td>141</td>
<td>136</td>
<td>96%</td>
</tr>
</tbody>
</table>
All of the staff groups met the trust target for completion of appraisals.

**Cumberland Infirmary Hospital**

From April 2017 to March 2018 95.6% of staff within maternity services at Cumberland Infirmary Hospital received an appraisal compared to a trust target of 95%. A breakdown of staff appraisal completion is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required</th>
<th>Appraisals completed</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>2</td>
<td>2</td>
<td>100%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>19</td>
<td>19</td>
<td>100%</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff (Qualified nurses)</td>
<td>70</td>
<td>66</td>
<td>94%</td>
</tr>
</tbody>
</table>

Two out of the three staff groups met the trust target for completion of appraisals with the other staff groups (nursing and midwifery staff) falling short of the target by 1%.

Junior doctors had cross site teaching with colleagues at West Cumberland via video conferencing. This included presentations and discussions on recent incidents within the service. The service ensured that staff were competent in their roles by ensuring staff received an annual appraisal, or through sharing information by email or at team meetings or in a newsletter, and by offering staff additional training, including support for the new professional midwife advocate role.

Staff we spoke with confirmed that they had received an annual appraisal or were booked to receive one.

Staff told us that there were trained professional midwife advocates. This role had replaced the supervisor of midwives role. Midwives felt supported, particularly around revalidation.

Student midwives and newly qualified midwives worked through a preceptorship package. Staff told us all newly qualified staff were allocated a preceptor. All staff, except specialist midwives and community midwives, worked on Delivery Suite and the antenatal/postnatal ward to ensure up to date skills and competence in all areas.

The service had a number of midwives occupying specialist roles, such as for young parents, substance misuse, safeguarding and quality.

Staff received training within their department or via video link from West Cumberland Infirmary, led by the consultant lead. This training was multi-disciplinary and attended by all staff.

Junior doctors reported to us that they felt well supported and felt able to approach senior colleagues if advice was needed.

**Multidisciplinary working**

We saw different teams and health professionals working together with staff at the service to ensure effective services were delivered to women.
All newborn baby checks were done at the hospital by staff in the adjacent neonatal unit with support from paediatricians, before the baby left. There were no plans to train midwives to enable them to carry out newborn baby checks.

Staff told us handover between shifts was open, with structured, and detailed communication between doctors and midwives. Anaesthetists joined the multidisciplinary handover, or the ward round shortly afterwards, and were made aware of any high-risk women and planned cases for theatre.

Education sessions and joint core governance meetings were open meetings so if any staff member wished to attend they were welcome to do so.

We saw that healthcare assistants were a highly valued part of the team and we saw a display of very positive comments from midwives about midwifery support workers.

A number of clinics that the service ran drew on specialist consultants or other health professionals from outside the service. However, staff told us they had difficulty identifying a medical consultant support for the diabetic clinic.

Specialist midwives worked closely with GPs, social workers, health visitors, and support workers, to ensure that vulnerable women and those with long term conditions received effective care. Staff told us they had good links with the perinatal mental health team who could provide assessment and treatment as necessary.

We were told of one incident where a patient who was pregnant and had mental health needs identified had attended the unit at Cumberland Infirmary, Carlisle. Staff had assessed the patient required help and support for their condition. However, the mental health team had not accepted the referral but after discussion the patient was seen. This incident was shared with the wider team across all sites and lessons had been learned as this incident had created further links with the mental health team to explore and understand mental health alongside pregnancy.

**Seven-day services**

There was a specific obstetric theatre team and was always available, out of hours this staffed between by emergency theatres. Anaesthetic cover was available 24 hours a day, however, this was shared with the intensive care unit, therefore there may be a delay in women receiving an epidural.

There was medical staff presence on the delivery suite 24 hours a day, with consultant presence 40 hours a week.

Maternity triage was provided on the Antenatal and postnatal ward 24 hours a day. The day assessment unit was available seven days a week and undertook routine day assessments of pregnant women including blood pressure profiles they also triaged all emergency admissions, pre-operation checks.

Ultrasound scans were available Monday to Friday 9.00am to 5.00pm, however, we were told there were not enough slots for urgent scans.
Community midwives provided seven-day cover. They provided antenatal clinics in community settings and postnatal visits took place in the home.

**Health promotion**

Between January 2018 and May 2018, the service reported the rate of women smoking at booking appointment was 8.8% (March 2018) and 21.6% (April 2018), this was worse than the target of less than 11%.

Between January 2018 and May 2018, the service reported the rate of women smoking at delivery was 9.6% (March 2018) and 18.7% (April 2018), this was worse than the target of less than 11%.

The service had a public health midwife manager whose portfolio includes Vaccinations, obesity pathways, infant nutrition, smoking cessation, substance misuse and teenage pregnancy. East workstream had a specialist midwife lead.

Women had access to aqua aerobics classes.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust set a target of 95% for completion of mental capacity act (MCA) and deprivation of liberty safeguarding (DoLS) training.

**Trust level**

Nursing and midwifery staff in maternity services had an overall MCA and DoLS training compliance rate of 94.8% for April 2017 to March 2018 which met the trust target. A breakdown of completion of MCA and DoLS courses for nursing and midwifery staff in maternity services is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental capacity level 2</td>
<td>37</td>
<td>36</td>
<td>97%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental capacity level 1</td>
<td>174</td>
<td>169</td>
<td>97%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Deprivation of liberty</td>
<td>37</td>
<td>30</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Maternity services met the training trust target for two of the three modules for which nursing and midwifery staff were eligible.

All medical staff in maternity services were reported as based at Cumberland Infirmary Hospital.

**Cumberland Infirmary Hospital**

Nursing and midwifery staff in maternity services at Cumberland Infirmary Hospital had an overall MCA and DoLS training compliance rate of 94.2% for April 2017 to March 2018 which was just below the trust target. A breakdown of completion of MCA and DoLS courses for nursing and midwifery staff in maternity services at Cumberland Infirmary Hospital is shown below:
Maternity services at Cumberland Infirmary Hospital met the training trust target for two of the three modules for which nursing and midwifery staff were eligible.

Medical staff in maternity services at Cumberland Infirmary Hospital had an overall MCA and DoLS training compliance rate of 70.0% for April 2017 to March 2018 which did not meet the trust target. A breakdown of completion of MCA and DoLS courses for medical staff in maternity services at Cumberland Infirmary Hospital is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental capacity level 1</td>
<td>84</td>
<td>83</td>
<td>99%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental capacity level 2</td>
<td>27</td>
<td>26</td>
<td>96%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Deprivation of liberty</td>
<td>27</td>
<td>21</td>
<td>78%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Maternity services at Cumberland Infirmary Hospital did not meet the training trust target any of the three modules for which medical staff were eligible, however the number of eligible staff for each module was low and there were two staff for each module that had not completed the training.

Staff knew the importance of gaining consent to treatment and had received training in consent, mental capacity and deprivation of liberty safeguards.

Our discussions with staff and review of patient records showed that consent was written where any medical procedure was carried out, such as a caesarean section, with verbal consent for everyday tasks, such as taking blood pressure. We reviewed two records of women undergoing a medical procedure and noted that consent was properly evidenced in writing in both records. Staff told us women were given relevant background information for procedures involving written consent, for example in a caesarean section preparation clinic. This promoted better understanding and ensured consent was informed consent.

Staff could describe what was meant by Gillick competence, (a test used to assess a young person’s ability to give consent), with staff informing us this was part of their mental capacity training. Staff gave examples of when they would use this.
Is the service caring?

Compassionate care

Friends and Family test (FFT) performance

Friends and family test performance (antenatal), North Cumbria University Hospitals NHS Trust

From March 2017 to March 2018 the trust’s maternity FFT (antenatal) performance (% recommended) was generally similar to the England average. In three of the reported months 100% of patients recommended the trust for antenatal care. Note that no data was published by NHS England for November 2017.

Friends and family test performance (birth), North Cumbria University Hospitals NHS Trust

From March 2017 to March 2018 the trust’s maternity FFT (birth) performance (% recommended) was generally similar to the England average. In five of the reported months 100% of patients recommended the trust for care during birth. Note that no data was published by NHS England for November 2017.

Friends and family test performance (postnatal ward), North Cumbria University Hospitals NHS Trust
From March 2017 to March 2018 the trust’s maternity FFT (postnatal ward) performance (% recommended) was generally better than the England average. The trust scored between 97% and 100% each month compared to the England average of between 94% and 95%. Note that no data was published by NHS England for November 2017.

Friends and family test performance (postnatal community), North Cumbria University Hospitals NHS Trust

From March 2017 to March 2018 the trust’s maternity FFT (postnatal community) performance (% recommended) was generally similar to the England average. In nine of the reported months 100% of patients recommended the trust for care during birth. Note that no data was published by NHS England for November 2017.

(Source: NHS England Friends and Family Test)

CQC Survey of women’s experiences of maternity services 2017

The trust performed better than other trusts for six out of 16 questions in the CQC maternity survey 2017

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>9.4</td>
<td>Best performing trusts</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>8.8</td>
<td>Best performing trusts</td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>9.7</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>8.8</td>
<td>About the same</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>9.3</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>8.6</td>
<td>Best performing trusts</td>
</tr>
<tr>
<td></td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>8.9</td>
<td>About the same</td>
</tr>
<tr>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>9.6</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>If you needed attention during labour and birth, did a member of staff help them within a reasonable amount of time?</td>
<td>9.3</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>9.1</td>
<td>Best performing trusts</td>
<td></td>
</tr>
<tr>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>9.6</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>9.3</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</td>
<td>8.0</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?</td>
<td>8.8</td>
<td>Best performing trusts</td>
<td></td>
</tr>
<tr>
<td>Thinking about your stay in hospital, how clean was the hospital room or ward you were in?</td>
<td>9.0</td>
<td>About the same</td>
<td></td>
</tr>
<tr>
<td>Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?</td>
<td>9.2</td>
<td>Best performing trusts</td>
<td></td>
</tr>
</tbody>
</table>

(Source: CQC Survey of Women’s Experiences of Maternity Services 2017)

We saw letters and cards of appreciation and positive comments about people’s experience displayed in the corridor. We noted there was no person identifiable information displayed.

We spoke with three women and three relatives and partners, all of whom spoke positively about their experience. Women told us they felt at ease, well cared for, and the midwives and support staff made them feel safe. Women told us staff were always available if they needed them and staff introduced themselves.

Partners were involved with the care and women had continuity of care in the community. Women told us they felt well supported by community midwives.

We observed staff reacted promptly to telephones and call bells in all areas we inspected.

Women could contact the unit or their community midwife if they had any concerns. We observed good interaction between midwives and women in all areas including those attending for antenatal assessment.

**Emotional support**

Staff valued and cared for families’ emotional needs in all departments we inspected.

The service provided an Afterthoughts service, a listening service for women or families experiencing difficulties following any birth. Staff discussed one issue where a woman had previously had a forceps delivery. The patient had not understood why this was necessary and they were very anxious that the same issues would occur in the current pregnancy. A staff
member had used a model to show and explain what would have occurred and why forceps would have been needed.

The delivery suite had a small quiet room set aside to use for bereaved families and had made plans for a bereavement suite, away from the main delivery suite, so women and their families experiencing pregnancy loss had privacy. The bereavement suite was being developed using donations of funds from bereaved families. The chaplaincy service could also provide support if requested.

Perinatal mental health risk assessments took place at the booking appointment, throughout pregnancy and during the post-natal period. Women with a suspected mental health illness were cared for in partnership with the perinatal mental health team for further assessment and treatment.

**Understanding and involvement of patients and those close to them**

Women we spoke with said they felt involved in decisions about their care and had been provided with all the relevant information to help them make an informed choice about where to have their baby.

From patient records we reviewed we saw evidence of discussions of the risks and benefits of different birthing locations and discussions about birthing preferences.

The service told us midwives completed birth plans to support women with complex and difficult birth choices.
Is the service responsive?

Service delivery to meet the needs of local people

Bed Occupancy

From July 2016 to December 2017 the bed occupancy levels for maternity were generally lower than the England average. During the reported period the trust’s bed occupancy for maternity ranged from 53.7% (Q4 2016/17) to 44.5% (Q3 2017/18)

The chart below shows the occupancy levels compared to the England average over the period.

(Source: NHS England)

Partners could visit delivery suite at any time. On the postnatal and antenatal ward partners and siblings could stay any time from 9am to 9pm. Other visitors were welcome on the ward from 3pm to 4pm and 7pm to 8pm.

Delivery suite facilitated, where possible, time for partners to spend on the ward with their partner and baby following the birth.

The service recorded babies born before arrival at the hospital and if the ambulance service were called to a woman in labour there was an agreement in place to bring her direct to hospital. The service took part in a regional arrangement for babies born before arrival. The regional ambulance service was working with Trusts to develop a standard response to these calls.

The community staff worked out of local GP surgeries and a community hospital which helped women to receive antenatal and postnatal care closer to home. Community midwife teams were organised around geographical areas to ensure women had a responsive local service.
Women had the option to deliver at home, at Penrith Birthing Centre with midwifery led care, at West Cumberland Infirmary and on the delivery suite at Cumberland Infirmary.

The trust website had a dedicated area about maternity services. In ward areas there was literature and leaflets supplied to women giving them information they might want to know about concerning their pregnancy.

Staff told us the day assessment unit was in the process of moving locations within the unit since the area currently used could sometimes be busy. The new area was planned to provide more space for women attending for triage.

Staff provided four sessions of antenatal classes on the unit.

Meeting people’s individual needs

The service treated women as individuals and strove to develop care plans that responded to their individual needs having taken into account any risk factors. Staff followed a process for supporting women who wished to birth outside of guidance.

Women we spoke with told us that they felt the service had listened to them and involved them in their care. Midwives told us they took time to listen to partners about their needs and wishes. Specialist midwives were responsible for planning the care of and supporting vulnerable women such as those with addictions that could harm the baby. They also provided a source of expertise for all staff to draw on. Careful assessment supported staff in shaping the care plan to respond to the needs of the woman and their baby. This included referral to the perinatal mental health team where necessary.

Staff explained how, for vulnerable women such as those with learning difficulties, they would often offer longer appointment times.

Community staff supported women with healthy living and could signpost women to aqua aerobics.

The labour, delivery and recovery rooms were spacious and supported wheelchair access and had mostly en-suite facilities. Two out of ten rooms shared a bathroom.

While we did not see any leaflets that were not in English staff told us that leaflets could be produced and supplied in a different language. Staff also described how they could access translation services.

Access and flow

The service had systems and processes in place to monitor access and flow through the service to ensure that it remained responsive to the needs of women in its care.

Women could self-refer into the service and community midwives conducted the booking appointments at GP surgeries or appropriate venues throughout the local area that was served. All booking appointments were offered according to national guidelines.
Community staff could access electronic discharge summaries. This supported community staff in ensuring they visited the mother and baby within 24 hours of discharge.

The service had not closed to women in labour in the last year (May 2017-June 2018). Women attended the ward for growth scans, amniotic fluid index (AFI) scans (to measure the amount of fluid was present around the baby before birth), and doppler scans (to measure the flow of blood to the baby through the umbilical cord) in clinics on Monday and Thursday mornings and afternoons. Staff could complete extra sessions on Fridays when required.

Women could attend the department with concerns or issues with their pregnancy. They could self-refer, or through their GP, or the emergency department. Midwives took calls and could give an approximate waiting time or a specific time to attend to minimise waiting in the department. One staff member on the ward worked within triage. Depending on capacity on the ward other midwives could support triage. Staff told us they tried to triage women within 30 minutes. However, they did not document triage waiting times.

We reviewed records for women who had attended triage between 22 June 2018 and 12 July 2018. A total of 133 women attended the unit and the greatest number of attendances in one day was 13.

Learning from complaints and concerns

Summary of complaints
From April 2017 to March 2018 there were seven complaints about maternity services. The trust took an average of 30 working days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be resolved within 30 working days. Six out of the seven complaints were resolved within the trust’s target timeframe. None of the seven complaints were re-opened.

There were four complaints about Cumberland Infirmary Hospital – three were regarding inpatient treatment or care, of which two were upheld and one was refuted. The remaining complaint was about the attitude of staff which was partially upheld.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

The service had a system in place to encourage complaints and compliments with a view to improving its service to women. Staff told us they would seek to resolve a concern quickly and informally and staff we spoke with were not aware of any formal complaints.

The service advertised by notices displayed within the unit how to raise concerns and signposted women or their carers or relatives to the trust’s afterthoughts service for support in making a complaint.

This service had seen 61 women across the trust. Staff felt that this reduced the number of complaints and supported women to understand why some decisions were made. Women completed a questionnaire following the meeting to review whether the meeting had been valuable and useful.
Any themes or trends about complaints were discussed at regular clinical and governance meetings as well as in other forums such as risk meetings. Staff told us one theme of concerns was women not receiving pain relief in a timely way following birth. Staff had trialled putting medicines in the locked cupboards next to the patient’s bed. The trial had worked well and this practice was implemented for all women.

Staff explained to us that they responded to complaints within the prescribed time limits but if, for any reason, they were unable to do so, they would keep the complainant informed about the revised timescales. The average time for closing complaints was 30 days.

**Is the service well-led?**

**Leadership**

The service sits within the trust’s Women and children’s care group. It had previously been part of the surgery care group. Staff we spoke with told us they now felt able to face challenges more positively. The service had a new leadership team led by an associate director of midwifery (ADM) who had been appointed in January 2018. There was a clinical midwifery manager in charge of maternity at Cumberland Infirmary and Penrith Birthing Centre.

The clinical director was appointed for the service in December 2017 with the support of a senior clinician from a separate trust to develop leadership skills and provide objective challenge and a lead consultant managed and led the medical team of consultants, middle grade doctors, including locums and junior doctors at West Cumberland Hospital.

The ADM reported to the associate operations manager for women and children’s services and directorate managers who together formed the leadership team at a local level. We met the local leadership team who were new to post. Some of the team had worked within the service for many years but had recently changed roles. We noted that collectively the team was able to draw on skills and experience of running a maternity service.

Members of the local leadership team met regularly with the director of nursing or the medical director and through them they had ready and open access to the board. No individual board member was designated as a lead for maternity but the ADM had direct and open access to the board. The team also networked with midwives in local trusts in order to benchmark its service against their services and share good practice and learning.

The team were approachable and available and this was confirmed by staff we spoke with who also said they felt supported and listened to. The team met regularly in different forums to discuss issues of quality, finance and governance.

The leadership team were supported by a team of matrons and specialist midwives including a governance manager. A local systems and transformation manager led work on developing the service, working with consultant leads and community staff in discussions and joint decisions to keep women and staff safe.
Staff we spoke with told us said they felt the new leadership had already made positive changes to working within the service. Staff felt supported and were offered opportunities to step up into a more senior role. Healthcare assistants (HCA’s) told us the new maternity ward manager at Cumberland Infirmary had supported them in gaining regrading for HCA’s who had previously been midwives.

Vision and strategy

Senior leaders we spoke with told us there was no documented strategy for the service but they were looking at the options for provision for the future to ensure maternity services in the local region meet the needs of local people. The senior leadership team confirmed its vision was to provide the right care at the right time and in the right place.

Staff we spoke with told us they felt involved in plans for the future of the service. Healthcare assistants we spoke with told us the maternity ward manager was new in post and had asked their opinions for unit improvements.

The proposal following internal and stakeholder consultation was that the service would be a continuity of caring model across the whole geographical area covered by the Trust. This would begin in the community and midwives would look after women across the whole pathway.

While the outcome of the planning of services to meet the needs of local people was not yet fully clear, staff did regularly review its local provision while preparing for any future changes.

Culture

All staff we spoke with told us they aimed to provide patient focussed care to women throughout their pregnancy journey.

Staff reported positive and negative aspects of culture within the department. Some staff felt supported within their own teams and were confident about raising concerns, although they did not always feel these would be addressed. Staff gave examples including:

Some staff we spoke with told us they felt well supported by midwives but not as supported by doctors. They had escalated their concerns to the lead midwife. Staff told us they felt some locum doctors were not very caring with women. Midwives triaged the women and then they were required to be seen by the doctors but women were sometimes left waiting. They felt the doctors took too much time and did not review patient notes. A midwife had challenged one of the doctors and had spoken with the consultants regarding the concerns.

Some staff we spoke with told us some lead midwives would send women to the ward from labour suite without consulting with the staff on the ward. Staff on the ward also triaged women attending with issues or concerns. Staff said this was raised with senior midwives but staff felt the behaviour had not changed. Other staff agreed and felt women moved around too quickly from the delivery suite.

Some staff told us they felt it was difficult to progress professionally within the department and explained that funding was lacking. However, other staff told us there were good progression pathways within the department.
We saw that staff were open and honest and we saw examples where duty of candour had been used.

HCA’s told us they received good support from doctors and midwives.

We did not come across any complaints or concerns about bullying or harassment.

Staff we spoke with told us the new ADM had provided some stability for the unit and kept staff informed. Staff received weekly emails and felt supported.

**Governance**

The service had a clear governance framework with staff assigned specific roles that ensured quality performance and risks were known about and managed.

Staff told us a weekly joint core risk group had been developed held where medical and midwifery staff met to discuss individual incidents and cases. These meetings were open to the whole team. Staff told us they took a summary from these meetings to management meetings.

Governance was the responsibility of the local leadership team which met regularly at clinical governance meetings to review a range of issues such as performance, risk, and quality measurement.

The service had a governance lead midwife whose role was to work full time on reviewing risks posed to the service, oversee root cause analyses into serious incidents, and distribute learning. A quality midwife role had been developed and they supported this programme by carrying out audits, monitoring the maternity dashboard and presenting results at learning meetings.

Staff confirmed that embedding of learning was ongoing regarding the never event in May 2018.

**Management of risk, issues and performance**

The service’s risk register supported the local leadership team in tracking risks and ensuring that staff were taking actions to reduce or extinguish the risk. We reviewed the service’s risk register and saw that each risk was given a unique identifier, a risk rate, a status, brief details, the review date, and the person who owned the risk. Each risk had an action plan and staff identified were responsible to manage the plan to completion.

The local leadership team had identified a range of policies that required updating. Tasks were allocated to consultants and lead midwives to review clinical guidelines and keep them up to date. However senior staff told us some staff had not met timeframes, some guidelines and policies had been updated and not yet ratified. There was a log of this information but did not seem to be any robust management of staff time or actions regarding the plan.
Information management

A new post had been developed and a midwife employed to ensure all staff at all levels were able to access and input information in a digital format which could be manipulated rapidly and used to provide effective patient care and help improve the service. They worked full time within the Trust’s IT department and provide advice, guidance and training to staff across all sites.

Engagement

Staff sought feedback and opinions of those who used the service. Friends and family cards which were distributed around the unit. Staff told us some family members had commented there were no public toilets to use on the unit and birth partners were having to leave the unit to find a toilet. Staff listened to this feedback and reported one toilet was changed into a visitors’ toilet.

Staff requested feedback from women attending antenatal classes and discussed examples of changes made in response to feedback received.

Staff described feeling engaged by the service with the new leadership for the service and explained how the service engaged with the public to ensure their views helped to shape the service. Consultations were taking place for women and staff about restructure and plans for the future of the service.

The staff meeting schedule had slipped and no meeting had taken place for several months at the beginning of the year but staff reported there had been a meeting in June 2018 and a new meetings programme was scheduled. Staff were given specific roles such as leading on planning and execution of clinical reviews or audits. Staff took part in audit production and presentation. In addition to a newsletter staff described how the service used email to share lessons or pass on important messages. Team leaders had regular meetings and passed on information to staff at handovers. All staff had regular appraisals.

Staff told us they took part in fundraising initiatives and had raised funds towards a new bereavement suite.

Learning, continuous improvement and innovation

The lead consultant at West Cumberland Hospital had taken on the role to provide education for all staff across the service at all sites. They organised learning sessions every Friday afternoon which all staff could attend. They used a video link to ensure staff at both main sites could benefit from these sessions.

The service was working with a better births model to gain a more sustainable model of care to meet the needs of the population, the geographical difficulties and to ensure women were safe throughout their pregnancy.

New leaders had been appointed for medical and midwifery leadership and management. There had been significant changes in roles and the teams were adjusting and recognised early benefits to teamwork and provision of patient care. Staff supported and respected their new leaders. However, staff had been in post for a matter of months before our inspection and they recognised there was still work to be done to implement and sustain positive changes.
Services for children and young people

Facts and data about this service

Cumberland Infirmary and West Cumberland Hospital provide care for children and young people aged 0-16 years, extended to 19 years for patients who have special or more complex needs as well as those with life limiting disease. The units provide an on call 24-hour service for emergency admissions via the accident and emergency department and general practitioners catering for paediatric medicine, surgical, orthopaedic, trauma, dental, ENT, ophthalmology, gynaecology and child protection issues. The wards also accommodate day case surgery, medical admissions for further investigations and procedures and diagnostic procedures. Both wards are consultant led with a consultant on call system in place 24/7. The service provides an outpatient facility across North Cumbria with clinics in community and hospital sites.

The trust has 47 inpatient paediatric beds across two sites:

Cumberland Infirmary:
- 16 paediatric inpatient and eight assessment beds located within one ward.
- Eight neonatal beds located within one ward

West Cumberland Hospital:
- Seven paediatric inpatient and seven assessment beds located within one ward
- Nine neonatal beds located within one ward.

(Source: Routine Trust Provider Information Request (RPIR Acute) – Context tab)

The trust had 6,393 spells from February 2017 to January 2018.

Emergency spells accounted for 90% (5,759 spells), 7% (471 spells) were day case spells, and the remaining 3% (163 spells) were elective.

Percentage of spells in children’s services by type of appointment and site, from February 2017 to January 2018, North Cumbria University Hospitals NHS Trust.
Total number of children’s spells by Site, North Cumbria University Hospitals NHS Trust.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>4,272</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>2,121</td>
</tr>
<tr>
<td>This trust</td>
<td>6,393</td>
</tr>
<tr>
<td>England total</td>
<td>1,101,678</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The trust set a target of 95% for completion of mandatory training.

Trust level

A breakdown of compliance for mandatory training courses as at March 2018 at trust level for qualified nursing staff in children’s services is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>BLS (paediatrics)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Hand hygiene (non clinical)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Infection control level 1</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Moving &amp; handling level 1 non clinical (3 yearly)</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Information governance</td>
<td>58</td>
<td>57</td>
<td>98%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>58</td>
<td>57</td>
<td>98%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Slips, trips and falls level 1</td>
<td>58</td>
<td>57</td>
<td>98%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Health and safety</td>
<td>58</td>
<td>56</td>
<td>97%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Risk management</td>
<td>58</td>
<td>56</td>
<td>97%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Duty of candour</td>
<td>58</td>
<td>55</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Calculating drug doses</td>
<td>49</td>
<td>46</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>58</td>
<td>54</td>
<td>93%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Hand hygiene (clinical)</td>
<td>57</td>
<td>53</td>
<td>93%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Fire safety</td>
<td>58</td>
<td>53</td>
<td>91%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Medicine management</td>
<td>54</td>
<td>49</td>
<td>91%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>
In children’s services the 95% target was met for ten of the 31 mandatory training modules for which qualified nursing staff were eligible. Four modules had completion rates of 100%, this however relates to only one member of staff for three modules and two staff members for the remaining module required to complete this training. Apart from the ten modules that met the 95% trust target a further five modules had completion rates above 90%.

A breakdown of compliance for mandatory training courses as at March 2018 at trust level for medical staff in children’s services is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information governance</td>
<td>13</td>
<td>11</td>
<td>85%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; handling level 1 clinical (3 yearly)</td>
<td>13</td>
<td>11</td>
<td>85%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Duty of candour</td>
<td>13</td>
<td>10</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>13</td>
<td>10</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>13</td>
<td>10</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety</td>
<td>13</td>
<td>10</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk management</td>
<td>13</td>
<td>10</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, trips and falls level 1</td>
<td>13</td>
<td>10</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health records management</td>
<td>13</td>
<td>9</td>
<td>69%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control level 2</td>
<td>13</td>
<td>9</td>
<td>69%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent level 1&amp;2</td>
<td>13</td>
<td>9</td>
<td>69%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Hand hygiene (clinical)</td>
<td>13</td>
<td>8</td>
<td>62%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>13</td>
<td>8</td>
<td>62%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Trust doctors patient safety programme</td>
<td>13</td>
<td>6</td>
<td>46%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>ALS (paediatrics)</td>
<td>9</td>
<td>4</td>
<td>44%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 02</td>
<td>13</td>
<td>4</td>
<td>31%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
In children’s services the 95% target was met for none of the 19 mandatory training modules for which medical staff were eligible. Information governance and moving & handling level 1 clinical (3 yearly) both had completion rates of 85%, although this relates to only two staff members not completing the training.

Cumberland Infirmary children’s services department

A breakdown of compliance for mandatory training courses as at March 2018 for qualified nursing staff in the children’s services department at Cumberland Infirmary is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slips, trips and falls level 2</td>
<td>1</td>
<td>3</td>
<td>300%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>BLS (paediatrics)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Hand hygiene (non clinical)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>41</td>
<td>41</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control level 1</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>41</td>
<td>41</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving &amp; handling level 1 non clinical (3 yearly)</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>News</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Duty of candour</td>
<td>41</td>
<td>40</td>
<td>98%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>41</td>
<td>40</td>
<td>98%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk management</td>
<td>41</td>
<td>40</td>
<td>98%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, trips and falls level 1</td>
<td>41</td>
<td>40</td>
<td>98%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>41</td>
<td>39</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety</td>
<td>41</td>
<td>39</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines management</td>
<td>37</td>
<td>35</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Calculating drug doses</td>
<td>35</td>
<td>33</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent level 1&amp;2</td>
<td>41</td>
<td>37</td>
<td>90%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Hand hygiene (clinical)</td>
<td>40</td>
<td>36</td>
<td>90%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control level 2</td>
<td>40</td>
<td>36</td>
<td>90%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health records management</td>
<td>41</td>
<td>33</td>
<td>80%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>ILS (paediatrics)</td>
<td>19</td>
<td>15</td>
<td>79%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Understanding end of life</td>
<td>41</td>
<td>32</td>
<td>78%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; handling level 2</td>
<td>39</td>
<td>30</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevention of suicide</td>
<td>21</td>
<td>16</td>
<td>76%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 02</td>
<td>35</td>
<td>25</td>
<td>71%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>37</td>
<td>24</td>
<td>65%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>BLS (adults)</td>
<td>17</td>
<td>11</td>
<td>65%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk management (board and senior management)</td>
<td>9</td>
<td>5</td>
<td>56%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
At Cumberland Infirmary children’s services department the 95% target was met for 15 of the 30 mandatory training modules for which qualified nursing staff were eligible. Apart from the 15 modules for which the 95% trust target were met a further four modules had completion rates of 90% or above.

Slips, trips and falls level 2 had a 300% completion rate, the data provided showed that although only one staff member was required to complete this training, two additional staff in the special care baby unit were also recorded as having completed it.

Seven modules had a 100% completion rate, although for five modules only one to two staff members were required to complete this training.

A breakdown of compliance for mandatory training courses as at March 2018 for medical staff in the children’s services department at Cumberland Infirmary is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duty of candour</td>
<td>8</td>
<td>6</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>8</td>
<td>6</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>8</td>
<td>6</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety</td>
<td>8</td>
<td>6</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health records management</td>
<td>8</td>
<td>6</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>8</td>
<td>6</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; handling level 1 clinical (3 yearly)</td>
<td>8</td>
<td>6</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk management</td>
<td>8</td>
<td>6</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, trips and falls level 1</td>
<td>8</td>
<td>6</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Hand hygiene (clinical)</td>
<td>8</td>
<td>5</td>
<td>63%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control level 2</td>
<td>8</td>
<td>5</td>
<td>63%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent level 1&amp;2</td>
<td>8</td>
<td>5</td>
<td>63%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>ALS (paediatrics)</td>
<td>6</td>
<td>3</td>
<td>50%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>8</td>
<td>3</td>
<td>38%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Trust doctors patient safety programme</td>
<td>8</td>
<td>3</td>
<td>38%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>8</td>
<td>2</td>
<td>25%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevention of suicide</td>
<td>8</td>
<td>2</td>
<td>25%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 02</td>
<td>8</td>
<td>1</td>
<td>13%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 04</td>
<td>8</td>
<td>1</td>
<td>13%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Cumberland Infirmary children’s services department, the 95% target was met for none of the 19 mandatory training modules for which medical staff were eligible. Nine modules had completion rates of 75%, although this relates to only two staff members not completing the training.

(Source: Routine Provider Information Request (RPIR) –P40)
The ward manager maintained a regular oversight of mandatory training for medical and nursing staff. At the beginning of each financial year, the mandatory training completion date returned to zero. At the time of the inspection visit, the service had already achieved 89% overall across both nursing and medical staff groups.

**Safeguarding**

The trust had a safeguarding children policy and had the necessary statutory staff in post, including the named nurse and named doctor. Staff we spoke with could explain what actions they would take if they had concerns about a child or young person.

Staff completed an information sharing form which alerted the safeguarding team and anyone reading it to the background of the child and any recommended treatments/actions going forward. The safeguarding team ensured they followed up the outcomes daily. The form was kept in the patient’s notes and uploaded into the electronic patient notes. We looked at one form for a child with learning disabilities. The form was completed fully with the reason for notification and contained all the required information such as consent, parental responsibility and history of attendances in the paediatric emergency department (ED).

The Trust used the Child Protection - Information sharing project (CP-IS) to share information securely to better protect society's most vulnerable children. Staff also used the hospitals internal patient record system to check for any internal alerts.

If there were alerts, the triage staff in the paediatric ED used the online CP-IS system to check the specific data relating to children (including unborn children) with a Child Protection Plan, or with Looked After Status. This was presented as a “flag” indicating the patient was a vulnerable child.

The CP-IS system was used trust wide and full access was only given to senior practitioners. Every time an alert was raised by the CP-IS the safeguarding team received an automatic email to make them aware. This mechanism ensured a consistent and safe approach to identifying vulnerable children.

The Children’s wards perform the check upon all admissions, including those from the paediatric ED, to ensure they have the current alerts.

There was a safeguarding team and structure in place across both sites with the main hub at Cumberland Infirmary. The team had dedicated roles in the safeguarding team such as a lead for children with learning disabilities, an independent domestic violence advisor (IDVA), a midwifery named nurse and dedicated administration support.

There was a safeguarding link nurse in all the children’s wards and recently an initiative had been put in place to have link nurses in the high-risk areas, such as the paediatric ED and maternity to look out for signs of domestic violence.

The safeguarding children leads were visible across both sites and within the wards and departments we inspected. Staff spoke highly of the availability and support they received from the safeguarding team and knew how to raise concerns using the correct forms.
The team stayed in contact via a bi-monthly teleconference across both sites, attending specific internal meetings such as the maternity safeguarding meetings and external meetings such as The Multi-Agency Risk Assessment Conference (MARAC), a coordinated community response to domestic abuse. Information from these meetings was shared across the safeguarding children team.

Consultants told us they usually undertook at least one child safeguarding medical examination a week. The findings were shared with the named doctor safeguarding children. In line with intercollegiate guidance (Third edition: March 2014), the named doctor chaired peer review meetings, which were held every six to eight weeks. One consultant spoke positively about the quality of peer review and told us the meetings included constructive challenge and debate.

The trust had a safeguarding children supervision guideline however this was out of date and had not been updated since 2014. Staff told us they had protected time for supervision, which supported practitioner’s reflection and learning in a supportive structured environment. Safeguarding formed part of the supervision and one-to-one discussions as well as being on the agenda at ward meetings.

The trust set a target of 95% for completion of safeguarding training.

**Trust level safeguarding training**

A breakdown of compliance for safeguarding training courses as at March 2018 at trust level for **qualified nursing staff** in children’s services is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 1</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 3 (specialist)</td>
<td>42</td>
<td>40</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>58</td>
<td>50</td>
<td>86%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>14</td>
<td>11</td>
<td>79%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In children’s services the 95% target was met for two of the four safeguarding training modules for which qualified nursing staff were eligible. Safeguarding children level 1 had a 100% completion rate, although this relates to only two staff members eligible to complete this training.

A breakdown of compliance for safeguarding training courses at March 2018 at trust level for **medical staff** in children’s services is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 3 (core)</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>13</td>
<td>10</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 3 (specialist)</td>
<td>11</td>
<td>8</td>
<td>73%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
In children’s services the 95% target was met for one of the three safeguarding training modules for which medical staff were eligible. Safeguarding children level 3 had a 100% completion rate, although this relates to only two staff members required to complete this training. The remaining two modules had completion rates below 80%, although this relates to only three staff members for each module not completing this training.

Cumberland Infirmary children’s services department safeguarding training

A breakdown of compliance for safeguarding training courses at March 2018 for qualified nursing staff in the children’s services department at Cumberland Infirmary is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 1</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 3 (specialist)</td>
<td>38</td>
<td>36</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>41</td>
<td>36</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Cumberland Infirmary children’s services department, the 95% target was met for two of the four safeguarding training modules for which qualified nursing staff were eligible. While safeguarding children level 1 & 2 had 100% completion rates, this relates to only two and one staff member respectively required to complete this training.

A breakdown of compliance for safeguarding training courses at March 2018 for medical staff in the children’s services department at Cumberland Infirmary is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 3 (core)</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>8</td>
<td>6</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 3 (specialist)</td>
<td>6</td>
<td>4</td>
<td>67%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

At Cumberland Infirmary children’s services department, the 95% target was met for one of the three safeguarding training modules for which medical staff were eligible. Although safeguarding adults’ level 1 and safeguarding children level 2 did not reach the trust target it relates to only two staff members per module not completing the training.

(Source: Routine Provider Information Request (RPIR) – P40)

We reviewed the latest figures presented by the trust which showed they were on track to meet the 95% target in most cases. The overall compliance rates were:
- Safeguarding children 1 was 92%
- Safeguarding children 2 was 87%
- Safeguarding children 3 (core) was 76%
- Safeguarding children (specialist) was 91%

The ward manager in the children’s ward told us recent changes had meant that the Level 3 training had moved from a one-day face-to-face interactive training session to a four-hour online course. This does not meet the guidance outlined in the ‘Safeguarding children and young people: roles and competences for health care staff intercollegiate document’. This states Level 3 training must be completed by ‘all clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns’.

The intercollegiate document also states ‘training, education and learning opportunities should be multi-disciplinary and inter-agency, and delivered internally and externally. It should include personal reflection and scenario-based discussion, drawing on case studies, serious case reviews, lessons from research and audit, as well as communicating with children about what is happening’.

We would expect that the method and expectations of training was properly designed, delivered and evaluated, and whilst there is room for some element of on-line training this is not a substitute for face to face training especially discussion of case studies and personal cases.

The ward manager was not aware of any other internal training but informed us there was external face to face training available via the Cumbria Local Safeguarding Children’s Board. The current safeguarding children policy (version 8) outlined the training levels required for each post, but did not outline how Level Three would be achieved.

There was confusion and discrepancy of how staff understood they would meet the Level 3 intercollegiate safeguarding guidance and many staff thought it was just via online training. There was no assurance that the trust had considered how they would ensure meeting the intercollegiate guidance going forwards.

We spoke with junior doctors who had only completed the online training for Level 3 and had deemed this to be sufficient for the Level 3 sign off.

The named nurse explained that they had moved to electronic learning for Level 3 at the end of December 2017. The safeguarding team told us they could provide bespoke safeguarding training to all the departments that may request this and they had some days planned in the future where they would hold training stalls for staff to attend and further their Level 3 training. However, this was in its infancy and staff on the wards were not aware of this service.

**Cleanliness, infection control and hygiene**

The children’s ward and special care baby unit were visibly clean.

There were handwashing facilities at the entrance of each clinical area and we observed staff and visitors using them appropriately upon entering and leaving the ward. Antibacterial hand gel dispensers were also available at various locations within each ward.
We saw personal protective equipment was readily available for staff to use and we observed staff using it appropriately. We also observed staff adhering to ‘bare below the elbow’ guidance, in line with national good hygiene practice.

Domestic and nursing staff followed cleaning schedules and updated cleaning logs. Tasks included the cleaning of examination equipment following use at the end of each clinic, such as blood pressure cuffs and specula for scopes.

At the last CQC inspection, we had concerns about the cleaning schedule for the children’s outpatient department because when we reviewed the documentation, we saw large gaps between the recorded dates. At this inspection, we noted the cleaning rota was completed appropriately and the unit was very clean and tidy.

Infection prevention and control (IPC) was part of the trust’s mandatory training programme and the compliance target was 95%. At March 2018, qualified nursing staff had achieved 90% and medical staff had achieved 63%.

The unit recorded no cases of clostridium difficile (C. diff), methicillin resistant staphylococcus aureus (MRSA) and methicillin sensitive staphylococcus aureus (MSSA) in the previous 12 months prior to the inspection.

Staff regularly took part in IPC audits. Hand hygiene audits showed staff from the children’s ward and SCBU consistently achieved 100%.

On the children’s ward, the play specialist was responsible for cleaning toys. They told us there was a toy cleaning protocol and they cleaned toys daily in line with the documented procedure.

We saw evidence of appropriate waste segregation and clinical waste disposal units. Staff were aware of the importance of and risks involved in handling of sharps.

In the CQC Children and Young People’s Survey 2016 the trust scored 8.70 out of ten for the question ‘How clean do you think the hospital room or ward was that your child was in?’ This was about the same as other trusts.

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Environment and equipment

Access to the children’s ward and to the special care baby unit was restricted. Staff monitored visitors entering and leaving the respective unit and granted access and egress via a secure entry system.

The environment across all areas where children and young people accessed care and treatment was very child and young person-friendly. The children’s ward included a large playroom (which included sensory play equipment) for younger children and separate facilities for older children and young people.

The children’s outpatient department was a self-contained unit adjacent to the children’s ward. All seven consulting rooms were child friendly, toys were readily available (for all age groups), and
equipment was suitable for children of different ages, such as various sizes in blood pressure cuffs.

The trust’s medical electronics department was responsible for the maintenance of all devices and equipment. Equipment we checked had been safety tested. Staff we spoke with told us they knew who to contact if they needed to report any faults and felt confident the system was robust.

Resuscitation trolleys held appropriate equipment, which was suitable for the needs of children. Staff completed a daily log to confirm the daily resuscitation equipment check was completed. Staff had received training to use the equipment and their competency recorded.

The children’s ward was equipped with high flow oxygen machines, which reduced the number of transfers of babies suffering from bronchiolitis, a common illness of the respiratory tract, to the regional tertiary care centre for additional care and treatment.

Assessing and responding to patient risk

The children’s ward used the paediatric early warning scores (PEWS), an early warning assessment and clinical observation tool. This included a clinical observation chart, coma scale and additional information such as the pain score tools with an assessment table to assist clinical staff in determining what action nursing and medical staff should take for an ill child. We spoke with medical staff and nurses who demonstrated a clear awareness of how to assess patient risk and what action they would take in response. PEWS charts were audited every month and staff from the children’s ward achieved consistently high results, except for blood pressure checks. Both managers and staff told us they were taking appropriate steps to improve this.

The neonatal unit did not use a new-born early warning trigger and track (NEWTT) tool. However, nursing staff told us they were working with colleagues from the maternity unit to develop a new process. Through our observations and conversations with nurses, babies on the unit were closely monitored at all times.

Daily handovers took place and included discussions about patient safety as well as detailed information sharing about each child. Based on the SBAR principles (situation; background; assessment and recommendation), the meeting highlighted any risks and enabled medical and nursing staff to reinforce plans to monitor deteriorating patients, for example, increasing observations or 1:1 nursing care.

Clinicians transferred children who required paediatric intensive care to the regional tertiary care centre. In the event of a child deteriorating and, for example, requiring intubation, staff from the intensive care unit would stabilise the patient with support from a paediatrician (with or without paediatric nurse) until medical staff had secured appropriate retrieval or transfer arrangements to the tertiary hospital.

The trust had a transfer of patient policy with a designated section for the care and management of paediatric and neonatal patients. SCBU was part of the Northern Neonatal Network, which provided specific transfer guidelines for the movement of babies who required high dependency or intensive care. This included arrangements for baby retrieval, preparation for transfer, and transport requirements.
The trust had a policy for the management of sepsis and paediatric sepsis six pathway for children under the age of five and between the ages of five and 11. Staff we spoke with were clear about what actions they would take. The service used a screening tool, which was audited by the specialist sepsis nurse.

Managers confirmed there was a member of staff trained in paediatric life support on every shift on the children’s ward and SCBU.

Nursing and medical staff continued to express concerns about the care and management of children requiring assessment by an approved mental health practitioner (AMHP) from the child and adolescent mental health service (CAMHS). This was highlighted at the last CQC inspection. Staff identified these children to be an additional risk factor on the ward where they required additional support from nursing staff. Staff reported delays in securing CAMHS assessment (provided by another trust) and escalated this concern to unit managers.

Staff completed risk assessments on admission for children and young people with mental health issues and had taken steps to mitigate the environmental risks on the ward. Staff worked collaboratively with the CAMHS team to ensure all potential hazards were removed such as shower curtains, pull cord and suction equipment before the room was made safe for accommodation. Locks were appropriately installed on relevant rooms, including the exit from the ward. Patients and visitors were required to seek assistance from a member of staff upon leaving the ward. The ward had appropriate contingencies in place in the event of a power failure.

In the CQC Children and Young People’s Survey 2016 the trust scored 7.73 out of ten for the question ‘Were the different members of staff caring for and treating your child aware of their medical history?’ This was about the same as other trusts.

In the CQC Children and Young People’s Survey 2016 the trust scored 9.76 out of ten for the question ‘Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?’ This was about the same as other trusts.

### CQC Children and Young People’s Survey 2016 questions, safe domain, North Cumbria University Hospitals NHS Trust

<table>
<thead>
<tr>
<th>Question number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>How clean do you think the hospital room or ward was that your child was in?</td>
<td>0-15 adults</td>
<td>8.70</td>
<td>About the same as other trusts</td>
<td>S1</td>
</tr>
<tr>
<td>20</td>
<td>Were the different members of staff caring for and treating your child aware of their medical history?</td>
<td>0-15 adults</td>
<td>7.73</td>
<td>About the same as other trusts</td>
<td>S3</td>
</tr>
<tr>
<td>36</td>
<td>Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?</td>
<td>0-15 adults</td>
<td>9.76</td>
<td>About the same as other trusts</td>
<td>S4</td>
</tr>
</tbody>
</table>
Nurse staffing

The trust reported the following qualified nursing staff numbers as at March 2018 and April 2018 for children’s services by site:

<table>
<thead>
<tr>
<th>Location</th>
<th>Mar-18</th>
<th>Apr-18</th>
<th>Fill rate</th>
<th>Mar-18</th>
<th>Apr-18</th>
<th>Fill rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Planned</td>
<td>Fill rate</td>
<td>Actual</td>
<td>Planned</td>
<td>Fill rate</td>
</tr>
<tr>
<td>Cumberland Infirmary</td>
<td>34.2</td>
<td>33.9</td>
<td>100.9%</td>
<td>33.9</td>
<td>34.4</td>
<td>98.5%</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>29.1</td>
<td>31.0</td>
<td>93.9%</td>
<td>31.0</td>
<td>29.1</td>
<td>106.5%</td>
</tr>
<tr>
<td>Total</td>
<td>63.3</td>
<td>64.9</td>
<td>97.5%</td>
<td>63.5</td>
<td>64.9</td>
<td>102.2%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16)

The service used the Safer Nursing Care Tool (endorsed by National Institute for Health and Care Excellence) to assess safe staffing levels for the children. There was an escalation process in place should a shortfall occur. Ward managers advised they obtained support from the wider unit, asked existing staff to extend or work additional shifts, and requested staff from the nurse bank.

The service used the trust e-rostering system.

The children’s ward manager confirmed the ward was fully staffed and any gaps in the rota were covered by bank nurses. There was a senior nurse on every shift. We reviewed the children’s ward off-duty rota for the previous six weeks and noted there were no gaps.

We reviewed the current escalation plan which outlined actions to take when the demand for paediatric beds exceeded the capacity. According to the plan, the ideal staffing establishment for the children’s ward was:

- Early shift: four qualified nurses and one healthcare assistant
- Late shift: four qualified nurses and one healthcare assistant
- Night duty: two qualified nurses and one healthcare assistant (with 16 beds overnight)

Information displayed on the Quality of Care board in the ward showed the actual levels met the planned establishment.

The ward manager had supernumerary time to fulfil management duties and responsibilities (one to two days per week). They also supported the main nursing rota and provided cover on shifts when required.
The escalation plan also included SCBU and highlighted the same actions to take when the demand for special care baby cots exceeded the capacity. According to the plan, the ideal staffing establishment for the SCBU was:

- Early shift: two qualified nurses and one healthcare assistant
- Late shift: two qualified nurses and one healthcare assistant
- Night duty: two qualified nurses and one healthcare assistant

Information displayed on the Quality of Care board in the unit showed the actual levels met the planned establishment.

Information provided by the trust showed the bed occupancy rate on the children’s ward (July 2017 to June 2018) was 52%.

The British Association of Perinatal Medicine (BAPM) recommends a staffing ratio of one neonatal nurse to four babies (1:4) in units providing level one special care. The unit met the standards.

The unit had 17 qualified nurses, of which 13 were qualified in specialty (QIS). The unit had plans to train the remaining four nurses over the next 12 months.

The two ward managers were currently on long-term sickness absence and staffing the unit had been challenging over recent months. There were five band 7 nurses, each of whom had been fulfilling the ward manager responsibilities, with oversight from the matron. Although the unit was primarily nurse-led, consultants were also providing support to ensure the unit was safe at all times. Senior nurses told us consultants would continue to lead the unit until all band 7 nurses had completed advanced neonatal nurse practitioner (ANNP) training. One out of the five nurses had completed this training. Senior nurses were unable to define a specific timeframe for the ANNP training and told us they were reliant upon the availability of the relevant courses.

We reviewed the off-duty rotas in SCBU for the previous three months and noted there was a QIS on every shift with only one exception. The matron and consultants provided additional cover when there was no QIS nurse on duty and this was reflected in the rota.

Information provided by the trust showed the bed occupancy rate in SCBU (July 2017 to June 2018) was 61.8%.

The unit recorded neonatal nurse staffing levels twice daily on BadgerNet (a single record of care for all babies within neonatal services, and used widely across the country). The data was replicated onto the trust’s acuity tool which enabled managers to view actual staffing levels and patient numbers.

From April 2017 to March 2018, the trust reported a vacancy rate of 1.6% in children’s services at Cumberland Infirmary. This was lower than the trust target of 5.0%.

A breakdown by site is shown below:
<table>
<thead>
<tr>
<th>Site name</th>
<th>Total vacancies (WTE)</th>
<th>Total number of staff establishment (WTE)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>6.4</td>
<td>409.8</td>
<td>1.6%</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>15.9</td>
<td>370.9</td>
<td>4.3%</td>
</tr>
<tr>
<td>Total</td>
<td>22.3</td>
<td>780.7</td>
<td>2.9%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Vacancy tab)

The trust did not provide any turnover rate data for Cumberland Infirmary.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Between May 2017 and May 2018, the trust reported a sickness rate of 2.2% in children’s services at Cumberland Infirmary. This was lower than the trust target of 4.0%.

A breakdown by site can be seen below:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total absence days</th>
<th>Total WTE days available</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>273.2</td>
<td>12,431.6</td>
<td>2.2%</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>414.4</td>
<td>10,698.9</td>
<td>3.9%</td>
</tr>
<tr>
<td>Total</td>
<td>687.6</td>
<td>23,130.5</td>
<td>3.0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

From April 2017 to March 2018, the trust reported a bank and agency usage rate of 90.4% in children’s services at Cumberland Infirmary. The wards used regular bank staff and no agency. Any external bank staff were required to undertake two induction shifts and a senior nurse completed a competency checklist as part of the assurance process.

A breakdown per site is shown below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Bank shifts</th>
<th>Total shifts</th>
<th>Bank shifts as a proportion of total shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>113</td>
<td>125</td>
<td>90.4%</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>31</td>
<td>35</td>
<td>88.6%</td>
</tr>
<tr>
<td>Total</td>
<td>144</td>
<td>160</td>
<td>90.0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Medical staffing

The trust reported the following qualified medical staff numbers as at March 2018 and April 2018 for children’s services by site:

<table>
<thead>
<tr>
<th>Location</th>
<th>Mar-18</th>
<th>Apr-18</th>
</tr>
</thead>
</table>

20171116 900885 Post-inspection Evidence appendix template v3 Page 227
Cumberland Infirmary had a 90.9% fill rate indicating that the site had only one less medical staff member in post than what was planned for.

(Source: Routine Provider Information Request (RPIR) –P16)

The medical team at Cumberland Infirmary was comprised of seven whole time equivalent (WTE) consultants, and three long-term locum consultants. This demonstrated an improvement from the previous CQC inspection in 2016 when there were 7 WTE consultants on post. The paediatric nurse practitioner supported the junior medical rota. There was no middle-grade tier.

Although the special care baby unit was fundamentally nurse-led, consultants provided support. Medical and nursing staff spoke positively about the current arrangement.

There was resident consultant cover 24 hours a day, seven days a week. Nursing staff and junior doctors did not report any problems when accessing a consultant out of hours.

The medical team operated a ‘consultant of the week’ (COW) rota and each consultant provided cover one week in every five. Clinicians did not have any clinics during their COW week.

At the last CQC inspection, we found the service did not meet all the Royal College of Paediatric and Child Health (RCPCH) – Facing the Future: Standards for Acute General Paediatric Services.

Since our previous visit, the service had received external advice and support from a RCPCH consultant in relation to the development of a new medical staffing model. The service had undertaken an audit against of the standards and audit outcomes demonstrated an improvement:

- Standard 2: 70% of children and young people who was admitted with an acute medical problem was seen by a health professional with the appropriate competencies within four hours of admission. Analysis provided by the RCPCH showed this was worse than the national average of 79%.

- Standard 3: every child or young person admitted to the paediatric department with an acute medical problem were seen by a consultant paediatrician within 14 hours of admission. Analysis provided by the RCPCH showed this was better than the national average of 48%.

- Standard 5: every child with an acute medical problem who was referred for a paediatric opinion was seen by, or had their case discussed with, a clinician with the necessary skills and competencies before they were discharged. Analysis provided by the RCPCH showed this was better than the national average of 94%.
At least two consultant-led medical handovers took place every 24 hours on weekdays and once at a weekend (although verbal handovers took place as and when required). A multi-disciplinary grand round took place every week.

The service defined peak hours of activity as 5.00pm to 10.00pm weekdays, and 11.00pm to 9.00pm at weekends. During weekdays, there was consultant presence on site for the full 24 hours. This meant the unit met the required RCPCH standard of consultant presence during peak times of activity, and this demonstrated an improvement since the previous CQC inspection.

The service planned to establish a steering group to review all audit outcomes and develop an action plan.

Consultants we spoke with told us their current job plans provided 10-11 programmed activities (PA) They no longer worked in excess of this, which was a concern identified at the previous inspection. A senior clinician explained the service had introduced an electronic job planning tool and told us the number of PAs for each consultant was around 12 (but pro-rated for part time staff). However, the built-in flexibility meant consultants had sufficient rest time in between shifts and periods of consecutive days off within the rota.

From April 2017 to March 2018, the trust reported a vacancy rate of 4.0% in children’s services at Cumberland Infirmary. This was lower than the trust target of 20%.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total vacancies (WTE)</th>
<th>Total number of staff establishment (WTE)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>6.2</td>
<td>154.4</td>
<td>4.0%</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>45.1</td>
<td>163.2</td>
<td>27.6%</td>
</tr>
<tr>
<td>Total</td>
<td>51.3</td>
<td>317.6</td>
<td>16.2%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

From May 2017 to April 2018, the trust reported a turnover rate of 15.2% in children’s services at Cumberland Infirmary. This was higher than the trust target of 13%.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total leavers (WTE)</th>
<th>Average number of staff establishment (WTE)</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>1.0</td>
<td>6.6</td>
<td>15.2%</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>3.3</td>
<td>8.4</td>
<td>39.3%</td>
</tr>
<tr>
<td>Total</td>
<td>4.3</td>
<td>15.0</td>
<td>28.7%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From May 2017 to May 2018, the trust reported a sickness rate of 3.0% in children’s services at Cumberland Infirmary. This was lower than the trust target of 4%.

A breakdown by site is shown below:
<table>
<thead>
<tr>
<th>Site name</th>
<th>Total absence days</th>
<th>Total WTE days available</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>71.0</td>
<td>2,385.0</td>
<td>3.0%</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>48.0</td>
<td>2,978.2</td>
<td>1.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>119.0</strong></td>
<td><strong>5,363.0</strong></td>
<td><strong>2.2%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Sickness)

The trust was unable to provide bank and locum usage data broken down by site or core service, due to system restrictions under the previous recording method.

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

In January 2018, the proportion of consultant staff reported to be working at the trust was slightly lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.

Staffing skill mix for the 18 whole time equivalent staff working in children’s services at North Cumbria University Hospitals NHS Trust:

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen speciality
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

**Records**

We reviewed six sets of care records. Overall, we saw notes were legible and staff completed them accurately and included appropriate information such as a documented diagnosis and management plan, input from the multi-disciplinary team and discussions with the family. Every child who was admitted with an acute medical problem was seen by a consultant paediatrician within 14 hours of admission and all notes were signed and dated appropriately.
The children’s ward and SCBU completed case note reviews as part of the NHS Litigation Authority (NHSLA) audit. Managers audited 10 case notes against 31 key indicators ranging from demographics to examination findings and treatment plans. The summary from an audit (February 2018) in the children’s ward showed an overall compliance of 90%. Areas for improvement highlighted the need to include immunisation and medication history, plus details relating to doctor’s grade and bleep.

We were unable to review a care record audit for SCBU. The trust advised they were in the process of developing a new health care record, with a schedule of audits throughout the year. A combined trust report, which included each speciality, would not be available until March 2019.

On the children’s ward, medical records were stored securely in a locked office with a key-code entry system. Nursing notes and charts were stored safely in folders behind the nurse’s station. In SCBU, notes were stored on a trolley and kept in the staff office.

**Medicines**

The trust had a policy for the administration and storage of medicines and staff we spoke with told us they followed standard procedures.

There was dedicated pharmacy support across the service. The paediatric pharmacist visited the unit during the week and there was appropriate out-of-hours support. Staff did not report any problems.

The children’s ward included a ‘take home’ cupboard that stored medications such as antibiotics and analgesia. This facilitated a timely discharge when children were ready to go home, as families did not have to wait for the pharmacy team to fulfil any medication requests.

Medicines were securely stored and handled safely, and the medicines we reviewed were within the use-by date. Storage cupboards and fridges were tidy and locked.

IV fluids were stored in a locked cupboard within the treatment room and the trust had implemented guidelines to ensure fluids were only available to authorised staff. This was identified as a risk on the service risk register however managers were assured there was appropriate mitigation in place. There had been no reported incidents. The ward manager told us of imminent plans to relocate the fluids to the blood gas room.

Staff recorded and monitored the minimum and maximum fridge temperature appropriately, however, staff we spoke with could not tell us what the expected range should be or describe the escalation process.

We reviewed nine prescription charts. Overall, staff completed the charts accurately and the writing was legible. Staff recorded the date and their signature, allergies were documented, and antibiotics were prescribed as per guidelines. Staff also recorded the weight of the child. However, we noted in one case, one clinician had neglected to include a signature.

A medicines audit, undertaken by one of the medical doctors identified a drug error. A nurse had accepted a verbal update from the child’s parent about the current weight. This led to the incorrect dosage of paracetamol prescribed to the child. Lessons were learned and shared across the team.
Incidents

The trust had an incident reporting policy and staff reported incidents of harm or risk of harm using the risk management reporting system. Medical and nursing staff told us they felt confident reporting incidents and near misses, and received feedback from managers.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From June 2017 to May 2018, the trust reported no incidents classified as never events for children’s’ services.

(Source: Strategic Executive Information System (STEIS))

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in children’s services which met the reporting criteria set by NHS England from June 2017 to May 2018.

(Source: Strategic Executive Information System (STEIS))

There were 49 incidents reported between January and June 2018 relating to children’s services at Cumberland Infirmary. Most incidents (88%) resulted in no or minor injuries. There was no clear theme or trend although the majority (22%) related to staffing levels in SCBU.

Staff could describe lessons learned from incidents. For example, discharge letters were not being filed in patient notes straight away. This practice has improved and letters were now completed at the time of discharge.

Staff we spoke with understood the duty of candour requirements. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

Managers held weekly risk meetings to review incidents, which included staff from the children’s ward and the special care baby unit (SCBU). Every month, managers reviewed emerging themes and trends from incidents at a unit governance meeting.

SCBU shared learning with colleagues from other trusts as part of the wider Northern Neonatal Network (NNN) at regional meetings held each quarter. The NNN aimed to improve outcomes for babies born and cared for across the network region, providing trusts with an opportunity to share good practice.

Medical and nursing staff discussed paediatric deaths at monthly mortality and morbidity meetings. Paediatric community deaths were reviewed in line with the Local Safeguarding Children’s Board recommendations and were discussed at the Child Death Overview Panel, attended by the named doctor for child protection.

Safety thermometer
The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, falls with harm or new urinary tract infections in patients with a catheter from April 2017 to April 2018 for children’s services.

(Source: NHS Digital)

Quality of Care boards were displayed within each unit for patients, families and visitors to view. Information included planned and actual staffing levels for the day, infection prevention and control data, staff appraisal and mandatory training rates, and the number of days/months since a medication error.

### Is the service effective?

**Evidence-based care and treatment**

Medical and nursing staff adhered to guidelines from the Royal College of Nursing (RCN), the Royal College of Paediatrics and Child Health (RCPCH), the National Institute for Health and Care Excellence (NICE), and other professional guidelines such as the British Association of Perinatal Medicine.

Policies and guidelines were accessible via the intranet and staff knew how to access them.

We saw evidence of appropriate evidence-based policies and care pathways, such as neonatal jaundice and sepsis, and diabetes. However, the service did not have an asthma management plan, only a viral wheeze plan. Care pathways for fever and respiratory conditions had been developed in conjunction with primary and community services.

Some pathways and guidelines had been produced by the regional tertiary care centre and the Northern Neonatal Network. We noted these were all up to date. However, within the treatment room there was a folder containing paper copies of out-of-date guidelines. Although staff told us they accessed information via the trust intranet, there was a risk someone could access incorrect information if referring to the paper version within the folder. In addition, some guidelines on the intranet, such as hypoglycaemia and meningitis, were due for review in 2017 and had not yet been updated.

Children’s services participated in national audits such as diabetes, seizures and epilepsy in children and young people, and the neonatal audit programme. We also saw evidence of local audit activity to assess compliance with quality standards. The audit plan for 2018/19 included NICE CG 29: intravenous fluid therapy in children and young people, and NICE CG149: management and treatment of neonatal sepsis on SCBU.
The neonatal unit (with maternity) had completed the UNICEF Baby Friendly Initiative stage two assessment and had been awarded Stage 2 Baby Friendly accreditation. The unit was also working towards achieving accreditation with the Bliss Baby Charter, a scheme to ensure babies received the best neonatal care and treatment.

**Nutrition and hydration**

The children’s ward used the STAMP (Screening Tool for the Assessment of Malnutrition in Paediatrics) nutritional tool. It is a simple five-step tool to identify if a child’s condition has any nutritional implications, what the child’s nutritional intake is plus their weight and height. Based on the results from the first three steps, the overall risk of malnutrition is calculated and a care plan developed as appropriate.

There was a variety of food choices for children and young people, including those with allergies. Pictorial menus available for children to assist them in making their preferred choice of food.

A dedicated paediatric dietician met with families upon admission to discuss any special dietary needs. Dieticians also worked with the ward housekeeper to discuss requirements and make appropriate recommendations to meet the needs of the patients.

**Pain relief**

Children and young people had access to a range of pain relief if needed, including oral analgesia and patient-controlled analgesics. We saw evidence of a pain scoring system and completed pain assessments in the care records we reviewed.

Other non-pharmacological methods were also utilised by staff across the service. The children’s ward had a dedicated play specialist who told us they used age appropriate play and activities as a means of helping to prepare children for procedures.

Staff in the neonatal unit did not use a specific pain assessment tool and instead used oral sucrose analgesia, administered pre-procedure, for new-born infants undergoing painful procedures. The use of sucrose as an analgesia is common practice across the UK and the rest of the world. Staff recognised that sucrose, ‘non-nutritive’ sucking, breastfeeding and physical comfort all had a role to play in providing relief from the pain associated with certain procedures. The unit had also introduced the use of breast milk as a means of comforting babies, and the practice of swaddling.

**Patient outcomes**

Children’s services participated in national clinical audits to monitor and improve patient outcomes.

**Paediatric diabetes audit 2015/16**

**Cumberland Infirmary**

HbA1c levels are an indicator of how well an individual’s blood glucose levels are controlled over
time. The NICE Quality Standard QS6 states “People with diabetes agree with their healthcare professional a documented personalised HbA1c target, usually between 48 mmol/mol and 58 mmol/mol (6.5% and 7.5%)."

The data below shows that in the 2015/16 diabetes audit Cumberland Infirmary performance was similar to the England average.

The proportion of patients receiving all key care processes annually was 48.1% which was within the expected range, compared to a national aggregate of 35.5%, the previous year's score was suppressed. The trust score however was very close to the "better than expected" control limit.

The average HbA1c value (adjusted by case-mix) at the trust was 75.4% which was a negative outlier, compared to a national aggregate of insert 68.3%, the previous year's score was rated as a negative outlier.

The median HbA1c value recorded amongst the 2015/16 sample was 69.0, which was better than the previous year's median which was 74.5 and demonstrates a clinically significant improvement.

(Source: National Paediatric Diabetes Audit 2015/16)

Recently published data from the National Paediatric Diabetes Audit 2016/17 showed the average HbA1c value (adjusted by case-mix) at the trust was 68.7%. This was better than the previous year's median of 75.4% but slightly worse than national aggregates of 67.3%.

Recently published data from the National Paediatric Diabetes Audit 2016/17 showed the median HbA1c value recorded amongst the 2016/17 sample was 63.0. This was better than the previous year's median of 69.0 (and significantly better than in 2014/15) but slightly worse than national aggregates 64.0.

(Source: National Paediatric Diabetes Audit 2016/17)

A senior clinician told us patient outcomes were continuing to improve. The trust shared the latest (April 2018) Clinical Service Quality Measure (CSQM) outcomes for paediatric diabetes which indicated performance was 'worse than expected and improving over time'.

A national diabetes peer review programme was in the process of being re-established (similar to the previous Diabetes Quality Improvement Network System – DQuINS) and the trust had signed up to this new process.

National Neonatal Audit Programme

Cumberland Infirmary

In the 2016 National Neonatal Audit Cumberland Infirmary performance was as follows:

Do all babies < 1501g or a gestational age of < 32 weeks at birth undergo the first Retinopathy of Prematurity (ROP) screening in accordance with the current guideline recommendations?
There were 14 babies born with a birth weight < 1501g or with a gestational age at birth < 32 weeks who were assigned to the unit for ROP screening. 100% of these babies were screened on time in accordance with the NNAP extended screening window; this was above the national average, where 98% of eligible babies had their screening performed within the NNAP extended screening window.

**Is there a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission?**

There were 132 first episodes of care that were eligible for inclusion in this audit measure for the unit. Episodes of care lasting less than 12 hours have been excluded from analysis. The first consultation following admission occurred within 24 hours for 87% of the eligible episodes; this was below the national average, where 90% of eligible episodes had the first consultation within 24 hours of admission.

Managers confirmed that consultation with families did occur, however staff acknowledged this was not always documented appropriately. In response, the unit amended the clinician communication sheet and there was now a box at the top to record the date and time that they spoke to the parents.

**Are rates of normal survival at two years comparable in similar babies from similar neonatal units?**

There were nine babies born at < 30 weeks born between July 2013 and June 2014 who have been assigned to the hospital for two year health assessment based on their final neonatal discharge. Data was entered for 11% of the babies assigned to the unit, whilst nationally data was available for 61% of babies born at < 30 weeks born between July and June 2014.

**What is the proportion of babies born <32 weeks who develop Bronchopulmonary Dysplasia?**

There were 31 babies born < 32 weeks in the hospital who were included in the analysis for Bronchopulmonary Dysplasia. Of these babies three were identified as having Significant BPD.

(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)

**Emergency readmission rates within two days of discharge:** The data shows that from December 2017 to November 2018 there was no readmissions for the under ones and no specialties had six or more readmissions for patients aged 1-17 years old following an elective admission.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>North Cumbria University Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmission rate</td>
<td>Discharges (n)</td>
<td>Readmissions (n)</td>
</tr>
<tr>
<td>Readmission rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>England</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
There were no emergency readmissions after elective admission at this trust among patients in the under one age group over this time period.

### Emergency readmissions within two days of discharge following elective admission among the 1-17 age group, by treatment specialty (DECEMBER 2016 to NOVEMBER 2017)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>North Cumbria University Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>4.6%</td>
<td>1,574</td>
</tr>
</tbody>
</table>

No specialty at this trust had six or more readmissions.

The tables below show the percentage of patients (by age group) who were readmitted following an emergency admission. The tables show the three specialties with the highest volume of readmissions and only those specialties where six or more readmissions recorded are shown in the table.

The data shows that from December 2016 to November 2017 there was a higher percentage of under ones readmitted following an emergency admission compared to the England average and a higher percentage of patients aged 1-17 years old readmitted following an emergency admission compared to the England average.

### Emergency readmissions within two days of discharge following emergency admission among the under 1 age group, by treatment specialty (DECEMBER 2016 to NOVEMBER 2017)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>North Cumbria University Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>4.6%</td>
<td>1,574</td>
</tr>
</tbody>
</table>

No other speciality at this trust had six or more readmissions.
Emergency readmissions within two days of discharge following emergency admission among the 1-17 age group, by treatment specialty
(December 2016 to November 2017)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>North Cumbria University Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>3.4%</td>
<td>3,613</td>
</tr>
<tr>
<td>Paediatric trauma and orthopaedics</td>
<td>3.0%</td>
<td>265</td>
</tr>
<tr>
<td>General surgery</td>
<td>4.1%</td>
<td>170</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics, provided by CQC Outliers team)

We spoke with staff and managers who all explained the ‘open door’ policy for children with chronic long-term conditions. This meant families were encouraged to return to hospital if they had further concerns about their child.

Rate of multiple emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes: From January 2017 to December 2017 the number of patients under the age of one who had multiple readmissions for asthma, diabetes and epilepsy was too small to be included in the analysis.

The trust performed better than the England average for the percentage of patients aged 1-17 years old who had multiple readmissions for asthma and worse for patients who had diabetes or epilepsy.

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Rate of multiple (two or more) emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes (for children aged under 1 year and 1 to 17 years).
(January 2017 to December 2017)

<table>
<thead>
<tr>
<th>Long term condition</th>
<th>North Cumbria University Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Multiple admission rate</td>
<td>At least one admission (n)</td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1 to 17</td>
<td>9.8%</td>
<td>112</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1 to 17</td>
<td>15.4%</td>
<td>39</td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1 to 17</td>
<td>37.9%</td>
<td>29</td>
</tr>
</tbody>
</table>
Note - For reasons of confidentiality, numbers below 6 and their associated proportions have been removed and replaced with ‘*’.
(Source: Hospital Episode Statistics, provided by CQC Outliers team)

**Competent staff**

**Trust level appraisal rate**

From April 2017 to March 2018, 97.4% of staff within services for children and young people care at the trust received an appraisal compared to a trust target of 95% for nursing staff and 90% or higher for medical staff. Appraisal completion rates for both medical and nursing staff met the respective trust targets. Only one staff member for both staff groups did not receive an appraisal.

In the 2017 staff survey, quality of appraisals was within the worst 25% of trusts nationally. However, nursing staff spoke positively about the quality of the appraisal within children’s services and told us the process had improved over recent years.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required</th>
<th>Appraisals complete</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>64</td>
<td>63</td>
<td>98.4%</td>
</tr>
<tr>
<td>Medical &amp; dental staff</td>
<td>13</td>
<td>12</td>
<td>92.3%</td>
</tr>
<tr>
<td><strong>Grand total</strong></td>
<td><strong>77</strong></td>
<td><strong>75</strong></td>
<td><strong>97.4%</strong></td>
</tr>
</tbody>
</table>

**Cumberland Infirmary appraisal rate**

From April 2017 to March 2018, 95.6% of staff within services for children and young people care at the trust received an appraisal compared to a trust target of 95% for nursing staff and 90% or higher for medical staff. Appraisal completion rates for both medical and nursing staff met the respective trust targets.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required</th>
<th>Appraisals complete</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>35</td>
<td>34</td>
<td>97.1%</td>
</tr>
<tr>
<td>Medical &amp; dental staff</td>
<td>10</td>
<td>9</td>
<td>90.0%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>45</strong></td>
<td><strong>43</strong></td>
<td><strong>95.6%</strong></td>
</tr>
</tbody>
</table>

(Source: Trust Provider Information Request – Appraisal tab)

Appraisals for locum consultants were completed by the relevant agency, who provided the trust with the appropriate assurances. Long-term locum (and substantive) consultants were also appraised locally by a consultant from a different service, not from paediatrics. The clinical director confirmed assurances in respect of competencies were sought from the appraisal process and there were no current concerns.

Junior doctors we spoke with told us they had an educational supervisor and attended regular teaching sessions. All staff told us they felt supported in their role.
Medical and relevant nursing staff had received paediatric life support training appropriate to their role and we noted there was at least one trained nurse on every shift. Healthcare assistants told us they had received training in basic paediatric life support.

Student nurses spoke positively about their placements and described a good support network to help develop their nursing knowledge.

**Multidisciplinary working**

Our observation of practice, review of records and discussion with staff confirmed effective multidisciplinary team (MDT) working practices were in place. Medical and nursing staff worked closely together and with other allied healthcare professionals such as dieticians, health visitors and GPs. Staff we spoke with also gave us positive examples of working with child and adolescent mental health services (CAMHS) and social services.

Staff spoke positively about the relationship with the local tertiary care centre. They gave examples of working and liaising with the bed manager and of arranging the transfer of children from one hospital to the other.

The pharmacist team supported the children’s ward to facilitate timely discharge. The ward had a ‘take home’ cupboard that stored standard medication such as antibiotics and analgesia. Pharmacists regularly checked and maintained stock levels and worked with ward staff to supply additional medication when required.

Medical and nursing staff told us relationships with obstetricians and midwives were very good. There were no reported problems.

The service held monthly meetings attended by healthcare professionals from the hospital, community and primary care services to monitor, review and improve the effectiveness of local unscheduled care services.

In the CQC Children and Young People’s Survey 2016 the trust scored 8.8 out of ten for the question ‘Did the members of staff caring for your child work well together?’ This was about the same as other trusts.

*(Source: CQC Children and Young People’s Survey 2016, RCPCH)*

**Seven-day services**

Consultants were available out-of-hours and actively encouraged nursing and junior medical staff to contact them if the need arose. There were no reported problems accessing out-of-hours support.

Children’s services accessed diagnostic services such as the x-ray department, pharmacy and laboratory services during the weekend. Staff did not raise significant concerns over accessing these services.

**Health promotion**
Nursing staff worked to empower children and young people with mental health problems through building strong relationships with them and working together with the child and adolescent mental health service (CAMHS).

Children are involved in their own asthma management plan and diabetes nurses support children and young people to manage their condition.

Leaflets and posters were available in relation cyber-bullying and how to access drug and alcohol support teams.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

The trust had a 'consent to examination and treatment' policy and this included information specifically relating to children and young people. Staff we spoke with understood the Gillick competency guidelines and gave examples of how they had applied it in practice. Staff explained that the consent process actively encouraged young people to be involved in decisions about their care.

Staff we spoke with fully understood the Mental Capacity Act 2005 as it related to young people and consent to treatment. If they needed further advice, they told us they would contact the safeguarding team.

**Trust level Mental Capacity Act and Deprivation of Liberty training completion**

The trust reported that at March 2018 Mental Capacity Act (MCA) training was completed by 86% of staff within services for children and young people compared to the trust target of 95%. Nursing staff had a completion rate of 94%, just short of the 95% trust target.

A breakdown per staff group is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental staff</td>
<td>18</td>
<td>10</td>
<td>56%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>78</td>
<td>73</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Grand total</strong></td>
<td><strong>96</strong></td>
<td><strong>83</strong></td>
<td><strong>86%</strong></td>
<td><strong>95%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

Note: The above figures include mental capacity level 1 and level 2 training.

Over the same period Deprivation of Liberty Safeguards training was completed by 87% of staff within services for children and young people compared to the trust target 95%.

A breakdown per staff group is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental staff</td>
<td>3</td>
<td>2</td>
<td>67%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>20</td>
<td>18</td>
<td>90%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
Although the trust target was not met by any of the staff groups, this relates to only one staff member for medical staff and two staff members for nursing staff not completing the training.

Cumberland Infirmary Mental Capacity Act and Deprivation of Liberty training completion

Cumberland Infirmary reported that at March 2018 Mental Capacity Act (MCA) training was completed by 88% of staff within services for children and young people compared to the trust target of 95%.

A breakdown per staff group is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental staff</td>
<td>8</td>
<td>3</td>
<td>38%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>50</td>
<td>48</td>
<td>96%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Grand total</strong></td>
<td><strong>58</strong></td>
<td><strong>51</strong></td>
<td><strong>88%</strong></td>
<td><strong>95%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

Note: The above figures include mental capacity level 1 and level 2 training.

Over the same period Deprivation of Liberty Safeguards training was completed by 89% of staff within services for children and young people compared to the trust target 95%.

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>9</td>
<td>8</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff had a completion rate of 89%, although this relates to only one staff member not completing the training. There were no medical staff members required to complete this training.

(Source: Trust Provider Information Request – P40)

Other CQC Survey Data

The trust performed better than other trusts for one question, worse than other trusts for no questions and about the same as other trusts for the remaining four questions relating to effectiveness in the CQC Children and Young People’s Survey 2016.

CQC Children’s Survey questions, effective domain, North Cumbria University Hospitals NHS Trust

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Did staff play with your child at all while they were in hospital?</td>
<td>0-7 adults</td>
<td>8.80</td>
<td>Better than other trusts</td>
</tr>
</tbody>
</table>
Is the service caring?

Compassionate care

Medical and nursing staff, and those in non-clinical roles, with were passionate about their job and were dedicated to making sure children and young people received the best patient and family-centred care possible. Throughout our inspection, we observed medical and nursing staff delivering compassionate and sensitive care that met the needs of children, young people, and families.

We observed members of staff who had a positive and friendly approach towards children and parents. Staff explained what they were doing and took the time to speak with them, offering reassurance and support.

Families we spoke with described staff as ‘lovely’ and ‘caring’. One family told us they felt the care was exceptional and praised nursing and medical staff for the care they gave to them as well as their child.

In addition to promoting interaction with children and young people through play and activity, the play specialist supported children who were anxious and distressed at outpatient clinics.

Services for children and young people participated in the national Friends and Family Test (FFT) and the percentage of children, young people and families who would recommend the service was consistently above 95%. Of the 214 surveys returned in the recent quarter (April to June 2018), 96% of children, young people and families would recommend the service. The score was consistently above 95% throughout the previous year.

The service regularly gathered feedback from children, young people and families through a local patient experience survey. The monthly feedback, including FFT, was collated in a report and displayed on the ward. The scores (out of 10) were consistently high within the period June 2017 to June 2018. Children, young people and families said they were treated with respect, they felt safe, staff were kind and compassionate, and involved them in their own care. Direct comments from families, which were on display, included: ‘care was way above expectation’, and ‘staff have all been great’.

The trust ran a ‘Glimpse of Brilliance’ scheme which encouraged members of the public to contact the trust with examples of outstanding care. Certificates were given to the staff who were nominated. Two members of staff had recently been nominated for an award for providing ‘outstanding care, compassion and professionalism’.

Children, young people and families told us they saw medical and nursing staff regularly and they always introduced themselves by name. One family told us doctors were ‘always popping in and out’ to speak with the family and check on the child.

The trust performed better than other trusts for one question, worse than other trusts for no
questions and about the same as other trusts for the remaining nine questions relating to compassionate care in the CQC Children and Young People’s Survey 2016.

CQC Children and Young People’s Survey 2016 questions, compassionate care, North Cumbria University Hospitals NHS Trust

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Did new members of staff treating your child introduce themselves?</td>
<td>0-7 adults</td>
<td>9.27</td>
<td>Better than other trusts</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

**Emotional support**

Families told us they felt staff understood the impact the condition and treatment had on their children. Parents told us staff constantly offered reassurances and support throughout the treatment process. Medical and nursing staff kept families informed at every stage and children and parents felt empowered to ask questions.

Families also told us they felt very confident their children were receiving the best care possible. They felt confident leaving their child on the ward, reassured their child was safe, supervised, and cared for.

Staff understood the impact the condition and/or treatment had on children, young people and families. With support from a local charity, SCBU provided welcome packs on admission which included a diary/journal to encourage parents to record relevant interactions or interventions to help them retain the information and experience. In the parents’ absence, staff made appropriate entries. The pack also included a scent toy, one for the parents and one for the infant, bootees and a water bottle.

Families could access counselling and bereavement support. Each main site had a bereavement midwife and they provided a link to the hospital bereavement team. There was a clear bereavement policy in place.

Support was available for children with long-term health conditions. For example, all children and young people with diabetes had an annual assessment of their psychological well-being by the multi-disciplinary team responsible for their care.

The trust performed about the same as other trusts for all five questions relating to emotional support in the CQC Children and Young People’s Survey 2016.

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

**Understanding and involvement of patients and those close to them**

Families we spoke with felt well informed about their child’s condition and treatment. Medical and nursing staff communicated with children, young people and families openly and checked their understanding of the facts that were presented. For example, one parent told us medical staff...
explained things to them using non-medical jargon, and in such a way to ensure their understanding.

Feedback from the children’s ward children and young people’s survey was positive in relation to patient involvement in decisions about care and treatment. Between April and June 2018, the score was 9.44 out of 10. The service scored 9.74 out of 10 from the question ‘did the staff listen and help you understand what was going to happen?’.

Medical and nursing staff actively involved families in caring for their children. Nurses from the neonatal unit described encouraging parents to undertake routine tasks to care for their baby as they would at home. One nurse described how they involved the young sibling of a baby who was receiving special care by encouraging the child to bottle-feed her doll whilst her mother was feeding the baby.

The trust performed about the same as other trusts for all questions relating to understanding and involvement of patients and those close to them in the CQC Children and Young People’s Survey 2016. No score was provided for one question.

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Is the service responsive?

Service delivery to meet the needs of local people

The facilities and environment in the children’s ward and outpatient department were suitable for children and young people, with age appropriate facilities and play activities.

There were separate areas for teenagers. For example, the ward manager explained older children and young people, if not in a single room, could be located together in a dedicated bay. Older male and female children could also be accommodated in separate bays.

There were appropriate facilities for parents and carers who chose to stay overnight. The children’s ward offered a fold away camp bed so parents could sleep beside their child while they were in hospital. There were also facilities for parents and carers to wash and dress.

Parents could stay overnight with their babies in SCBU. There were two dedicated parent rooms within the unit with appropriate facilities to help them feel comfortable. Parents could also remain by their child’s bedside on a fold away camp bed.

The play specialist was available five days a week. They also supported outpatient clinics and we saw children interacting with them positively and confidently. The play specialist also ensured older children were included in all activities.

Medical and nursing staff spoke positively about working with GPs, the child and adolescent mental health services (CAMHS) and health visitors although acknowledged links with the children’s community nursing team could be stronger. Although the service did not have a link consultant for each local GP practice or group of GP practices, clinicians provided a minimum of two education and knowledge exchange sessions per year with GPs and other healthcare professionals who worked with children with unscheduled care needs.
The service facilitated a hospital and home tuition service which was provided by Cumbria County Council, for children and young people who were hospitalised for 15 (or more) school days. Young people who were undertaking their GCSE’s had direct access to the service to allow the exam process to continue if their health and wellbeing allowed. Children and young people with complex needs and already registered with the service also qualified for direct access. Children and young people who did not meet the criteria of the service often received homework from their local school. The play specialist also contributed to the patient’s education and development.

The children’s outpatient department provided a range of specialist clinics to meet the needs of children and young people. These included cystic fibrosis, rheumatology, respiratory medicine, ophthalmology, and diabetes. Clinicians also held diabetes outreach clinics in different venues across the county.

The service had introduced a local specialist epilepsy clinic, supported by a paediatrician with a specialist interest and a community paediatric epilepsy nurse specialist. The purpose was to improve services for children and families and meet epilepsy best practice standards.

Wi-Fi was readily available across the service, which meant children and young people could keep in touch with family and friends whilst in hospital.

**Meeting people’s individual needs**

The trust classified children to be 0-18 years of age. All children and young people between these ages were seen in the paediatric emergency department (ED) and children up to the age of 16 are usually placed in the children’s wards, however, if it is deemed they may be mature and fit better in the adult wards then they are offered this opportunity.

Staff told us children and young people who were known to the service and had learning disabilities would be treated in the paediatric ED if it was felt they could be better accommodated. Staff from the children’s wards would assist those children if they were known to the service.

Nursing staff told us any children who were reaching 18 would undergo a transition process into the corresponding adult service. All children known to the service such as looked after children and those with mental health issues would still have some involvement from the child safeguarding team as required. The service was currently looking at creating a joint transition policy with Cumbria Partnership NHS FT, in line with the development of the care group.

The majority of surgical procedures for children and young people took place at Cumberland Infirmary. This did not include children under one years old or under 10 kilograms in weight who were instead transferred to the local tertiary care centre. There were no dedicated children’s lists in main theatres and the lists were mixed adult’s and children’s lists under each specialty. There were separate recovery areas for adults and children.

Leaflets for children and families were widely available in the ward and outpatient areas. Staff knew how to access an interpreter and gave examples of when they had used the service.
There were arrangements to support children and young people with complex needs or who required psychiatric support. Child and adolescent mental health services (CAMHS) were provided by the Cumbria Partnership NHS Foundation Trust, and was available during office hours only. Any patients requiring CAMHS outside of office hours were cared for on the ward until the service was open. Since May 2017 to April 2018 the service had cared for 278 CAMHS patients in the children’s ward, with their length of stay ranging from 30 hours to 10 days.

Managers told us they had seen an improvement since out last inspection, as CAMHS now provided a seven-day service, however this did not extend to out-of-hours.

The play specialist had received CAMHS training to enable her to understand and meet the needs of children and young people with mental health problems.

Children and young people in receipt of end-of-life care could choose where they wished to receive their care. Medical and nursing staff worked collaboratively with a local children’s hospice to discuss the needs of children who may require acute care. The ward manager gave an example when a child requested to remain on the children’s ward. Nursing staff liaised with their community nursing colleagues while consultants from the trust liaised with the hospice consultant to ensure the needs of the child were met. The ward manager told us of plans to hold monthly meetings to discuss caseloads in relation to admission.

The trust performed better than other trusts for no questions, worse than other trusts for two questions and about the same as other trusts for the remaining 15 questions relating to responsiveness in the CQC Children and Young People’s Survey 2016.

**CQC Children and Young People’s Survey 2016 questions, responsive domain, North Cumbria University Hospitals NHS Trust**

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>71</td>
<td>Did a member of staff tell you who to talk to if you were worried about anything when you got home?</td>
<td>8-15 CYP</td>
<td>6.39</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>73</td>
<td>Did a member of staff give you advice on how to look after yourself after you went home?</td>
<td>8-15 CYP</td>
<td>7.48</td>
<td>Worse than other trusts</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

**Access and flow**

Children and young people were admitted to the children’s ward through the paediatric emergency department or via a direct referral from a GP. Some children and young people were granted long-term open access to the ward or SCBU, particularly those suffering from chronic conditions or babies who had recently been discharged.

There was an escalation policy when the number of patients exceeded the number of available beds. Staff we spoke with could explain what actions they would take in such an event. Ward
managers at both hospital sites also had regular contact with each other throughout each day to maintain oversight of bed capacity on each ward.

The service used a paediatric dashboard to monitor performance in relation to outpatient referrals, attendances, and did not attend (DNA) rates, emergency readmission rates and length of stay (elective and non-elective). The dashboard also included referral to treatment times (RTT).

Between April 2017 and March 2018, the number of new outpatient attendances was 3305 across both hospitals. Within the same time frame, there were 5418 review attendances. We did not see the figures for each individual site however, the service was consistently above the 92% trust target for RTT 18-week, ranging from 98% to 99%.

The DNA rate from April 2017 to March 2018 was 16.1%, which was worse than the 8% target. Staff could explain the process outlined in the DNA policy when a child or young person did not attend and told us what action they would take.

Cumbria Partnership NHS Foundation Trust provided community children’s nursing services across the local region. Some staff felt the current provision was limited in terms of the links with the hospital. However, the recent merger between the community healthcare provider and North Cumbria University Hospitals NHS Trust indicates the relationship between the two organisations will become stronger going forward.

Specialist paediatricians were available for immediate telephone advice for acute problems within the trust or through a network. Specialties included gastroenterology, endocrinology, oncology, respiratory medicine, intensive care medicine, nephrology, paediatric cardiology and neurology. The unit maintained close working links with the local regional tertiary centre.

Discharge summaries were provided to GPs, other healthcare professionals and parents within 24 hours of discharge from hospital. As not all GP practices were set up to receive electronic communication, letters were sent directly to the relevant practice.

On all the records we reviewed, a consultant saw a child or young person within 14 hours of admission.

The trust has no neonatal critical care beds. The Special Care Baby Units (SCBUs) are level one, providing care for babies who require additional care post-delivery by the neonatal service, but do not require intensive or high dependency care. Both units engage with the Northern Neonatal Network, CNST and Developmental Care. At times, and during neonatal emergencies, the units are required to provide high dependency and intensive care, hence can provide short term intensive care for babies who are intubated, ventilated and awaiting transfer to the tertiary centre by the retrieval teams. Intensive care delivery requirements may be required for 4 -12 hour periods, depending on the demands of the retrieval teams.

The SCBU initiates mechanical ventilation and stabilisation, but does not ventilate long term. Instead the Northern Neonatal Network will find a ventilator for the baby usually in the Northern Region and organise the baby to be transferred out by a neonatal transfer team.

(Source: Routine Trust Provider Information Request (RPIR Acute) – Context tab)
Learning from complaints and concerns

From April 2017 to March 2018 there were three complaints about children’s services. The trust took an average of 31 days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be responded to and closed within 30 working days. All complaints were about inpatient care and treatment. Cumberland Infirmary received one, West Cumberland Hospital one and one complaint was not allocated to a specific site. One complaint was upheld, one partially upheld and one complaint refuted.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Parents we spoke with told us they felt they could raise concerns if they felt they wanted to and told us they knew how to make a complaint. There were posters and leaflets in visiting areas about how people could raise concerns. Staff explained, in most cases, parents spoke to nurses on the ward and issues tended to be resolved informally.

Is the service well-led?

Leadership

There were clear lines of management and accountability across the service at all levels.

Staff spoke positively about leadership at ward, service and care group level. They felt they had the relevant skills, knowledge, experience, and integrity required. Managers were visible and approachable.

The matron and clinical directors for paediatrics and neonates maintained a regular and visible presence in the hospital. The matron and ward manager had a one-to-one meeting every week to discuss concerns, risks and issues. The matron also held daily update meetings (morning and evening), either face-to-face if on site, or via telephone, to keep abreast of activity on the unit.

The neonates ward manager had not received any internal leadership training. We were informed the trust no longer provided this and it was difficult to source any external training. The ward manager from the children’s ward was providing peer support and the matron recognised the need for a preceptor. The matron was arranging internal human resources training and had good oversight of the training needs.

Consultants had job plans and these were reviewed annually as part of the appraisal process.

Vision and strategy

The trust had recently formed merged with Cumbria Partnership NHS Foundation Trust and senior managers continued to work collaboratively with the Cumbria Clinical Commissioning Group (CCG), Cumbria County Council, North West Ambulance Service, NHS England and neighbouring NHS Foundation Trusts to deliver a business case to remodel services for children and young people. The primary aim was to ensure services were safe by creating a one-team, sustainable, integrated service across both acute sites.
Managers continued to acknowledge the development of such an integrated model of care meant the service was better able to respond to the demands upon it. This included the needs of its population, geography, local infrastructure, and recruitment issues.

The trust, in alliance with Cumbria Partnership NHS Foundation Trust, had created a joint operational plan entitled ‘This is us’. Core objectives, aims and priorities for services for children and young people receiving acute and community across Cumbria were included with the strategy.

The child health business plan reflected the changing nature of childhood illness which meant fewer children require an inpatient hospital stay, while those who are admitted tend to have a shorter length of stay than in the past. This was reflected in the development of the short stay paediatric assessment units at both sites.

Senior managers also recognised the need to look at a longer-term approach to the stabilisation of SCBU. This included developing a transitional care model and generating closer links with the maternity service. The associate director of midwifery, appointed in January 2018, worked closely with the matron and maintained oversight of SCBU.

**Culture**

The culture of the service was centred on the needs and experiences of children and young people. Feedback from patient experience surveys was widely shared across the units and staff demonstrated resilience and passion to ensure they delivered excellent care.

Medical and nursing staff spoke positively about good teamwork across the service. Our observations showed staff worked well together and there were positive working relationships between the multidisciplinary teams and other services involved in the delivery of care for children and young people.

Staff described a culture of openness and honesty, and told us they felt safe to challenge senior members of the team and express their own opinion. They were proud to work for the trust, and most staff felt valued and respected. Everyone we spoke with was aware of duty of candour and practitioners were encouraged to report incidents. Staff felt confident that if they raised a concern, managers would take appropriate action.

**Governance**

At previous inspection, services for children and young people was part of the Surgical division. Children’s services were now currently part of the Women’s and Children’s Services Care Group which also included radiology, however managers felt it did not meet the governance needs of the service. In response, managers and service leads had resurrected child health unit governance meetings.

Managers and senior nurses described a governance structure that included regular meetings to discuss the performance, quality, and sustainability of the service.

There was a governance dashboard which included all reported incidents, complaints, PALS (patient advice and liaison service) enquiries, clinical audit activity, ongoing risks, and NICE exceptions.
Site governance meetings took place every Wednesday and cross-site governance meetings were held on the first Tuesday of every month. The ward manager also held bi-monthly ward meetings with staff. Information from governance meetings was shared with staff via email. The ward manager also maintained a governance folder which held up-to-date and relevant information such as minutes from governance and risk meetings. Staff were aware of the file and told us they regularly accessed it.

We reviewed the minutes from the previous three cross-site child health governance meetings, noted the regularity of meetings and the good representation from staff. They included the matron, business manager, ward managers, consultant paediatricians, and governance facilitator, plus the named nurse safeguarding children, and finance lead. The clinical director for paediatrics was unable to attend due to clinical responsibilities. There was a standard agenda which included operational issues, workforce updates, incident review, finance and risk.

Moving forward, the trust was in the process of establishing a cross-organisational Family Services Care Group with Cumbria Partnership NHS FT (CPFT). The current associate medical director for children and young people at CPFT, a consultant paediatrician, would have a leadership role within this.

Management of risk, issues and performance

There were 11 current risks relating to children’s services on the divisional risk register. Of these, five related specifically to Cumberland Infirmary, which included paediatric administrative support, fluids stored within the treatment room, and the staffing pressures within SCBU. Five other risks were cross-site, and one was specific to West Cumberland Hospital.

Risks associated with both hospitals included lack of clarity around postcode divert when either hospital had reached capacity, inappropriate admissions of patients with mental health issues and nasogastric tube training and level of competency.

Managers reviewed the children’s services risk register every month in accordance with allocated timeframes. Managers recorded progress made against the risks along with risk controls, gaps in controls and gaps in assurance measures within the risk register. There was evidence of re-evaluation of risk grading and on-going review.

Nursing and medical staff we spoke with had a good understanding of the risks within the service. Delays in appropriate care for children with mental health issues and medical staffing at West Cumberland Hospital were the two main risks staff spoke about, although the latter issue did not feature on the divisional risk register. Managers had taken steps to mitigate some of the risks posed to children and young people with mental health problems through collaboration with the CAMHS team.

Staff could describe the escalation process in relation to risk. Staff escalated risks directly to the ward managers, matron or clinical directors. Escalation to the Board was via the medical director or director of nursing.
Performance was monitored through the paediatrics dashboard and reviewed at monthly governance meetings. In the event of a deterioration in performance, the business manager advised an action plan or recovery plan is created and monitored in governance meetings.

In respect of the service’s business continuity plans, the current plans required updating. A tabletop exercise was scheduled at the end of the month with the clinical commissioning group lead who was supporting the process.

Although there was a system of clinical and internal audit to monitor quality, the service did not have specific progress reports for audit action plans. Managers were currently developing a process to monitor and follow-up on action plans and had created an action plan escalation process with the governance facilitators for each Care Group. The new process included a spreadsheet that automatically sent out reminders for overdue action plans. This had only been developed very recently and the service had not used it yet. As part of this work managers also told us they also planned to develop progress reports.

Managers and staff from both sites completed a detailed '15 Steps' safety and quality assessment to monitor ward compliance against the CQC’s five key questions. The assessment team included staff from West Cumberland Hospital. We did not see a copy of the latest report although we did review the assessment that took place in May 2018 at West Cumberland Hospital. The report highlighted good practice within each domain plus any concerns and learning. A 15 Steps safety and quality action plan detailed the actions taken and progress updates.

**Information management**

Staff we spoke with told us they could access the information they needed to ensure they provided safe and effective care to patients. This included policies and standard operating procedures.

The intranet was available to all staff and contained links to guidelines, policies, safeguarding information and contact details for colleagues within the trust. This meant staff could access advice and guidance easily. All staff we spoke with knew how to access the intranet and the information contained within.

Managers could access governance and performance dashboards that provided relevant data about the service. This was discussed at ward and governance meetings.

The information accessed by managers was stored in line with data security standards, for example, confidential and personal information pertaining to staff was protected through the use of smart cards, issued only to staff with line management responsibilities.

**Engagement**

The service proactively engaged with children, young people and their families and sought feedback through patient experience surveys. Feedback was displayed on boards in the children’s ward and SCBU. Recognising that some children were too poorly to put their thoughts in writing, staff also engaged with them face-to-face to capture their views.

The service displayed ‘You Said, We Did’ boards within each unit, demonstrating that the service listened to and took appropriate action in response to feedback.
Medical and nursing staff engaged daily with the children and young people in their care and ensured parents were included. We saw evidence of positive and caring interactions between staff of all grades with the children and their families.

Staff told us they felt informed about the current plans for children’s services at West Cumberland Hospital, particularly in respect to the development of the paediatric short stay assessment unit.

The trust communications team distributed regular bulletins and newsletters via email, and uploaded trust information onto the intranet for staff to access.

**Learning, continuous improvement and innovation**

Medical and nursing staff spoke positively about changes in the consultant rota which meant children and young people were reviewed and discharged in a timelier way.

Managers and staff demonstrated continuous improvement through the plan to re-model children’s services at both sites- the paediatric short stay assessment unit and increasing the number of higher-acuity patients.

Staff were proud of their achievements in relation to BLISS and the Baby Friendly Initiative.

In SCBU, staff spoke of their family integrated care approach. Due to the regular presence of parents on the unit, staff encouraged them to proactively engage in the care of their child. Nurses explained the aim was to empower parents to look after their baby and staff promoted initiative such as skin to skin contact for a sustained period. Representatives from the service had been involved in discussions at the local neonatal network and had implemented the practice within the unit.
Urgent and emergency care

Facts and data about this service

Details of emergency departments and other urgent and emergency care services

Urgent and emergency care at the North Cumbria University Hospital NHS Trust operates from two district general hospital sites: West Cumberland Hospital (WCH) in Whitehaven; and Cumberland Infirmary in Carlisle (CIC).

(Source: Routine Provider Information Request (RPIR) – Sites tab)

Both hospitals operate a 24/7 consultant-led emergency department (ED). However, the WCH ED accepts trauma cases for stabilisation only, before transferring these to either CIC or a tertiary centre.

At WCH there are also a selected number of conditions that follow a high-risk transfer pathway from WCH to CIC. These include:

- Gastro-intestinal bleed
- Respiratory patients assessed as high risk (i.e. those with an initial diagnosis of pneumothorax or potential empyema, cardiac NSTEMI/ACS/endocarditis, or bradycardia requiring urgent cardiac pacing).

Both sites operate emergency assessment units; there is a 29-bedded unit at WCH for medicine and surgical admissions. The unit is supported by acute care physicians (ACPs).
Each site also operates an emergency ambulatory care unit Monday to Friday, supported by the acute medical and surgical consultants and nurse practitioners. The WCH unit operates five chairs, one bed and two examination couches from 8am to 8pm.

(Source: Routine Provider Information Request (RPIR) – Context acute tab)

The emergency assessment unit and ambulatory care unit were inspected under our Medical Care Core Service Framework. This part of our report focuses on the emergency department (ED). The ED has a large waiting-room, with a reception station behind transparent screens, a triage room, a ‘majors’ area comprising six cubicles, a ‘minors’ area comprising eight cubicles, including one room designed to accommodate patients who present with mental health needs and another designed for ear, nose and throat (ENT) patients, a separate paediatrics area, comprising a waiting room and three cubicles (one of which can be used flexibly as an adult or paediatric room), a spacious resuscitation area containing three bays (one of which is also equipped for paediatric patients), a viewing room, and a relatives’ room.

Activity and patient throughout

Total number of urgent and emergency care attendances at North Cumbria University Hospitals NHS Trust compared to all acute trusts in England, April 2016 to March 2017

From April 2016 to March 2017 there were 92,105 attendances, of which 17,420 (19%) were children, at the trust’s urgent and emergency care services, as indicated in the chart above.

(Source: NHS England)
Urgent and emergency care attendances resulting in an admission

The percentage of A&E attendances at this trust that resulted in an admission increased in 2016/17 compared to 2015/16. In both 2016/17 and 2015/16 the proportions were higher than the England average. (Source: NHS England)

Urgent and emergency care attendances by disposal method, January to December 2017

- Admitted to hospital: 24,528
- Discharged*: 54,216
- Referred*: 11,060
- Transferred to other provider: 645
- Died in department: 139
- Left department#: 2,418
- Other: 288
- Not known

* Discharged includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)

During our inspection of ED at WCH we spoke with 26 members of staff, including managers, doctors, nurses, and non-clinical staff. We also spoke with ambulance crew members who brought people to the ED.

We reviewed 18 sets of patient records (six adults and 12 paediatrics) and spoke with eight patients and two relatives. We observed the interaction of staff with patients and of staff with each
other. We reviewed comments from people who contacted us to tell us about their experiences, information from external stakeholders, and performance information about the hospital.

**Is the service safe?**

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

**Mandatory training**

The trust set a target for mandatory training of 95%.

A breakdown of compliance for mandatory training courses as at March 2018 for **qualified nursing staff** in the urgent and emergency care department at West Cumberland Hospital (WCH) is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>BLS (adults)</td>
<td>22</td>
<td>22</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk management</td>
<td>72</td>
<td>72</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, trips and falls level 1</td>
<td>72</td>
<td>72</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Duty of candour</td>
<td>72</td>
<td>70</td>
<td>97%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent level 1&amp;2</td>
<td>72</td>
<td>70</td>
<td>97%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>72</td>
<td>69</td>
<td>96%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>72</td>
<td>69</td>
<td>96%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety</td>
<td>72</td>
<td>68</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>72</td>
<td>68</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>72</td>
<td>67</td>
<td>93%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines management</td>
<td>72</td>
<td>67</td>
<td>93%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia</td>
<td>72</td>
<td>66</td>
<td>92%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Calculating drug doses</td>
<td>72</td>
<td>64</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health records management</td>
<td>72</td>
<td>64</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control level 2</td>
<td>72</td>
<td>63</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>ALS (adults)</td>
<td>7</td>
<td>6</td>
<td>86%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>ALS (paediatrics)</td>
<td>7</td>
<td>6</td>
<td>86%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>News</td>
<td>72</td>
<td>60</td>
<td>83%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 01</td>
<td>72</td>
<td>53</td>
<td>74%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Understanding end of life</td>
<td>72</td>
<td>53</td>
<td>74%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Hand hygiene (clinical)</td>
<td>72</td>
<td>51</td>
<td>71%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; handling level 2</td>
<td>72</td>
<td>51</td>
<td>71%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 02</td>
<td>72</td>
<td>50</td>
<td>69%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, trips and falls level 2</td>
<td>47</td>
<td>31</td>
<td>66%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>ILS (adults)</td>
<td>41</td>
<td>27</td>
<td>66%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk management (board and senior managers)</td>
<td>8</td>
<td>5</td>
<td>63%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
At WCH urgent and emergency care department the 95% target was met for seven of the 29 mandatory training modules for which qualified nursing staff were eligible. Three of the seven modules had completion rates of 100%. Apart from the seven modules for which the trust targets were met, a further five modules had completion rates above 90%.

A breakdown of compliance for mandatory training courses as at March 2018 for medical staff in the urgent and emergency care department at WCH is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>ILS (adults)</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>11</td>
<td>9</td>
<td>82%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Trust doctors’ patient safety programme</td>
<td>11</td>
<td>9</td>
<td>82%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Duty of candour</td>
<td>11</td>
<td>8</td>
<td>73%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines management</td>
<td>11</td>
<td>8</td>
<td>73%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk management</td>
<td>11</td>
<td>8</td>
<td>73%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, trips and falls level 1</td>
<td>11</td>
<td>8</td>
<td>73%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Calculating drug doses</td>
<td>11</td>
<td>7</td>
<td>64%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia</td>
<td>11</td>
<td>7</td>
<td>64%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>11</td>
<td>7</td>
<td>64%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>11</td>
<td>7</td>
<td>64%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>11</td>
<td>7</td>
<td>64%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 01</td>
<td>11</td>
<td>6</td>
<td>55%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety</td>
<td>11</td>
<td>6</td>
<td>55%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health records management</td>
<td>11</td>
<td>6</td>
<td>55%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control level 2</td>
<td>11</td>
<td>6</td>
<td>55%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>News</td>
<td>11</td>
<td>6</td>
<td>55%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent level 1&amp;2</td>
<td>11</td>
<td>6</td>
<td>55%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>ALS (adults)</td>
<td>4</td>
<td>2</td>
<td>50%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 02</td>
<td>11</td>
<td>5</td>
<td>45%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Hand hygiene (clinical)</td>
<td>11</td>
<td>5</td>
<td>45%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; handling level 1 clinical (3 yearly)</td>
<td>11</td>
<td>5</td>
<td>45%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>11</td>
<td>4</td>
<td>36%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>ALS (paediatrics)</td>
<td>4</td>
<td>1</td>
<td>25%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevention of suicide</td>
<td>9</td>
<td>2</td>
<td>22%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

At WCH urgent and emergency care department the 95% target was met for only one of the 25 mandatory training modules for which medical staff were eligible. ILS (adults) had a 100% completion rate, although the number of staff eligible for this training was only two.

(Source: Routine Provider Information Request (RPIR) – P40)
Despite the poor levels of training compliance in the ED, managers in the department told us that they closely monitored training compliance.

The information supplied by the trust demonstrated that qualified nursing staff and medical staff had not all received all of the training required to make them aware of the potential needs of people with mental health conditions, a learning disability, autism, or dementia, but, when we spoke with staff working in triage areas, they told us that they had had basic training to make them aware of the potential health needs of those groups of people.

The trust had a policy for sepsis management, and staff we spoke with in the department were aware of it. The policy had been updated in December 2016, along with a new sepsis care bundle, and staff had received training in this.

We spoke with staff about wider access to both mandatory and elective training. They told us that they were able to access the training they needed and were supported to do so. Training was accessed in different ways. Some could be done via e-learning and some was practical, hands-on training. None of the staff we spoke with expressed any concerns about standards of training or ease of access either online or in person.

Safeguarding

Staff Training

The trust set a target of 95% for completion of safeguarding training.

A breakdown of compliance for safeguarding training courses from as at March 2018 for **qualified nursing staff** in the urgent and emergency care department at West Cumberland Hospital (WCH) is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 2</td>
<td>40</td>
<td>40</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>72</td>
<td>67</td>
<td>93%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 3 (core)</td>
<td>32</td>
<td>27</td>
<td>84%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

At WCH urgent and emergency care department the 95% target was met for one of the three safeguarding training modules for which qualified nursing staff were eligible. Safeguarding children level 2 had a 100% completion rate, and one further module had a completion rate above 90%.

A breakdown of compliance for safeguarding training courses from as at March 2018 for **medical staff** in the urgent and emergency care department at WCH is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 3 (specialist)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>11</td>
<td>7</td>
<td>64%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
At WCH urgent and emergency care department the 95% target was met for two of the four safeguarding training modules for which medical staff were eligible. Safeguarding children level 3 (specialist) had a 100% completion rate, although only one staff member was eligible for this training.

(Source: Routine Provider Information Request (RPIR) – P40)

The safeguarding children standards produced by the Royal College of Emergency Medicine (RCEM) were not fully met within the emergency department (ED); only 84% of the nursing staff and 20% of the medical staff required to undergo core level 3 Child Protection training had done so. Additionally, from January 2018, the trust had moved from providing level 3 safeguarding training via a one-day, face-to-face course, to the use of a four-hour, e-learning module, with a requirement for departments to contact the safeguarding team for additional bespoke training, or individuals to attend externally-provided face-to-face training, to achieve the full requirements of level 3. However, there was confusion amongst staff about this, with many believing that completion of the e-learning module was the sole requirement for level 3. This would not be sufficient to be compliant with RCEM guidance, and the trust policy did not clarify how full level 3 compliance would be achieved.

There were named safeguarding link nurses in the ED, who attended quarterly trust-wide safeguarding meetings and shared information with other staff in the department. However, they were not available to speak with us at the time of our inspection. Staff we spoke with were aware of the trust’s safeguarding policies in respect of vulnerable adults and of children. Safeguarding awareness and referral information, including appropriate contact details and a step-by-step guide, was displayed on the wall in the ‘majors’ area of the department, and there was a ‘safeguarding box’ available to staff, containing additional information. Staff knew the names of the trust’s safeguarding leads and described them as visible within the department. They spoke highly of their availability and of the support they received from the safeguarding team. Nursing staff also knew how to report issues using the correct forms, but other staff said that they would do so via the nurse in charge.

We reviewed three sets of safeguarding case records, which were well-documented and showed that there were adequate safeguarding guidelines and protocols to follow when a child or an adult with children attended the department. Staff had access to systems and processes to detect and protect any hidden children when adults were admitted to the department, for example, in cases of domestic violence. All such cases were referred internally to the independent domestic violence advisor (IDVA) in the safeguarding team. The IDVA then completed referrals to the local Multi-Agency Risk Assessment Conference (MARAC), which is a regular information-sharing and risk-management meeting attended by all key agencies to facilitate and monitor action by the appropriate body.

However, the department’s electronic patient report form (EPRF) for children had sections to record a presenting child’s social and family history. We looked at 12 EPRFs and could not see any instances of recording by the clinician of having checked previous attendances to discount any safeguarding risks. We reviewed one case, relating to a young person who had a history of
self-harm, in detail with the named nurse. We found that the attending consultant had not reviewed the patient’s previous admissions and had noted ‘no’ to previous safeguarding concerns.

The department used the ‘condition, witness, incident, location, time, escort, description’ (CWILT ED) screening tool when triaging children. This prompted practitioners to ask pertinent questions to ascertain a history and establish how any injury had occurred. When completed, this provided a very good basis to determine any safeguarding issues. However, we looked at six recent emergency department admissions and noted that the CWILT ED tool had not been completed for four of these. We spoke with a consultant, who told us that they would bypass triaging of children during busy times, picking up admissions cards directly, to ensure that those children received swift treatment. Consequently, a medical practitioner might discharge a child, once treated, from the emergency department without completing the CWILT ED tool, thus meaning that safeguarding risks to that child had not been assessed. We drew our concerns about this system to the attention of the safeguarding team and senior emergency department staff, who told us they had assumed the system was fail-safe and would now act to address our concerns.

Staff had access to online training in awareness of Child Sexual Exploitation (CSE) and Female Genital Mutilation (FGM), but we were not supplied with information about rates of completion. We looked at the safeguarding prompts in the department’s electronic patient reporting (EPR) system and found that there were no obvious or specific questions to ask about CSE, FGM or other matters, such as under-aged smoking. The staff we spoke with at all levels did not routinely question children about these issues and were not aware of the tools for identifying CSE that were available on the trust’s intranet site.

The department also used the Child Protection - Information Sharing (CP-IS) project system to share information securely (CP-IS is nationwide initiative that helps clinicians in unscheduled care settings to identify vulnerable children), and the trust’s own patient-record system to check for any internal alerts. Emergency department reception staff told us that they would check CP-IS for information about any child presenting there. They would then follow an agreed flagging system to alert attending clinicians to the presence of any CP-IS information about that child. We observed reception staff routinely checking CP-IS.

Only 10% of nursing staff and 22% of medical staff in the emergency department had undergone training in prevention of suicide training, against a trust target of 95%.

Staff understanding of the Mental Health Act was very limited; most were not aware of the Act’s S5(2) doctor’s holding power and S5(4) nurse’s holding power, and so did not know when and how they should be used to ensure a patient’s safety. However, they sought advice from the trust’s partner mental health trust if they felt patients might have mental health problems.

Overall, safeguarding processes and tools within the department were not a failsafe mechanism to ensure that all safeguarding issues were identified, although, once any risks had been identified, systems to protect vulnerable adults and children appeared to be robust.

Cleanliness, infection control and hygiene

At West Cumberland Hospital (WCH) urgent and emergency care department only 88% of nursing staff and 55% of medical staff were up-to-date with mandatory infection control level 2 training, against a trust target of 95%, and only 71% and 45% of medical staff were up-to-date with
mandatory clinical hand-hygiene training, against a trust target of 95%. The trust did not provide us with compliance rates for infection control training for other staff in the department.

When we visited the emergency department (ED), we found it to be visibly clean. Waiting-area floors and seating were in good order. Toilets for patients and visitors were clean. We found that the environment was compliant with infection prevention and control guidelines, and there was no dust below or on top of surfaces. In the paediatric waiting area, toys met infection control standards and had been cleaned regularly.

There were cleaning schedules and completed, signed and dated paperwork which confirmed that cleaning had been carried out. We saw staff completing the required tasks in line with schedules.

Equipment that we examined was visibly clean, and there were cleaning schedules in place for all equipment. Health care assistants were responsible for general cleaning of patient equipment such as blood pressure machines. We witnessed staff carrying out cleaning of equipment between patient usages. The department did not carry out audits of mattress condition. However, mattresses that we checked were in good condition and met infection prevention and control standards.

The ED had solid-walled cubicles for use by patients who required isolation for the prevention and management of actual or potential infection.

There was sufficient personal protective equipment (PPE), such as gloves, aprons and masks, available to staff. We saw staff using these items and disposing of them correctly during our inspection.

We requested information about local cleaning and hand hygiene audits, but the trust did not provide us with this information.

**Environment and equipment**

At West Cumberland Hospital (WCH) the emergency department (ED) was located in a purpose-built building that had been in use since 2015. It was clean, light, and spacious. The layout of the building had been well-planned to promote optimum flow of patients into, around, and on from the department. Signage to the department from the main entrance of the hospital was poor, making it difficult for those unfamiliar with the hospital to locate the department.

The waiting-area used by patients was spacious, with sufficient seating for several patients and their accompanying family/friends. It benefited from natural light, making it a relatively pleasant environment. There was a separate, secure waiting-area designated for children and young people. It was brightly decorated, and there were toys for children to play with.

The reception station was behind transparent screens, and there was no easy way to keep conversations between the receptionist and patients standing at the screen private from other persons in the waiting area. However, the receptionist told us that, should patients ask to speak privately, she would direct them back into the entrance lobby, where she could meet them at a door to the office-area of the department, where privacy was easier to obtain. This was not ideal, as others might pass through during private conversations, but it did afford more privacy than the reception-desk area.
Consulting and treatment cubicles were generously sized. All cubicles had solid walls and solid doors to maintain privacy. The triage room had two doors and so was accessible from both the waiting-area and the department corridor. The cubicles in the 'majors' area were arranged around, and therefore visible from, the majors base station. The cubicles in the 'minors' corridor were also mostly visible from the minors base station.

However, the room in the 'minors' area which was designated for patients with mental health conditions was not fully visible from the base station. Furthermore, in order to meet the standards set out by the Psychiatric Liaison Accreditation Network (PLAN) for carrying out high-risk assessments, such rooms must be free of potential ligature points and contain nothing that could be used as a missile or weapon or for self-harm. The room failed to meet these standards: its doors did not open outwards; it contained a desk which had sharp corners; it bore multiple potential ligature points (including metal wall-fixings); it contained objects which could cause harm or be used as missiles (including oxygen tanks, chairs, and bins); and there were stocks of sheets, blankets, gloves, and aprons, which could be used to cause self-harm. We spoke with senior staff in the department about our concerns. We asked whether a risk assessment of the room had been carried out and were told that it had not. Following our inspection, the trust told us that it had undertaken significant work to improve the room: door handles and locks were ligature-proof and barricade-proof; taps had been replaced with ligature-free sensor taps; a new panic-alarm system was being added; and new, heavy, missile-proof furniture had been ordered to furnish the room.

The paediatrics area, comprising a waiting room and three cubicles, was contained within a separate, secure section of the department. One of the cubicles could be used flexibly as an adult or paediatric room during quieter times with lower staffing levels, meaning that visibility of those using it could be maintained.

The resuscitation area comprised three bays, one of which was equipped for paediatric use. The bays were spacious and well-equipped.

There was also a viewing room, and a relatives’ room, which were comfortable, had pleasant décor, and were separated from the busy areas of the department.

Finally, the department had a decontamination room, designed for isolation and treatment of chemical, biological, radiation or nuclear (CBRN) contamination. However, staff told us that the room was used to store appropriate equipment for this purpose and, should a decontamination space be needed, a tent would be erected adjacent to the building and would be used as the main facility, thus keeping the decontamination unit separate from but accessible to the rest of the department.

We found that equipment in the department had been safety-checked. Each of the items of electrical equipment that we checked bore a sticker with its most recent test date and its due date for checking; each was up-to-date. Equipment was serviced and maintained in line with manufacturers’ guidelines, as there were maintenance contracts in place. To ensure accuracy, equipment was regularly calibrated.

Resuscitation equipment was available and fit-for-purpose. The bay used for paediatric resuscitation was well-stocked with appropriate equipment and information. Checklists bore evidence of regular reviews, although we also noted that planned daily checks of the defibrillator in one of the bays had not been carried out for three days prior to our inspection. Daily checklists
were also present for oxygen and suction equipment in the treatment cubicles, but, again, these checks had not always been completed daily.

The paediatrics resuscitation trolley was checked daily and cleaned weekly.

We checked some of the stocks held in the store rooms, and found all items to be within their expiry dates.

**Assessing and responding to patient risk**

We observed the handover process from ambulance crew to emergency department (ED) staff at West Cumberland Hospital (WCH). Ambulance crew members told us that they would hand over patients to any available nurse, regardless of seniority. Handover was very fast, and minimal information about only the presenting complaint was initially given to the ED nurse; there was no discussion of past medical history or background before the patient was moved to the area the nurse judged most appropriate area for full handover and triage. There was no use of any handover communication tool forms, such as ‘situation, background, assessment, recommendation (SBAR); instead clinicians wrote information on a whiteboard.

We observed the initial assessment of patients on arrival. Patients were prioritised so that the most seriously ill patients were seen first. Those with, mainly, minor injuries who arrived at the ED reception were seen promptly by a member of reception staff to receive initial signposting. Patients under 18 years old were directed to a separate paediatric waiting room. Patients arriving by ambulance used a separate entrance and were seen promptly on arrival by ED staff without having to wait in non-treatment areas. They were cared for by sufficient numbers of hospital staff.

The department used the *Manchester Triage* system to assess the level of urgency with which a patient should be seen. Triage is an important step in the care of a patient as it is the first opportunity for a member of the clinical team (usually a nurse) to examine a patient, speak with them about their symptoms, and decide about whether they can wait to see a doctor or need to be seen urgently. The department’s electronic patient record (EPR) system showed that clinical assessment by a registered healthcare practitioner was usually within 15 minutes of the time of arrival at WCH.

A mounted ambulance handover screen displayed average handover and turnaround times. At the time of our inspection these were 11 minutes and 28 minutes respectively.

**Median time from arrival to initial assessment (emergency ambulance cases only)**

The median time from arrival to initial assessment was slightly worse than the overall England median for all months over the 12-month period from April 2017 to March 2018.

Patients at the trust waited on average 3.5 minutes longer from arrival to initial assessment than the England average. Waiting times were consistently higher over the period April 2017 to March 2018, with patients waiting on average 11 minutes from arrival to assessment.
The overall trend over the period worsened slightly from a ten-minute wait in April 2017 to 13 minutes in March 2018. Waiting times increased slightly over the winter months of December 2017 to January 2018.

**Ambulance – Time to initial assessment from April 2017 to March 2018 at North Cumbria University Hospitals NHS Trust**

(Source: NHS Digital - A&E quality indicators)

**Percentage of ambulance journeys with turnaround times of over 30 minutes**

From May 2017 to April 2018 there was a slight upward trend in the monthly percentage of ambulance journeys with turnaround times of over 30 minutes at WCH.

During this period, an average of 27% of ambulance journeys had a turnaround time of over 30 minutes. The overall trend increased from 27% in May 2017 to 30% of ambulance journeys with a turnaround time of over 30 minutes in April 2018.

Percentages increased over the winter months from December 2017 to March 2018, with the highest percentage of 38% reported in January 2018.

**Ambulance: Number of journeys with turnaround times over 30 minutes**
Ambulance: Percentage of journeys with turnaround times over 30 minutes

(Source: National Ambulance Information Group)

Number of black breaches for this trust

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. From April 2017 to March 2018 the trust reported 628 black breaches. The number of black breaches reported each month varied from 21, reported in August 2017, to 113, reported in December 2017. High numbers were reported in April 2017 (75), and during the winter months of December 2017 (113) and January 2018 (81).

(Source: Routine Provider Information Request (RPIR) - Black Breaches tab)

Number of black breaches for WCH

The department did not use a specific mental health assessment tool for patients presenting with suspected mental health issues.

Patients with allergies were given a red wristband to ensure that they were easily identifiable. Staff were required to record known patient allergies within patient records. Seventeen of the 18 sets of patient records that we looked at recorded whether the patient had been asked about allergies.

The trust’s paediatric sepsis pathway was under development; in the meantime, a regionally-recognised process was used.

The trust had an adult sepsis pathway which was in line with best practice. It had appointed two lead nurses for sepsis in 2016, and had subsequently designated a nurse as ‘sepsis champion’ within the ED. The lead nurses and champion were tasked with promoting use of the sepsis...
pathway to ensure that patients received the correct treatment in a timely manner. However, during our inspection we observed the care of a patient who arrived in the ED with suspected sepsis. The patient arrived by ambulance, and the ambulance handover clearly documented the potential sepsis concern, but the patient was not seen by a triage nurse until 29 minutes after arrival, and antibiotics were not prescribed until 107 minutes after arrival. There had also been a serious incident (SI) earlier in the year, in which there was a delay in treatment for sepsis, and the patient suffered a cardiac arrest and died later that day.

We raised this issue with senior managers at the trust. They told us that they were already aware of concerns surrounding sepsis screening and management. They provided us with meeting minutes that demonstrated sepsis being discussed at infection control meetings, patient safety meetings, and board meetings. They also provided us with evidence from sepsis clinical audits, which showed that, although the department was not meeting the 100% compliance for screening all possible sepsis cases and treating all septic patients with one hour, compliance was improving. For example, in quarter one of 2017/2018, 58% of patients who should have been screened were screened. In quarter one of 2018/2019 this had improved to 88%. Of patients with a confirmed diagnosis, in quarter one of 2017/2018, 68% had received antibiotics within an hour, in line with best practice. In quarter one of 2018/2019 this had improved to 83%.

The ED had information and equipment available for the investigation of sudden, unexpected deaths in infancy and childhood (SUDIC).

The department used the national early warning score (NEWS) for adults and the paediatric early warning score (PEWS) for children to assist in monitoring patients and identifying whether a patient’s condition was deteriorating. NEWS training was included as part of corporate induction, which was mandatory for all clinical staff. We looked at 18 sets of patient records and found that NEWS or PEWS was recorded in each of these. We also examined monthly NEWS audits for the six months prior to our inspection.

Staff told us that they were aware of the action they should take if patients deteriorated, and there was a standard process for staff to follow. However, when we looked at the results of the NEWS audits that had been carried out, we identified some areas of concern:

- 100% compliance was achieved in only three of the six months prior to our inspection, with compliance falling as low as 47% in February 2018
- The issues omitted from some of the NEWS charts audited were:
  - parameters for escalation for patients whose chronic condition means they have a NEWS score above zero
  - documenting evidence of escalating a deteriorating patient
  - recording a response to any escalation
  - recording whether there had been any intervention.

Therefore, it appeared that, although NEWS had been recorded, in some cases no action had been taken.

The trust identified 42 incidents at WCH ED as being attributable to a delay in patients’ care or treatment from July 2017 to June 2018. Ten of these incidents resulted in actual harm, with failure to properly assess and respond to risk, leading to a failure to escalate, a potential concern in such cases.
Qualified nursing staff were required to be trained in a minimum of immediate life support (ILS) or paediatric immediate life support (PILS). Training figures showed that only 66% were up-to-date with their ILS and 50% with their PILS. Medical staff were 100% up-to-date with ILS training but did not undertake PILS training.

Royal College of Emergency Medicine (RCEM) guidance states that there should be at least one member of the medical staff in the department overnight who is trained in advanced life support (ALS) and advanced paediatric life support (APLS). Information from the trust showed that only two members of medical staff were trained in ALS and only one was trained in APLS. This meant that the WCH ED could not have at least one member of medical staff trained in ALS and APLS present overnight every night. However, support could be found from among qualified nursing staff; six out of seven nurses who were required to undertake both ALS and APLS had done so.

Staff had access to 24/7 mental health liaison support for adults, and those we spoke with knew how to make an urgent referral to that service. However, staff told us that accessing Child and Adolescent Mental Health Services (CAHMS) often took a long time, and out-of-hours access was particularly difficult.

Senior staff were available in the department to support less experienced staff until at least midnight, and by telephone from then until 8am.

**Emergency Department Survey 2016**

The trust scored better than other trusts for two of the five emergency department survey questions relevant to safety. The trust scored about the same as other trusts for the remaining three questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>7.3</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>7.3</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?</td>
<td>9.8</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

*(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)*
Nurse staffing

The trust reported the following qualified nursing staff numbers as at March 2018 and April 2018 for urgent and emergency care at West Cumberland Hospital (WCH):

<table>
<thead>
<tr>
<th>Location</th>
<th>March 2018</th>
<th>April 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>32.1</td>
<td>30.3</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16)

From April 2017 to March 2018, the trust reported a vacancy rate of 8.9% for qualified nursing staff in the emergency department (ED) at WCH. This was higher than the trust target of 5.0%. A breakdown by site is shown below:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total vacancies (WTE)</th>
<th>Total number of staff establishment (WTE)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Cumberland Hospital</td>
<td>32.2</td>
<td>361.7</td>
<td>8.9%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From May 2017 to April 2018, the trust reported a turnover rate of 5.3% for qualified nursing staff in urgent and emergency care at WCH. This was lower, thus better, than the trust target of 13%.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total leavers (WTE)</th>
<th>Average number of staff establishment (WTE)</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Cumberland Hospital</td>
<td>3.6</td>
<td>68.4</td>
<td>5.3%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From May 2017 to May 2018, the trust reported a sickness rate of 2.6% for qualified nursing staff in urgent and emergency care at WCH. This was below, thus better than, the trust target of 4%.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total absence days</th>
<th>Total WTE days available</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Cumberland Hospital</td>
<td>598.6</td>
<td>22,933.6</td>
<td>2.6%</td>
</tr>
</tbody>
</table>
Bank and agency staff usage

From April 2017 to March 2018, the trust reported that 26.2% of qualified nursing shifts in urgent and emergency care were filled by bank staff at WCH.

<table>
<thead>
<tr>
<th>Site</th>
<th>Bank shifts</th>
<th>Total shifts</th>
<th>Bank shifts as a proportion of total shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Cumberland Hospital</td>
<td>140.0</td>
<td>535.0</td>
<td>26.2%</td>
</tr>
</tbody>
</table>

The trust was unable to provide comparable data for agency and shifts left unfilled, due to system restrictions.

The trust did not use an acuity tool, such as BEST assessment, to inform nurse staffing requirements for the ED. Instead, senior managers in the department told us that they used their local knowledge and clinical experience to plan staffing around expected fluctuations in attendances. However, during our inspection, they were unable to tell us exactly how many whole time equivalent (WTE) nursing staff were employed at WCH ED. They were also unable to tell us how many vacancies there were, what the establishment should be, and what actual staffing numbers were. There did not appear to be any analysis of previous attendances or consideration of growing demand and acuity of patients documented.

At the time of the inspection, the department had three registered sick children’s nurses (RSCNs) who covered the ED from 8am until 8pm every day. When there was no RSCN on duty, nurses trained to work with adults saw paediatric patients. Staff were unable to tell us what additional training those nurses had undergone to make it safe for them to treat children.

There was an overall lead for children’s care in the department, and staff told us that at least one member of staff (nursing or medical) on each shift was PILS/PLS trained.

Medical staffing

The trust reported the following medical staffing numbers as at March 2018 and April 2018 for urgent and emergency care at West Cumberland Hospital (WCH):

<table>
<thead>
<tr>
<th>Location</th>
<th>March 2018</th>
<th>April 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>12.6</td>
<td>19.7</td>
</tr>
</tbody>
</table>

Vacancy rates
From April 2017 to March 2018, the trust reported a vacancy rate of 45.3% for medical staff in the ED at WCH. This was lower, thus better, than the trust target of 20%. A breakdown by site is shown below:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total vacancies (WTE)</th>
<th>Total number of staff establishment (WTE)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Cumberland Hospital</td>
<td>-32.0</td>
<td>33.6</td>
<td>-95.1%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

From May 2017 to April 2018, the trust reported a 31.8% turnover rate for medical staff in urgent and emergency care at WCH. This was much higher than the trust target of 13%.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total leavers (WTE)</th>
<th>Average number of staff establishment (WTE)</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Cumberland Hospital</td>
<td>5.0</td>
<td>15.7</td>
<td>31.8%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**

From May 2017 to May 2018, the trust reported a sickness rate of 0.9% for medical staff in urgent and emergency care at WCH. This was lower, thus better, than the trust target of 4%.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total absence days</th>
<th>Total WTE days available</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Cumberland Hospital</td>
<td>37.0</td>
<td>4,062.6</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Bank and locum staff usage**

The trust was unable to provide this data broken down by site or core service, due to system restrictions under the previous recording method.

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

**Staffing skill mix**

As at January 2018, the proportions of consultant and junior (foundation year 1-2) staff reported to be working at the trust were higher than the England averages. This meant the proportion of middle-career doctors was lower than the England average, and so it could prove difficult to find sufficient middle-career staff to safely cover overnight shifts.
Staffing skill mix for the 27 WTE staff working in urgent and emergency care at North Cumbria University Hospitals NHS Trust.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>36%</td>
<td>30%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>12%</td>
<td>14%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>19%</td>
<td>33%</td>
</tr>
<tr>
<td>Junior*</td>
<td>33%</td>
<td>23%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Doctors staffed the department 24 hours per day, seven days a week. There was consultant cover from 7am to 11pm. This met the Royal College of Emergency Medicine (RCEM) standard of consultant cover for 16 hours each day.

RCEM guidance also states that overnight cover should be provided by staff who are, at minimum, specialist trainee level 4 (ST4). This is to ensure that senior staff are competent to cover the department, and, in particular, that they are trained in both advanced life support (ALS) and advanced paediatric life support (APLS). We found that senior overnight cover was frequently provided by doctors who had reached only specialist trainee level 3 (ST3). We spoke with senior managers about this, and they told us that they were not aware of the concern. However, doctors of all grades told us that consultants would stay in the department for as long as needed in the evenings and that they would return to the hospital if their skills or experience were needed. Consultants who did not live within 30 minutes of the department would stay on site when they were on call.

There was 24/7 on-site paediatric doctor cover; paediatric cover was provided out-of-hours by a paediatric consultant.

The trust reported to us that all medical staff were up-to-date with revalidation requirements.

Records

The trust required all members of staff in West Cumberland Hospital (WCH) emergency department (ED) to attend training in information governance, but only 94% of qualified nursing staff and 64% of medical staff had completed this training, against a trust target of 95% for both. The trust did not provide us with information about compliance rates for other ED staff members.
The trust required all members of staff in WCH ED to complete training in medical records management, but only 89% of qualified nursing staff and 55% of medical staff had completed this training, against a trust target of 95% for both. The trust did not provide us with information about compliance rates for other ED staff members.

The WCH ED used an electronic system to record patient attendances. This was on display in the nurses’ stations away from the sight of the public. This ensured that patients’ personal information was not seen by other patients/visitors in the department. Staff used both the electronic system and paper records to record patient information, which appeared in some cases to create an unnecessary duplication of effort. The document store was well-organised and secure.

The electronic record system had several mandatory fields for staff to complete, to ensure that vital information was captured. It had facilities to alert staff to the specific needs of some patients, including those living with a learning disability or mental health needs. There were also alerts about potentially violent patients and patients with previously-diagnosed conditions. The system was also able to indicate when patient observations were due, when patients had been referred for diagnostic tests, and when results had been returned. The named nurse and treating doctor were easily identifiable from the patient record.

We examined the electronic and paper records of six adult patients and 12 paediatric patients and found that each was completed comprehensively and legibly. Each of the records we looked at had been dated and timed, and national early warning scores (NEWS) scores had been recorded. There was information such as risk assessments for moving and handling patients, falls assessments, skin integrity (pressure care) assessments, nutrition and hydration assessment, and malnutrition universal screening tool (MUST) assessments. When people were prescribed an antimicrobial, they had the clinical indication, dose, and duration of treatment documented in their clinical record.

The records also contained information about safety checklists and comfort rounds (regular checks with patients to make sure they are as comfortable as possible, and to ask whether they need assistance to the toilet, require a drink or snack, or need pain relief). However, of the six adult patients’ records we examined, only one had evidence of proper completion of the patient safety checklist; the others had been started but not carried on throughout the patients’ time in the department.

Once a patient was discharged from the department, medical staff completed a discharge letter which was then sent automatically to the patient’s GP. There were checks within the system to ensure that these were sent.

**Medicines**

The department used an automated medication-dispensing system to store and manage medicines safely and securely. The storage units and fridge were within a locked room, which was accessed via swipe cards. Access to controlled drugs (CDs) and benzodiazepines required two signatures. We checked two print-outs from the system against the CD register and found that these had been processed correctly.

Some emergency medicines were also kept in a cupboard, a fridge, and a separate CD cabinet within the resuscitation room. Again, access to the room was via swipe cards, and the CD cabinet
complied with legislation. There were resuscitation trolleys at the ‘majors’ and ‘minors’ nurses’ stations. These bore tamper-proof seals and were checked daily. There was a locked room for storage of IV fluids. A further medicine cupboard in the triage room contained paracetamol and ibuprofen for nurse administration. We found that all medicines and medical gases were stored securely.

Staff told us that they checked and recorded the temperatures of the fridges in the automated medication-dispensing system and the resuscitation room each day, in line with trust policy. However, that policy did not reflect current best practice, which is to record maximum and minimum, in addition to actual, temperatures each day. Additionally, at the time of our inspection, the temperature of the main fridge had been recorded on only five out of 18 days that month, and temperature checks of the resuscitation room fridge had been omitted several times during the month preceding our inspection.

Patient group directions (PGDs), which allow some registered health professionals to give specified medicines (such as painkillers) to a predefined group of patients without those patients having to see a doctor, were used in the department. Not all eligible staff had signed to say that they understood them and were working within their guidance. Advanced care practitioners (ACPs) who were originally trained paramedics used a combination of PGDs and medicines that they were allowed to use as a paramedic until they were fully qualified as non-medical prescribers. We were not able to check PGDs to make sure all relevant staff had signed them and were deemed competent, because the person who was responsible for them was on long-term absence from the trust at the time of our inspection.

**Incidents**

The trust used an electronic system to reports incidents. The was a named nurse for incident reporting in the West Cumberland Hospital (WCH) emergency department (ED), and all incidents that were graded as moderate or above were reviewed by the divisional leads at weekly governance meetings.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death, but neither need have happened for an incident to be a never event.

From June 2017 to May 2018, the trust did not report any incidents that were classified as never events for urgent and emergency care in WCH.

*(Source: NHS Improvement - Strategic Executive Information System [StEIS])*

**Breakdown of serious incidents reported to StEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 11 serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from June 2017 to May 2018. Of these, the most common type of incident reported was treatment delay meeting SI criteria, with seven incidents (64%).
No site was allocated for one incident (treatment delay meeting SI criteria). Of the remaining 10 incidents reported, six were at West Cumberland Hospital (WCH).

(Source: NHS Improvement - STEIS (01/05/2017 - 30/04/2018)

However, according to the trust’s own records for the same period, seven of the 11 incidents reported were at WCH ED. Four of these were categorised as ‘Treatment delay meeting SI criteria’; two were ‘Diagnostic incident including delay meeting SI criteria (including failure to act on test results)’; and one was ‘Sub-optimal care of the deteriorating patient meeting SI criteria’.

The trust reported a total of 284 incidents in WCH ED from July 2017 to June 2018, at the following levels of impact: catastrophic (1); moderate harm (7); minor harm (47); no injuries (160); and near miss (69). We examined details of these incidents, and saw evidence that the duty of candour had been applied.

We looked to see if there were any common themes in the incidents reported by the trust. We found 17 incidents where sepsis or septic were mentioned, five where a stroke was mentioned, and nine where diabetes or diabetic ketoacidosis (DKA) was a factor. There had been seven incidents of sepsis where patients had come to harm. Six passed away and one went to intensive care. The trust had also done some thematic analysis and carried out investigations to identify if any changes to practice were needed. Common causes included failure to diagnose and failure to start appropriate treatment in a timely way.

Managers told us that all staff groups took responsibility for reporting incidents and were encouraged to do so. They also told us that there was a strong self-reporting culture. Staff we spoke with knew when to report an incident and how to use the electronic reporting system, and information provided by the trust showed that incidents were reported via the electronic system and reviewed by a manager. However, we found that there was a lack of meaningful subsequent action; follow-up actions noted included “reminded staff”, “informed (person’s name)”, “escalation policy followed”, or “(person’s name) aware,” and similar incidents subsequently occurred.
Furthermore, there was no evidence that systems were checked to ensure that any follow-up action had been effective. The action plans were frequently repetitions of previous plans, and we saw no evidence of any meaningful change as a result of these.

Staff we spoke with told us that they received feedback about incidents they had reported at morning huddles. Lessons learned were also disseminated via these huddles.

Senior staff from the ED attended mortality and morbidity meetings held at WCH. However, department managers told us that they would prefer these to be held more frequently than was current practice in the trust.

We spoke with staff about their responsibilities in respect of the duty of candour. Providers of healthcare services must be open and honest with service users and other ‘relevant persons’ (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information, and a written apology. Staff understood that the duty related to being open and honest. Senior staff in the department took responsibility for the formal duty of candour process. They could describe, and give examples of when they had used, the process.

**Safety thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm-free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given, but wards may change this. Data must be submitted within ten days of the suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported five new pressure ulcers, eight falls with harm, and four new urinary tract infections in patients with a catheter from April 2017 to April 2018 within urgent and emergency care.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at North Cumbria University Hospitals NHS Trust**

![Graph showing prevalence rate of pressure ulcers](image)
A total of five pressure ulcers were reported for urgent and emergency care. No pressure ulcers were reported for most months over the period April 2017 to April 2018. Numbers of pressure ulcers reported were irregular, with one in May 2017, three in July 2017, and one in January 2018. No apparent trend could be identified.

Urgent and emergency care reported eight falls in the period from April 2017 to April 2018; all were reported within the months from April to October 2017 inclusive, with three falls per month reported in both May and July, one reported in September, and one reported October 2017. Overall a trend of decline can be seen.

During the period from April 2017 to April 2018, urgent and emergency care reported four catheter-acquired urinary-tract infections (CUTIs) across the trust. Three of these were reported during the winter months of December 2017 (2) and January 2018 (1).

(Source: Safety thermometer - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

Staff in the department used a comprehensive variety of pathways and NICE guidelines, together with Royal College of Emergency Medicine (RCEM) guidance, to support them to achieve effective outcomes for patients in their care. However, there were occasions when staff did not adhere to the timings of pathways, such as the sepsis pathway.

We saw guidance which was based on NICE guidelines on the trust’s intranet. There were also links to trust-wide policies, standard operating procedures, checklists, and additional support information. This meant that staff could ensure that patients were receiving care and treatment that was informed by best practice.
New NICE guidelines were reviewed, reported on, and approved, and then training was organised where applicable to ensure staff were aware of any changes in practice.

Patient safety and medication alerts were brought to staff attention, and practice guidelines were changed in accordance with these.

**Nutrition and hydration**

**Emergency Department Survey 2016**

In the CQC Emergency Department Survey, the trust scored 7.3 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as other trusts.

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

We spoke with eight patients and their relatives about hydration and nutrition needs. All of them told us that they had not been offered a drink. We did not see any patients being offered food or drinks, but staff told us that, if patients needed to eat for medical reasons, food was available. If a patient was assessed as requiring fluid management, for example, following vomiting, diarrhoea, or dehydration, fluid balance charts were used to monitor and assess the need for additional fluids. We saw some of these charts in use.

**Pain relief**

**Emergency Department Survey 2016**

In the CQC Emergency Department Survey, the trust scored 6.2 for the question “How many minutes after you requested pain relief medication did it take before you got it? This was about the same as other trusts.

The trust scored 8.0 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

<table>
<thead>
<tr>
<th>Question – Effective</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q31. How many minutes after you requested pain relief medication did it take before you got it?</td>
<td>6.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q32. Do you think the hospital staff did everything they could to help control your pain?</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

The West Cumberland Hospital (WCH) emergency department (ED) had systems that supported staff to assess and record the level of pain that patients were experiencing, and we saw that staff had access to appropriate pain relief medicines.

We observed triage and witnessed patients being given pain relief if they needed it. We looked at 18 patient records (adults and children), and found that pain scores had been recorded in 15 of those sets of records.
Patient outcomes

Royal College of Emergency Medicine Audit: Moderate and acute severe asthma 2016/17

In the 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma report, West Cumberland Hospital (WCH) emergency department (ED) failed to meet any of the standards.

The department was not in the upper UK quartile for any standard.

The department was in the lower UK quartile for one standard:

- Standard 4 (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. This department: 40%; UK: 77%.

The department’s results for the remaining six standards were all between the upper and lower UK quartiles:

- Standard 1a (fundamental): O₂ should be given on arrival to maintain sats 94-98%. This department: 16.3%; UK: 19%.

- Standard 2a (fundamental): As per RCEM standards, vital signs should be measured and recorded on arrival at the emergency department. This department: 32.7%; UK: 26%.

- Standard 3 (fundamental): High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the emergency department. This department: 20.4%; UK: 25%.

- Standard 5: If not already given before arrival to the emergency department, steroids should be given as soon as possible as follows:
  - Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV
  - Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
  - Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV
    - Standard 5a (fundamental): within 60 minutes of arrival (acute severe). This department: 23.5%; UK: 19%.
    - Standard 5b (fundamental): within 4 hours (moderate). This department: 21.9%; UK: 28%.

- Standard 9 (fundamental): Discharged patients should have oral prednisolone prescribed as follows:
  - Adults 16 years and over: 40-50mg prednisolone for 5 days
  - Children 6-15 years: 30-40mg prednisolone for 3 days
  - Children 2-5 years: 20mg prednisolone for 3 days
    - This department: 38.4%; UK: 52%.

(Source: Royal College of Emergency Medicine)

The trust re-audited the WCH ED performance against these standards in June 2017; it found acceptable practice and low risk and made recommendations for further improvements.

RCEM Audit: Consultant sign-off 2016/17
In the 2016/17 Consultant sign-off audit, WCH ED failed to meet any of the standards. The department was in the upper UK quartile for two standards:

- **Standard 2 (developmental):** Consultant reviewed: fever in children under 1 year of age. This department: 21.4%; UK: 8%.

- **Standard 3 (fundamental):** Consultant reviewed: patients making an unscheduled return to the emergency department with the same condition within 72 hours of discharge. This department: 36.7%; UK: 12%.

The department was not in the lower UK quartile for any standard.

The department’s results for the remaining two standards were all between the upper and lower UK quartiles:

- **Standard 1 (developmental):** Consultant reviewed: atraumatic chest pain in patients aged 30 years and over. This department: 13%; UK: 11%.

- **Standard 4 (developmental):** Consultant reviewed: abdominal pain in patients aged 70 years and over. This department: 14.1%; UK: 10%.

(Source: Royal College of Emergency Medicine)

**RCEM Audit: Severe sepsis and septic shock 2016/17**

In the 2016/17 severe sepsis and septic shock audit, WCH ED was in the upper UK quartile for two standards:

- **Standard 3:** O\textsubscript{2} was initiated to maintain SaO\textsubscript{2}>94% (unless there is a documented reason not to) within one hour of arrival. This department: 68.2%; UK: 30.4%.

- **Standard 8:** Urine output measurement/fluid balance chart instituted within four hours of arrival. This department: 54.7%; UK: 18.4%.

The department was not in the lower UK quartile for any standard.

The department’s results for the remaining six standards were all between the upper and lower UK quartiles.

- **Standard 1:** Respiratory rate, oxygen saturations (SaO\textsubscript{2}), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. This department: 70%; UK: 69.1%.

- **Standard 2:** Review by a senior (ST4+ or equivalent) emergency department medic or involvement of critical care medic (including the outreach team or equivalent) before leaving the emergency department. This department: 62%; UK: 64.6%.

- **Standard 4:** Serum lactate measured within one hour of arrival. This department: 58%; UK: 60%.

- **Standard 5:** Blood cultures obtained within one hour of arrival. This department: 53%; UK:
44.9%.

- Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. This department: 49%; UK: 43.2%.

- Standard 7: Antibiotics administered: Within one hour of arrival. This department: 46%; UK: 44.4%.

(Source: Royal College of Emergency Medicine)

The trust re-audited the WCH ED performance against these standards in January 2017; it found good and acceptable practice and low risk, and made recommendations for further improvements.

RCEM Audit: Vital signs in children 2015/16

In the 2015/16 Vital signs in children audit, WCH met one of the developmental standards:

- Standard 5 (developmental). Children with any recorded persistently abnormal vital signs who are subsequently discharged home should have documented evidence of review by a senior doctor (ST4 or above in emergency medicine or paediatrics, or equivalent non-training grade doctor).

The sample size however for this metric was very small, only two cases, and results must be interpreted within this context.

The department was in the upper England quartile for none of the fundamental standards.

The department was in the lower England quartile for one fundamental standard:

- Standard 4 (fundamental). There should be documented evidence that the abnormal vital signs (if present) were acted upon in all cases. This department: 46.3%; England: 73.2%.

The department was in the lower England quartile for two developmental standards:

- Standard 1. All children attending the emergency department with a medical illness should have a set of vital signs recorded in the notes within 15 minutes of arrival or triage, whichever is the earliest. This department: 86.5%; England: 88.9%.
  - Standard 1a (fundamental). Temperature, respiratory rate, heart rate, oxygen saturation, GCS or AVPU scores. This department: 29%; England: 37.6%.

  Standard 1b (developmental). Capillary refill time. This department: 8%; England: 22.5%.

- Standard 3 (developmental). There should be explicit evidence in the emergency department record that the clinician recognised the abnormal vital signs (if present). This department: 69.7%; England: 76.2%.

The department’s results for the remaining two standards were all between the upper and lower England quartiles.

- Standard 1. All children attending the emergency department with a medical illness should have a set of vital signs recorded in the notes within 15 minutes of arrival or triage, whichever is the earliest. This department: 86.5%; England: 88.9%.
  - Standard 1a (fundamental). Temperature, respiratory rate, heart rate, oxygen saturation, GCS or AVPU scores. This department: 29%; England: 37.6%.

20171116 900885 Post-inspection Evidence appendix template v3
• Standard 2 (developmental). Children with any recorded abnormal vital signs should have a further complete set of vital signs recorded in the notes within 60 minutes of the first set. This department: 4.9%; England: 4.4%.

(Source: Royal College of Emergency Medicine)

The trust re-audited the WCH ED performance against these standards in August 2016; it found that practice required improvement, although two standards were met, and made recommendations for further improvements. One of the recommendations was that the trust re-audit performance again in October 2016, following implementation of the others, to assess improvement. However, we could find no evidence that these recommendations had been acted upon, nor that the further re-audit had been carried out.

RCEM Audit: Procedural sedation in adults 2015/16

In the 2015/16 Procedural sedation in adults’ audit, WCH failed to meet any of the audit standards (which were all 100%).

The department was in the upper England quartile for none of the fundamental standards.

The department was in the upper England quartile for two developmental standards:
• Standard 2 (developmental): There should be documented evidence of the patient’s informed consent unless lack of mental capacity has been recorded. This department: 94.0%; England: 51.8%.

• Standard 6 (developmental): Oxygen should be given from the start of sedative administration until the patient is ready for discharge from the recovery area. This department: 94.0%; England: 41.0%.

The department was in the lower England quartile for three fundamental standards and no developmental standards:
• Standard 1 (fundamental): Patients undergoing procedural sedation in the emergency department should have documented evidence of pre-procedural assessment, including:
  o Standard 1a. ASA grading
  o Standard 1b. Prediction of difficulty in airway management
  o Standard 1c. Pre-procedural fasting status

  This department: 0%; England: 7.6%.

• Standard 3 (fundamental): Procedural sedation should be undertaken in a resuscitation room or one with dedicated resuscitation facilities. This department: 70.0%; England: 90.0%.

• Standard 5 (fundamental): Monitoring during procedural sedation must be documented to have included all of the below:
  o Standard 5a. Non-invasive blood pressure
  o Standard 5b. Pulse oximetry
  o Standard 5c. Capnography
o Standard 5d. ECG

This department: 0%; England: 23.9%.

The department’s results for the remaining two standards were between the upper and lower England quartiles:

• Standard 4 (fundamental): Procedural sedation requires the presence of all of the below:
  o Standard 4a. A doctor as seditionist
  o Standard 4b. A second doctor, ENP or ANP as procedurist
  o Standard 4c. A nurse

  This department: 36.0%; England: 40.8%.

• Standard 7 (fundamental): Following procedural sedation, patients should only be discharged after documented formal assessment of suitability, including all of the below:
  o Standard 7a. (Fundamental): Return to baseline level of consciousness.
  o Standard 7b. (Fundamental): Vital signs within normal limits for the patient.
  o Standard 7c. (Fundamental): Absence of respiratory compromise.
  o Standard 7d. (Fundamental): Absence of significant pain and discomfort.
  o Standard 7e. (Developmental): Written advice on discharge for all patients.

  This department: 3.2%; England: 2.6%.

(Source: Royal College of Emergency Medicine)

The trust re-audited the WCH ED performance against these standards in July 2016; it found acceptable practice and moderate risk and made recommendations for further improvements.

RCEM Audit: Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast 2015/16

The trust did not take part in this audit.

(Source: Royal College of Emergency Medicine)

We asked the trust for information about changes made to practice as a result of the RCEM audits and the trust’s re-audit results. We were provided with action plans in respect of sepsis and vital signs.

The trust had set up a sepsis group, which was a multi-agency group that fed into the trust’s infection prevention committee (IPC) and had NEWS within its remit. Its terms of reference were due to be updated and agreed at the IPC shortly after our inspection. Two ‘sepsis lead’ nurses had been employed, and the ED had a sepsis champion.

We saw that staff had access to a sepsis screening tool and a pathway to support them in identifying and managing patients with sepsis. Information about sepsis was readily available to staff via the electronic patient record. However, the trust’s sepsis policy for children was still being developed at the time of our inspection.

The trust had a commissioning for quality and innovation (CQUIN) target for 2017/2018 related to sepsis. In WCH the ED did not fully meet the target (100%) for identifying patients at risk of sepsis...
or the target (100%) for administering antibiotics to septic patients within one hour. It also failed to meet either target in the first quarter of 2018/19. However, performance against both targets improved from 58% and 68% respectively in quarter 1 of 2017/18 to 88% and 83% respectively in quarter 1 of 2018/19.

Staff told us that they had specified treatment plans for regular attenders to the department, particularly those with mental health diagnoses, to support them in achieving the best outcomes for those patients.

**Unplanned re-attendance rate within seven days**

From April 2017 and March 2018, the trust’s unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% and mostly slightly worse than the England average; Unplanned re-attendances were on average less than 0.5% worse than the England average.

**Unplanned re-attendance rate within seven days - North Cumbria University Hospitals NHS Trust**

(Source: NHS Digital - A&E quality)

**Competent staff**

The trust allocated a mentor to each newly-registered member of staff who joined the department as part of their preceptorship. All staff joining the department for the first time also received an induction, which included checking of competencies. Staff told us that they found this induction useful because there were items of equipment that they would otherwise have been unfamiliar with.

The department carried out teaching sessions for nurses and doctors, during which specific topics such as equipment, medical conditions, and treatments were discussed. This ensured that staff from both disciplines were up-to-date with new developments and techniques. Senior staff told us that informal monitoring of staff was undertaken within the department and any concerns were
addressed quickly with the staff involved. Junior medical staff told us that the support and mentorship that they received from senior doctors was excellent.

The department also carried out simulation training for staff to ensure that they could work confidently in previously-unknown scenarios. This included training in Chemical, Biological, Radiological, and Nuclear (CBRN) scenarios, during which staff practised erecting a decontamination tent and wearing outfits to protect them from hazardous materials.

**Appraisal rates**

From April 2017 to March 2018, 97.6% of required staff within the emergency department (ED) at West Cumberland Hospital (WCH) received an appraisal, compared to the trust target of 95% for nursing staff and 90% or higher for medical staff. The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required</th>
<th>Appraisals complete</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>72.0</td>
<td>70.0</td>
<td>97.2%</td>
</tr>
<tr>
<td>Medical &amp; dental staff</td>
<td>13.0</td>
<td>12.0</td>
<td>92.3%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>85.0</strong></td>
<td><strong>83.0</strong></td>
<td><strong>97.6%</strong></td>
</tr>
</tbody>
</table>

Nursing staff met the 95% target with an appraisal rate of 97.2%, and medical staff met the trust target of 90% with a completion rate of 92.3%, which relates to only one member of staff not having an appraisal.

*(Source: Routine Provider Information Request (RPIR) - Appraisal tab)*

**Multidisciplinary working**

The West Cumberland Hospital (WCH) emergency department (ED) operated 24/7, and staff we spoke with reported no concern about response times for diagnostic or pathology results that had been ordered.

Staff in the department confirmed that they had 24/7 access to diagnostic services such as x-rays and computerised tomography (CT), which was available within an hour from the dedicated radiology suite.

Pathology support, such as blood testing was available 24/7, and staff reported no issues with the accessibility of the service or its response time, which we were told was usually within an hour. Staff in the department were also able to carry out their own point-of-care testing for some blood tests.

The department worked closely with the frailty team to support patients who had additional health and social care needs. They could arrange access to equipment such as walking aids and could organise short-term social care for patients. This meant that patients who were medically well enough to go home were supported to do so.
The trust worked closely with local care providers such as community health teams to provide a 24/7 team that could support patients in their own homes and prevent admission and reattendance at the department.

**Health promotion**

Staff told us that they offered health promotion advice to patients about smoking cessation, weight management, and healthier lifestyles, in addition to specific advice about the patient’s condition.

There were some posters on display in the department advising patients about support services, including for those living with drug/alcohol addiction. Staff could refer patients to support services for additional help or support.

Staff were aware of safeguarding, domestic violence, and sexual exploitation and could access appropriate support for patients who may be at risk.

The frailty team could identify patients who may need extra support to ensure a safe and effective discharge. This team worked closely with outside agencies to ensure that patients leaving the department were looked after, so promoting better health amongst those vulnerable patients who had visited the department.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust reported that, as at March 2018, Mental Capacity Act (MCA) training had been completed by 92% of medical and nursing staff in WCH urgent and emergency care, compared to the trust target of 95%. Nursing staff had a completion rate of 96%. A breakdown per staff group is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental staff</td>
<td>22</td>
<td>16</td>
<td>73%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>85</td>
<td>82</td>
<td>96%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>107</strong></td>
<td><strong>98</strong></td>
<td><strong>92%</strong></td>
<td><strong>95%</strong></td>
<td><strong>No</strong></td>
<td></td>
</tr>
</tbody>
</table>

Note: The above figures include mental capacity Level 1 and level 2 training, although only Level 1 was mandatory.

Over the same period, Deprivation of Liberty Safeguards training was completed by 75% of medical and nursing staff within WCH urgent and emergency care, compared to the trust target of 95%. Nursing staff had a training completion rate of 92%, which relates to only one staff member not having completed the training. A breakdown per staff group is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental staff</td>
<td>11</td>
<td>6</td>
<td>55%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>
Staff we spoke with were aware of the MCA and the Mental Health Act (MHA). They appeared to have a good understanding of what the MCA was and what it was used for. However, their understanding of the MHA was very limited, and they relied heavily on staff from the associated mental health trust if they felt patients might have mental health problems.

Staff were capable of carrying out mental capacity assessments and understood that decisions relating to capacity were decision-specific and time-specific. However, capacity assessments were usually left to doctors as most of nursing staff thought that they were not allowed to complete assessments.

Is the service caring?

Compassionate care

Friends and Family test performance

The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was better than the England average for seven months and worse than the England average for five months from April 2017 to March 2018.

Recommendation rates over the period followed a decreasing trend. From April to July 2017 rates were consistently better than the England average. Rates from August to December 2017 varied from 2% below average in August to 6.7% above average in November and 5.2 above average in December 2017. Rates fell to below the England average from January to March 2018.

A&E Friends and Family Test performance - North Cumbria University Hospitals NHS Trust

(Source: NHS England Friends and Family Test)
Staff in the emergency department (ED) at West Cumberland Hospital (WCH) respected people’s dignity, for example, by ensuring that cubicle doors and curtains were closed when care and treatment was being given. Patients described to us how staff treated them with respect and our observations corroborated this.

When we discussed care of patients with staff, there was a consistent message that staff wanted the patients to feel safe and cared for. Staff were working very hard and were dedicated to looking after patients throughout their ED journey.

In the patient-led assessment of the care environment (PLACE) survey undertaken in April 2017, WCH scored 81.7% for privacy, dignity and wellbeing against a national average of 83.7%. There were no figures specifically for the ED at WCH.

During our time in the department, we saw patients being treated with dignity and respect. Staff were conscious of the cultural needs of patients and made sure these were respected whilst planning and delivering care. When patients expressed preferences for a male/female nurse or doctor, staff tried to accommodate their preferences whenever possible.

Staff took time to deliver care that was compassionate, and we saw patients being treated with patience and kindness by members of staff at all levels.

Reception staff told us that, because it was difficult to keep conversations with patients standing at the reception desk screen private from other persons in the waiting area, should patients ask to speak privately, they would be met at a door to the office-area of the department, where privacy was easier to obtain. Although this was not ideal, staff took care to afford patients as much privacy as they could.

**Emotional support**

We observed staff talking with patients and relatives and offering reassurance to them. They offered support and gave information about additional support services available if this was required.

Pastoral support was available for patients of any/no religious belief.

**Understanding and involvement of patients and those close to them**

**Emergency Department Survey 2016**

The trust scored about the same as other trusts for all 24 questions in the emergency department (ED) survey questions relevant to the caring domain.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.9</td>
<td>About the same as</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------</td>
<td>----------------------------------------------</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>explain your condition and treatment in a way you could understand?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>did a doctor or nurse discuss them with you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>examine and treating you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you</td>
<td>9.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>weren't there?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q18. If you’re family or someone else close to you wanted to talk to a</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>doctor, did they have enough opportunity to do so?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>about your condition or treatment was given to you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>medical or nursing staff to help you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and</td>
<td>9.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>another will say something quite different. Did this happen to you in</td>
<td></td>
<td></td>
</tr>
<tr>
<td>the emergency department?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>your care and treatment?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency</td>
<td>7.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>department, did a member of staff help to reassure you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>you could understand?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>of your tests?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>way you could understand?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the</td>
<td>9.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
During our inspection we saw patients being given information and support to help them make decisions about their treatment. Parents of paediatric patients told us that staff involved both them and their children in discussions about treatment options. We saw that staff took time to reassure patients and explain to them why they may need to wait and/or what the next stage of their treatment or care would be.

Staff made sure that information that they shared was understood by patients and their families, avoiding complicated medical terminology. They gave patients and families opportunities to ask questions and time to think before making any decisions. Patients and relatives told us that they had no concerns about how information was presented to them.

Overall, patients told us that staff responded compassionately when people needed help, and helped patients and those close to them to cope emotionally with their care and treatment.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

**Emergency Department Survey 2016**

The trust scored “about the same” as other trusts for the three emergency department survey questions relevant to the responsive domain.
| Q7. Were you given enough privacy when discussing your condition with the receptionist? | 7.2 | About the same as other trusts |
| Q11. Overall, how long did your visit to the emergency department last? | 7.7 | About the same as other trusts |
| Q20. Were you given enough privacy when being examined or treated? | 9.4 | About the same as other trusts |

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

The emergency department (ED) at West Cumberland Hospital (WCH) was located in a purpose-built building that had been in use since 2015. It was clean, light, and spacious. The layout of the building had been well-planned to promote optimum flow of patients into, around, and on from the department. However, signage to the department from the main entrance of the hospital was poor, making it difficult for those unfamiliar with the hospital to locate the department.

The main waiting-area used by patients was spacious and could easily accommodate wheelchairs and mobility aids. There were accessible toilets adjacent to the waiting room. The children’s waiting area was also spacious and able to accommodate wheelchairs/pushchairs.

There was equipment, including chairs, wheelchairs, and trolleys, available for use by bariatric patients. Specialist bariatric equipment such as hospital beds were stored as part of the trust’s equipment library and could be requested when needed.

Chaplaincy services were available to all patients and relatives.

**Meeting people’s individual needs**

The trust used a telephone interpreting service for people whose first language was not English. Staff we spoke with knew how to access the service. The department also had access to sign language interpreters.

Leaflets associated with several patient pathways were available. Those we saw were in English. When we asked staff whether they were available in other languages or formats such as large print or Braille, we got a mixed response; some staff were aware of the process to access alternative formats and others were not.

The ED had a private relatives’ room and a viewing room. These were somewhat separate from the main areas of activity, and so afforded a quiet and comfortable space for those who were bereaved.

We spoke to staff about patients who were living with dementia or learning disabilities, and they told us that they would treat patients as individuals and would try to involve family and carers in discussions about care needs. Dementia training was a mandatory training module, which 92% of nursing staff and 64% of medical staff had completed, against a trust target of 95%. Some patients with learning disabilities had patient passports. When the patient or carer presented this at the department, staff used the information to assist in making decisions about patient care. However, staff working in triage areas were not using any additional or separate, specialist triaging tools or observation tools for people with complex needs, learning disabilities, or dementia.
Staff in the department had access to psychiatric liaison support and child and adolescent mental health services (CAHMS), and they told us that they would refer any patient who presented with a mental health condition to one of these teams. Psychiatry cover for the ED ended at 8pm each night, meaning that people who were thought to have mental health conditions were often left for long periods of time before being seen by an appropriate doctor or referred to the appropriate service. Staff told us that during the day patients may wait for two or three hours, but after 8pm they would often wait for over eight hours. Young people needing support from CAMHS often waited a long time to be seen, no matter what the time of day.

Patients could access addiction services, and there was an alcohol withdrawal pathway in place.

The ED had allocated a team to carry out holistic assessments of frail and/or elderly patients and their physical, mental, and social needs, so that they could be discharged safely when ready.

**Access and flow**

**Median time from arrival to treatment (all patients)**

The Royal College of Emergency Medicine (RCEM) recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust met this standard for all months over the 12-month period from April 2017 to March 2018. During this period performance against the standard followed an even trend, with only small monthly variances.

Trust performance was consistently much better than the England median, with patients waiting from 44 to 50 minutes less than the England median. However, senior managers told us that it was not always possible to measure this time accurately, as medical staff did not always write the time that they saw a patient on the paper copy of the patient record form. This meant that the data later input to the Electronic Patient Record (EPR) system could not necessarily be relied upon. This concern had already been raised during our 2016 inspection, and the trust had set up a user group for the EPR system in response to this concern, so that key staff could learn the proper procedure and then cascade their knowledge to colleagues. The trust had also planned to audit the EPR and paper record systems monthly, but had not begun to do so until June 2018.

The department used a floor coordinator to help with flow.

Staff told us that patient did not usually wait too long to be seen by specialist staff from other disciplines and departments, such as surgeons. The department had some pathways in place, such as a fractured neck of femur pathway, which meant that patients could be transferred to the appropriate ward quickly once a bed became available. Staff also told us that the department had good links with the intensive care unit, and anaesthetists and intensivists would come to the ED if required.
Median time from arrival to treatment from April 2017 to March 2018 at North Cumbria University Hospitals NHS Trust

(Source: NHS Digital - A&E quality indicators)

Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department. From April 2017 to March 2018 the trust failed to meet the standard but performed mostly better than the England average.

From April 2017 to March 2018 performance against this metric followed a deteriorating trend. Rates were consistently better than the England average and followed an even trend from May to November 2017, although rates deteriorated from December 2017 to below the England average in January 2018. Although performance improved in February 2018, rates decreased again in March 2018.

Four-hour target performance - North Cumbria University Hospitals NHS Trust

(Source: NHS England - A&E waiting times)

Percentage of patients waiting more than four hours from the decision to admit until being admitted

From April 2017 to March 2018 the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was mostly better than the England average.
From April 2017 to March 2018 performance against this metric followed a deteriorating trend, with an increase in percentages during the winter months of December 2017 and January 2018. Rates improved to below the England average in February 2018, although percentages increased again in March 2018.

**Percentage of patients waiting more than four hours from the decision to admit until being admitted - North Cumbria University Hospitals NHS Trust**


**Number of patients waiting more than 12 hours from the decision to admit until being admitted**

Over the 12 months from April 2017 to March 2018, two patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours was in January 2018 (2); no patients waited longer than 12 hours to be admitted for the remaining 11 months in the period.

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients waiting more than four hours to admission</th>
<th>Number of patients waiting more than 12 hours to admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-17</td>
<td>189</td>
<td>0</td>
</tr>
<tr>
<td>May-17</td>
<td>223</td>
<td>0</td>
</tr>
<tr>
<td>Jun-17</td>
<td>124</td>
<td>0</td>
</tr>
<tr>
<td>Jul-17</td>
<td>106</td>
<td>0</td>
</tr>
<tr>
<td>Aug-17</td>
<td>168</td>
<td>0</td>
</tr>
<tr>
<td>Sep-17</td>
<td>204</td>
<td>0</td>
</tr>
<tr>
<td>Oct-17</td>
<td>198</td>
<td>0</td>
</tr>
<tr>
<td>Nov-17</td>
<td>215</td>
<td>0</td>
</tr>
<tr>
<td>Dec-17</td>
<td>406</td>
<td>0</td>
</tr>
<tr>
<td>Jan-18</td>
<td>571</td>
<td>2</td>
</tr>
<tr>
<td>Feb-18</td>
<td>303</td>
<td>0</td>
</tr>
<tr>
<td>Mar-18</td>
<td>527</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: NHS England - A&E waiting times)
Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment

From April 2017 to March 2018 the monthly median percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was slightly better than the England average. Performance against this metric followed a stable trend with small variances month on month. Trust performance was on average only 0.5% better than the England average over the period.

Percentage of patient that left the trust’s urgent and emergency care services without being seen - North Cumbria University Hospitals NHS Trust

(Source: NHS Digital - A&E quality indicators)

Median total time in A&E per patient (all patients)

From April 2017 to March 2018 the trust’s monthly median total time in A&E for all patients was lower than the England average. The performance against this metric showed a slight increase in trend over this period.

The longest median time spend in A&E at the trust were reported during the winter months of December 2017 and January 2018.
Learning from complaints and concerns

Summary of complaints

From April 2017 to March 2018 there were 12 complaints about urgent and emergency care services at West Cumberland Hospital (WCH). Of the 12 complaints received, one was re-opened and re-closed within 30 days. Two complaints (17%) were upheld, four (33%) were partially upheld, five were (42%) were refuted and one (8%) complaint was transferred to serious incidents.

Most complaints were about medical staff (67%) while 33% of complaints were about nursing staff. Themes from the 12 complaints are shown in the table below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment/care - inpatient</td>
<td>5</td>
<td>42%</td>
</tr>
<tr>
<td>Treatment/care - outpatient</td>
<td>4</td>
<td>33%</td>
</tr>
<tr>
<td>Information &amp; communication</td>
<td>2</td>
<td>17%</td>
</tr>
<tr>
<td>Attitude of staff</td>
<td>1</td>
<td>8%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

The trust was unable to provide data broken down per core service.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)
Is the service well-led?

**Leadership**

The West Cumberland Hospital (WCH) emergency department (ED) was overseen by a chief matron, a general manager, and an associate medical director (AMD). The AMD was covering this work, which was usually done by a clinical director (CD), as, at the time of our inspection, the trust was in the process of recruiting to the WCH CD post. Shortly after our inspection, the trust told us that a new CD who had lots of ideas about new ways of working had been appointed. This team also oversaw the trust’s other ED, at Cumberland Infirmary in Carlisle. The senior team members told us that they were very proud of the resilience of the ED staff across the trust, although they were unable to tell us the exact number of staff working in the department.

Staff we spoke with in the ED gave a mixed response when asked about the visibility of the senior leadership team (SLT), with some describing them as very visible, and others saying that they were mostly absent from WCH ED and focused on other parts of the trust. The business manager, chief matron, and previous CD (now an emergency medical consultant) were all present in the department during our inspection, and interacted with other staff, who clearly knew them.

The adult ED and paediatric ED both had a senior nurse lead who oversaw the daily management and requirements of the department. We met these staff and found they were clearly focused on the challenges of the department in respect of performance, demand, staffing, and risks. They led a cohesive team committed to the ED and its staff.

Nursing staff we spoke with during the inspection told us that they felt well-led at a local level and had no concerns about their line management. They told us that the local management team was approachable and supportive.

Similarly, medical staff told us that their local leadership was supportive, inclusive, and provided good direction within the department and strong representation for the department within the trust. There was a lead consultant in the ED; a role which rotated six-monthly. Junior doctors were supported by their senior colleagues, mentors and education supervisors.

We reviewed minutes from the emergency medicine operational board (EMOB) meetings, which covered strategic, operational, divisional, and business-unit items. The meeting chair updated action plans following the meeting, and these plans were revisited as a standing agenda item at subsequent meetings. We saw that sepsis pathways and delays in treatment for stroke patients were discussed.

**Vision and strategy**

The trust had developed clear objectives and aims for 2018/19 in its *This Is Us: Aims for the future* document, which focused on four areas of priority for the year: staff; system working; service quality; and sustainable finances. The trust’s website displayed its vision, mission, and values.

An emergency medicine and acute medicine strategy group had been formed. We saw minutes from these meetings, which included a draft of “Eight high impact system changes to improve medical patient safety”.
The senior management team in West Cumberland Hospital (WCH) emergency department (ED) told us that there was no formal ED vision/strategy at the time of our inspection, but that the vision for the service would be prepared jointly with its trust partner following merger, although there is no ED within the partner trust. This suggested that the team might be uncertain about the future strategy and direction of the EDs within the trust.

Managers in the ED were aware of the changing and increasing demands on the department and the types of issue that patients accessing the department were presenting with.

**Culture**

In the emergency department (ED) at West Cumberland Hospital (WCH), staff we spoke with were passionate about the quality of care that they delivered. They were proud of the department, and described their commitment to deliver the best possible care.

Some staff expressed concerns about medical staffing levels, but they were aware of some the innovative plans that managers had for recruitment. They recognised that this was a difficult issue, and were aware of progress being made where possible to fill vacancies.

The NHS staff survey outcomes for 2017 showed a 54.4% return rate for the trust and reflected some of the feelings expressed by staff. The survey was made up of 88 questions separated into five themes. We found that, compared with 2016, 13 out of 88 questions showed outcomes that were significantly better, 72 showed no change, and three were significantly worse.

Compared with other acute trusts the percentage of staff reporting that they had had an appraisal was very good. However, the percentages of staff reporting that they were: working extra hours; experiencing harassment, bullying, or abuse from patients, relatives or the public in last 12 months; having good-quality appraisals; getting support from immediate managers; and experiencing good communication between senior management and staff were all poor when compared with the survey results of other acute trusts.

Staff told us that they felt able to suggest new ways of working and to try new things to improve patient experience or the efficiency of the department.

Health care assistants, junior doctors, and nurses told us that senior clinicians were keen to educate colleagues. They thought the learning culture was good, and said that they were comfortable asking questions to broaden their knowledge.

We saw positive examples of professional communication between staff members from different disciplines.

Staff we spoke with told us that they were able to report concerns and incidents without fear of reprisals and were confident that, should they raise issues, these would be dealt with appropriately.

If staff made errors they were able to report them and were confident they would be supported and managed fairly. Managers told us there was a strong culture of self-reporting within the department.
Staff felt that their hard work was recognised and they felt appreciated by their colleagues.

Access to the department was restricted, and entry could be gained only by use of a swipe card or by another member of staff. The department could be locked down easily in an emergency situation.

**Governance**

The senior management team for the trust’s emergency departments (EDs) told us that divisional management meetings, operational team meetings, and clinical governance meetings took place each month. The risk register, incidents, complaints, and lessons learned were discussed. Matrons and ward managers disseminated information to ward staff through ward meetings, communication books, and notices on staff boards. We reviewed monthly divisional governance and safety and quality board meeting minutes for January and February 2018, which corroborated this.

We also reviewed minutes from the emergency medicine operational board (EMOB) meetings. These covered strategic, operational, divisional, and business-unit items. The meeting chair updated action plans following the meeting, and these plans were revisited as a standing agenda item at subsequent meetings. We saw that sepsis pathways and delays in treatment for stroke patients were discussed.

We found that there appeared to be some disconnect between senior management focus and that of the front-line staff working in the department; we were concerned that senior management were not fully-sighted on the challenges faced by front-line staff and that governance processes did not always address the issues that these staff were dealing with. Clinical audit reporting arrangements were designed to flow from the monthly dashboard, via the emergency medicine operational board (EMOB), and the safety and quality committee, to the trust board. However, for example, several the Royal College of Emergency Medicine (RCEM) audits carried out in the department showed poor results, with lack of robust action planning or timely re-audit.

We were also concerned about the governance of medicines, in respect of Patient Group Directions (PGDs), which was acknowledged in the trust’s medicines optimisation strategy for 2014 to 2019. The strategy outlined seven strategic challenges the trust must overcome to ensure delivery of safe and effective use of medicines, and described some early signs of improvement. Our observations of practice in respect of medicines highlighted that some further work was needed.

Nonetheless, senior staff were motivated and enthusiastic about their roles. Ward managers, senior managers, and clinical leads demonstrated knowledge, skills, and experience. Staff at all levels understood their level of accountability and responsibility.

The trust had appointed two ‘sepsis lead’ nurses in 2016, and the WCH ED had a named ‘sepsis champion’ nurse.

**Management of risk, issues and performance**

We examined the emergency department (ED) risk register. Senior managers confirmed that the risk register was a live document which was subject to ongoing review. They described their main
areas of concern at West Cumberland Hospital (WCH) as sepsis screening and management, meeting the four-hour standard, flow into and from the department, and medical staffing. The risk register cited flow, overcrowding, meeting the four-hour standard, corridor-waits, accessibility of CAHMS, and triage time and quality as the major risks for ED trust-wide, and medical staffing as an additional risk specific to WCH ED. These were the issues that staff we spoke with in the department also felt were of greatest concern.

However, there were other issues, including lack of risk assessment of the mental health assessment room, proper use of the electronic patient reporting (EPR) system, black breaches, management of sepsis, and suboptimal completion of patient records, which we identified as areas of concern during our inspection, but were not on the risk register at all.

**Information management**

The trust’s policies and clinical guidelines were available on the trust intranet. Information governance policies and procedures were designed to ensure that information was stored securely and protected patients’ privacy and security.

Information governance training was mandatory, and the trust set a target of 95% for completion of this training. In the emergency department (ED) at West Cumberland Hospital (WCH) 94% of qualified nursing staff and 64% of medical staff had completed information governance training in 2017/18.

The ED collected information used to monitor and manage its performance against local and national indicators. These were closely observed by the management team. We carried out checks to make sure that information recorded reflected actual activity accurately and found that it did.

The department used a number of IT systems to collect and share information such as test and x-ray results, admission and discharge times, and ambulance handover times as well as patient records.

Staff could access patient information using an electronic system. This included information such as previous clinic letters, test results, and x-rays. Staff could also access patients’ GP records with the agreement of the patient. This meant that staff had information about the most up-to-date information about patients’ health conditions, symptoms, and prescribed medicines to enable them to make the best possible diagnoses and treatment plans. However, in some cases the electronic information was repeated separately in paper record form. This appeared to be an unnecessary duplication of effort, and to increase the risk of errors when transferring data from one format to the other.

Some information such as test results and discharge letters were shared with GPs with the consent of patients.

Patients transferred to other services or sites took photocopies of their medical records with them. Staff were aware of their responsibilities in relation to data protection and making sure that information was accurate and managed securely.
Information governance including data protection and confidentiality was monitored, and any incidents were reported appropriately.

**Engagement**

Patients and those close to them could provide feedback on the West Cumberland Hospital (WCH) emergency department (ED) via the friends and family test (FFT) and the ‘two minutes of your time’ survey. They could also leave feedback on comments cards. Staff told us that they promoted these methods of feedback to patients where possible. Information about giving feedback, including via PALS, was also displayed in the waiting areas, provided in leaflets, and available on the trust website.

Information about local and national charities and support groups was also on display. To collect staff feedback, the trust chief executive had held roadshows, and the senior leadership team had arranged staff forums and drop-in sessions. Staff we spoke with were aware of these sessions but told us it was often difficult to find time away from the ED to attend.

Staff were provided with information updates from senior managers via the trust intranet, email, and team meetings.

The FFT found that 57 out of 251 staff responding recommended the trust as a place to work.

**Learning, continuous improvement and innovation**

The trust had used some innovative initiatives to attract new staff to the emergency department (ED), including creating consultant posts with time on the local air ambulance. This had led to two new consultants moving to the trust (one to West Cumberland Hospital [WCH]). The trust’s Advanced Care Practitioner (ACP) programme had also been key to ensuring safe staffing levels within the ED, and had proved popular with internal staff wanting to move into the programme.

The trust had employed two sepsis lead nurses to support staff and ensure sepsis management was high on the agenda of staff. It had also employed a clinical educator within the ED. This post was held by a band 7 nurse who spent two thirds of her time in this role and one third as an ED nurse in charge. This was a developing role, intended to provide one-to-one teaching within the department for junior staff, and to faceplate monthly training groups, with a focus on improving quality of care.

We saw evidence that the department undertook work as a result of incidents to support staff learning. However, systems and processes for learning were not always robust, as evidenced by, for example, ongoing issues with compliance with agreed sepsis pathways and continuing concerns about the proper use of the electronic patient record system.

The trust did not provide us with any examples of ED involvement in continuous improvement.
Medical care (including older people’s care)

Facts and data about this service

The medical care service at North Cumbria University Hospitals NHS Trust provides care and treatment for:

- Care of the elderly (including a frailty assessment unit at Cumberland Infirmary Hospital)
- Stroke services including thrombolysis
- Neuro rehabilitation (Cumberland Infirmary Hospital only)
- Gastroenterology (including endoscopy)
- Renal (including renal dialysis unit)
- Cardiology and Coronary Care Unit (CCU) (Including the Heart Centre and Catheterization Laboratory (Cath Lab) at Cumberland Infirmary hospital)
- Respiratory care
- Oncology

(Source: Routine Provider Information Request (Acute) context)

The division of medicine also includes divisions of emergency care (including emergency department, cardiology and acute medicine).

There are 335 medical inpatient beds located across 19 wards trust wide. Cumberland Infirmary is the largest site with 224 inpatient beds. West Cumberland Hospital (WCH) has 109 inpatient beds and is broken down as below:

West Cumberland Hospital

- Coronary Care Unit (CCU) – eight beds
- Emergency Assessment Unit (EAU) – 29 beds
- Ward 2 – 27 beds
- Ward 3 – 15 beds
- Ward 4 – 30 beds

(Source: Routine Provider Information Request (Universal) – Sites tab)

The trust had 35,069 medical admissions from January 2017 to December 2017. Emergency admissions accounted for 20,126 (57%), 587 (2%) were elective, and the remaining 14,356 (41%) were day case.

Admissions for the top three medical specialties were:

- General medicine – 18,266
• Gastroenterology – 5,630
• Clinical oncology – 4,150

(Source: Hospital Episode Statistics)

Following a comprehensive inspection in 2016, the trust was required to complete the following actions:

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

The trust was also requested to:

• Continue to progress patient harm reduction initiatives;
• Ensure Infection, prevention and control (IPC) compliance improvement and consistency in standards, regarding catheter and cannula care;
• Ensure best practice guidelines for medicines related documentation is reinforced to all prescribers;
• Ensure oxygen prescribing is recorded and signed for accordingly;
• Ensure medicines management training compliance improves in line with trust target;
• Ensure all relevant clinical observations are recorded at the required frequent, NEWS scores are accurately calculated and trigger levels are adhered to (or document deviation/individual baseline triggers in the clinical records);
• Ensure care and treatment of service users is appropriate, meets their needs and reflects their preferences.
• Specifically, ensure the endoscopy pathway design meets service user preferences and care or treatment needs.
• Ensure staff are given time to complete all necessary mandatory training modules;
• Ensure all fields within medical and nurse clerking documentation are completed in full, in line with local policy and best practice guidelines;
• Ensure all equipment checks are completed in line with local guidance;
• Progress JAG accreditation application for new endoscopy suite at WCH;
• Continue to proactively recruit nursing and medical staff, considering alternate ways to attract, such as utilising social media;
• Ensure measures are put in place to support units where pending staffing departures will temporarily increase vulnerability;
• Progress the ‘Composite Workforce Model’ and further embed support from substantive medical colleagues at CIC;

• Ensure food satisfaction standards are maintained and where relevant improved;

• Work with partnership colleagues to address static diabetes patient outcomes;

• Evidence improvements in patient outcomes for respiratory patients around time to senior review and oxygen prescribing;

• Support staff development in line with organisational/staff appraisal objectives protecting/negotiating study time where required;

• Ensure appraisal rate data recorded at trust level coincides with figures at divisional/ward level;

• Ensure patients are given sufficient time to converse with staff regarding care related matters;

• Revisit the patient journey, booking and listing procedures at the endoscopy suite at WCH;

• Ensure where escalation beds are utilised, they are staffed accordingly with due consideration of existing ward staffing requirements;

• Consider local leads for patient flow initiatives and reinforce processes with staff;

• Ensure processes seek to repatriate medical outliers at the earliest opportunity to minimise impact into surgical services.

During this inspection we visited six wards and the endoscopy unit.

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

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

Mandatory training completion rates

The trust set a target of 95% for completion of mandatory training. Ward staff told us there were sometimes difficulties booking onto face to face courses as they accommodated a maximum of 12 staff at any one time. Staff also told us that there was no time during working hours and came in on their days off, to complete the training. All staff told us they would be paid for this time.

Trust level

The trust submitted data prior to inspection which showed the mandatory target was not met for
23 of the 26 mandatory courses. A breakdown of compliance for mandatory training courses as at March 2018 at trust level for **qualified nursing staff** in medicine is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving &amp; handling level 1 clinical (3 yearly)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, trips and falls level 1</td>
<td>303</td>
<td>294</td>
<td>97%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk management</td>
<td>303</td>
<td>292</td>
<td>96%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>303</td>
<td>285</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Duty of candour</td>
<td>303</td>
<td>282</td>
<td>93%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>303</td>
<td>280</td>
<td>92%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety</td>
<td>303</td>
<td>278</td>
<td>92%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines management</td>
<td>297</td>
<td>271</td>
<td>91%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>303</td>
<td>275</td>
<td>91%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>303</td>
<td>275</td>
<td>91%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia</td>
<td>274</td>
<td>244</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent level 1 &amp; 2</td>
<td>303</td>
<td>263</td>
<td>87%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Hand hygiene (clinical)</td>
<td>303</td>
<td>259</td>
<td>85%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Calculating drug doses</td>
<td>295</td>
<td>251</td>
<td>85%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control level 2</td>
<td>303</td>
<td>254</td>
<td>84%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health records management</td>
<td>303</td>
<td>242</td>
<td>80%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>News</td>
<td>235</td>
<td>177</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; handling level 2</td>
<td>301</td>
<td>213</td>
<td>71%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 01</td>
<td>290</td>
<td>190</td>
<td>66%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>ILS (adults)</td>
<td>235</td>
<td>149</td>
<td>63%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 02</td>
<td>290</td>
<td>181</td>
<td>62%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk management (board and senior management)</td>
<td>58</td>
<td>36</td>
<td>62%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>220</td>
<td>130</td>
<td>59%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Understanding end of life</td>
<td>303</td>
<td>176</td>
<td>58%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>BLS (adults)</td>
<td>52</td>
<td>28</td>
<td>54%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, trips and falls level 2</td>
<td>300</td>
<td>102</td>
<td>34%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In medicine the 95% target was met for three of the 26 mandatory training modules for which qualified nursing staff were eligible. Moving and handling level 1 clinical (3 yearly) had a 100% completion rate although there was only one staff member eligible to complete this training.

Apart from the three modules that met the 95% target, there were a further seven modules that had a completion rate above 90%.

The trust submitted data prior to inspection which showed the trust target was not met for 25 of the 29 courses. A breakdown of compliance for mandatory training courses from as at March 2018 at trust level for **medical staff** in medicine is shown below:
<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALS (adults)</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Hand hygiene (non-clinical)</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control level 1</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving &amp; handling level 1 non-clinical (3 yearly)</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>NG tubes</td>
<td>21</td>
<td>17</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>45</td>
<td>36</td>
<td>80%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; handling level 1 clinical (3 yearly)</td>
<td>43</td>
<td>31</td>
<td>72%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Hand hygiene (clinical)</td>
<td>43</td>
<td>29</td>
<td>67%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>News</td>
<td>37</td>
<td>24</td>
<td>65%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Calculating drug doses</td>
<td>34</td>
<td>22</td>
<td>65%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines management</td>
<td>34</td>
<td>21</td>
<td>62%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, trips and falls level 1</td>
<td>45</td>
<td>27</td>
<td>60%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk management</td>
<td>45</td>
<td>26</td>
<td>58%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>42</td>
<td>24</td>
<td>57%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Duty of candour</td>
<td>45</td>
<td>25</td>
<td>56%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia</td>
<td>43</td>
<td>23</td>
<td>53%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>45</td>
<td>24</td>
<td>53%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent level 1&amp;2</td>
<td>45</td>
<td>23</td>
<td>51%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Trust doctors patient safety programme</td>
<td>43</td>
<td>21</td>
<td>49%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>45</td>
<td>21</td>
<td>47%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety</td>
<td>45</td>
<td>21</td>
<td>47%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health records management</td>
<td>45</td>
<td>21</td>
<td>47%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>BLS (adults)</td>
<td>25</td>
<td>11</td>
<td>44%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control level 2</td>
<td>43</td>
<td>16</td>
<td>37%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 01</td>
<td>20</td>
<td>5</td>
<td>25%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 03</td>
<td>2</td>
<td>0</td>
<td>0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>1</td>
<td>0</td>
<td>0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>ILS (adults)</td>
<td>2</td>
<td>0</td>
<td>0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevention of suicide</td>
<td>1</td>
<td>0</td>
<td>0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In medicine the 95% target was met for four of the 29 mandatory training modules for which medical staff were eligible. Although four modules had completions rates of 100%, the number of staff eligible for these training modules were low; only two staff members for each of the four modules were required to complete the training.

Four modules had a 0% completion rate, although this relates to only one to two staff members that did not complete the training.

**West Cumberland Hospital medicine department**

A breakdown of compliance for mandatory training courses as at March 2018 for **qualified nursing staff** in the medicine department at West Cumberland Hospital is shown below:
<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slips, trips and falls level 1</td>
<td>77</td>
<td>74</td>
<td>96%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk management</td>
<td>77</td>
<td>72</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>77</td>
<td>70</td>
<td>91%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety</td>
<td>77</td>
<td>70</td>
<td>91%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Duty of candour</td>
<td>77</td>
<td>69</td>
<td>90%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>77</td>
<td>69</td>
<td>90%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines management</td>
<td>77</td>
<td>69</td>
<td>90%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia</td>
<td>77</td>
<td>68</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>77</td>
<td>68</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>77</td>
<td>68</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Hand hygiene (clinical)</td>
<td>77</td>
<td>66</td>
<td>86%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent level 1 &amp; 2</td>
<td>77</td>
<td>66</td>
<td>86%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control level 2</td>
<td>77</td>
<td>63</td>
<td>82%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Calculating drug doses</td>
<td>77</td>
<td>62</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health records management</td>
<td>77</td>
<td>59</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; handling level 2</td>
<td>77</td>
<td>55</td>
<td>71%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk management (board and senior management)</td>
<td>13</td>
<td>9</td>
<td>69%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 01</td>
<td>77</td>
<td>53</td>
<td>69%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 02</td>
<td>77</td>
<td>52</td>
<td>68%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>News</td>
<td>60</td>
<td>37</td>
<td>62%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Understanding end of life</td>
<td>77</td>
<td>47</td>
<td>61%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>ILS (adults)</td>
<td>66</td>
<td>39</td>
<td>59%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>69</td>
<td>39</td>
<td>57%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>BLS (adults)</td>
<td>8</td>
<td>4</td>
<td>50%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, trips and falls level 2</td>
<td>76</td>
<td>20</td>
<td>26%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

At West Cumberland Hospital medical department, the 95% target was met for one of the 25 mandatory training modules for which qualified nursing staff were eligible.

Apart from the one training module that met the 95% trust target a further six modules had completion rates of 90% or higher.

A breakdown of compliance for mandatory training courses from as at March 2018 for medical staff in the medicine department at West Cumberland Hospital is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALS (adults)</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>10</td>
<td>10</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving &amp; handling level 1 clinical (3 yearly)</td>
<td>10</td>
<td>10</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Training Module</td>
<td>Staff</td>
<td>Completed</td>
<td>Completion Rate</td>
<td>Pass Rate</td>
<td>Action</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>-------</td>
<td>-----------</td>
<td>-----------------</td>
<td>-----------</td>
<td>--------</td>
</tr>
<tr>
<td>NG tubes</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>News</td>
<td>10</td>
<td>8</td>
<td>80%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Hand hygiene (clinical)</td>
<td>10</td>
<td>7</td>
<td>70%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Calculating drug doses</td>
<td>2</td>
<td>1</td>
<td>50%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>10</td>
<td>3</td>
<td>30%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia</td>
<td>10</td>
<td>2</td>
<td>20%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Duty of candour</td>
<td>10</td>
<td>2</td>
<td>20%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>10</td>
<td>2</td>
<td>20%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>10</td>
<td>2</td>
<td>20%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety</td>
<td>10</td>
<td>2</td>
<td>20%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health records management</td>
<td>10</td>
<td>2</td>
<td>20%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control level 2</td>
<td>10</td>
<td>2</td>
<td>20%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent level 1&amp;2</td>
<td>10</td>
<td>2</td>
<td>20%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk management</td>
<td>10</td>
<td>2</td>
<td>20%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, trips and falls level 1</td>
<td>10</td>
<td>2</td>
<td>20%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Trust doctors patient safety programme</td>
<td>10</td>
<td>2</td>
<td>20%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 01</td>
<td>10</td>
<td>0</td>
<td>0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management</td>
<td>2</td>
<td>0</td>
<td>0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

At West Cumberland Hospital medicine department, the 95% target was met for four of the 21 mandatory training modules for which medical staff were eligible. Although the four modules had a 100% completion rate, staff numbers for two of these were low, with only two staff members eligible to complete this training.

Calculating drug doses and medicine management had completion rates of 50% and 0% respectively, although this relates to only one and two staff members not completing the training.

(Source: Routine Provider Information Request (RPIR) – P40)

Ward staff told us that training figures were updated each month and a report was sent to the ward managers. Training needs of the ward were displayed as a monthly priority on the main information board for patients, staff and visitors.

**Safeguarding**

**Safeguarding training completion rates**

The trust set a target of 95% for completion of safeguarding training. We were not assured that safeguarding training was delivered in accordance with ‘Adult Safeguarding Levels And Competencies For Healthcare, Intercollegiate guidance (2016)’. Training data submitted by the trust prior to inspection, showed that all staff appear to be completing level one adults safeguard training. This includes managers investigating safeguarding alerts. Intercollegiate guidance (2016) recommends level two training for clinical staff and level three for staff responsible for the review of alerts. We reviewed the trusts adults safeguard policy and saw that all clinical staff working with adults should complete level two adults safeguarding training. Staff are instructed to inform their line managers when raising alerts, but the policy does not provide guidance for line managers to support any further action and no additional training is provided.
Trust level

A breakdown of compliance for safeguarding training courses from as at March 2018 at trust level for qualified nursing staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults level 1</td>
<td>303</td>
<td>264</td>
<td>87%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>294</td>
<td>258</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 3 (core)</td>
<td>9</td>
<td>8</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In medicine the 95% target was not met for any of the safeguarding training modules for which qualified nursing staff were eligible. Safeguarding children level 3 (core) had a completion rate of 89% although this relates to only one staff member not completing the training.

A breakdown of compliance for safeguarding training courses from as at March 2018 at trust level for medical staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 1</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>45</td>
<td>20</td>
<td>44%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>43</td>
<td>19</td>
<td>44%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In medicine the 95% target was met for one of the three safeguarding training modules for which medical staff were eligible. Safeguarding children level 1 had a 100% completion rate, although staff numbers eligible for this training were low with only two staff members required to complete this training.

As stated above these training levels and figures are not in line with ‘Adult Safeguarding Levels And Competencies For Healthcare, Intercollegiate guidance (2016)’.

West Cumberland Hospital medicine department

A breakdown of compliance for safeguarding training courses at March 2018 for qualified nursing staff in the medicine department at West Cumberland Hospital is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults level 1</td>
<td>77</td>
<td>68</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>77</td>
<td>64</td>
<td>83%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

At West Cumberland Hospital medicine department, the 95% target was not met for any of the safeguarding training modules for which qualified nursing staff were eligible.
A breakdown of compliance for safeguarding training courses from at March 2018 for **medical staff** in the medicine department at West Cumberland Hospital is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults level 1</td>
<td>10</td>
<td>2</td>
<td>20%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>10</td>
<td>2</td>
<td>20%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

At West Cumberland Hospital medicine department, the 95% target was not met for any of the safeguarding training modules for which medical staff were eligible. Only two out of the ten staff members’ eligible completed training for both modules.

*(Source: Routine Provider Information Request (RPIR) – P40)*

All staff we spoke with were aware who their safeguarding lead was and when to report safeguarding concerns. Staff explained that training was delivered through electronic learning and some staff told us they could complete electronic training at home.

Staff told us that managers offered safeguarding supervision following an alert raised. This offered staff a debrief opportunity and discussion around learning, following specific incidents. We saw safeguarding champions were utilised across the directorate of medicine.

**Cleanliness, infection control and hygiene**

All areas we inspected were visibly clean and we saw infection prevention control compliance figures for individual wards displayed on the walls. Wards we visited displayed the number of and date of last case of Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C. diff).

The wards displayed clear instructions and signage to encourage staff and visitors to wash their hands on entering the ward. The signage was repeated throughout the ward environments, and there were numerous washbasins for handwashing. Wards provided wall mounted gel and soap for ease of use.

Staff told us that they had sufficient access to all personal protective equipment (PPE) and we saw hand sanitising gel was readily available throughout the wards we visited.

Infection control audits showed high rates of compliance (e.g. 100% hand hygiene compliance, 100% clostridium difficile toxin high impact intervention). Ward staff were given priority goals each month which could include maintenance or improvement of infection control compliance. We saw staff washed their hands, used hand gel between patients and complied with ‘bare below the elbows’ policies.

At the previous inspection the trust was asked to ensure infection, prevention and control (IPC) compliance improvement and consistency in standards, regarding catheter and cannula care. We saw monthly audits for both catheter and cannulation care and specific improvement plans for
urinary catheter insertion rates and associated infections and peripheral cannula improvement plan.

We reviewed the improvement plan dated June 2018 in relation to urinary catheter insertion rates and associated infections and saw the average number of patients at North Cumbria University Hospitals Trust, who are recorded as having a new patient harm from a catheter associated urinary tract infection was 2%, which was higher than the national average of 1%. The trust outlined plans to reduce the number of patients with a urinary catheter within the improvement plan.

The trust had an Adult Cannulation policy and Aseptic Non-Touch Technique (ANTT) policy on the intranet which staff must comply with. Cannula audits were carried out monthly on all wards and departments.

The first cannula prevalence audit was completed in July 2017 and compared to the December 2017 audit, with the aim of demonstrating improvement since the initiatives were implemented. Some aspects of the repeat audit had shown an improvement; however, further improvement is required.

Rooms were available on all wards for the isolation of patients with signage in place to advise anyone before entering an isolation room. We saw across several wards extensive deep cleaning processes in place including air purification.

We observed that clinical waste and sharps were disposed of appropriately.

**Environment and equipment**

Medical wards were clearly signposted along the corridors of the hospital and the environment was bright and modern.

All equipment inspected had been electrical safety tested. The trust had systems in place for recording the service and maintenance of equipment identified through compliance stickers.

We saw that resuscitation trolleys were checked daily and they were accessibly located in ward areas. We saw on two wards there was an issue in obtaining intraosseous needles. Stock issues had been escalated to the designated matrons but we did not see any evidence of action taken to address the concern. We brought this to the attention of staff during inspection.

Staff confirmed there was adequate equipment to meet the needs of patients, e.g. moving and handling equipment and equipment for bariatric patients.

We saw on ward two, that the defibrillator trolley was not tamper proof or locked which meant items such as syringes, drugs and may be accessed by unauthorised personnel.

**Assessing and responding to patient risk**

Ward sisters stated they escalated staffing risks to their specific matrons, who then escalated to the chief matron. Some sisters told us they completed a risk assessment each time they
encountered staffing concerns, to highlight the level of risk. Some staff told us they would add an 
electronic flag to the system. We observed matrons, assessing and deploying staff appropriately.

We asked staff how risk was managed when staffing numbers were reduced and below the 
planned numbers. Four staff told us it made “no difference” if staffing were short as patients 
continued to be admitted regardless.

All staff spoke positively about their local matrons but were unclear how risk was managed and 
mitigated once escalated.

Ward staff told us that deteriorating patients were escalated to the doctors. However, three ward 
sisters told us at weekends the wards have no consultants or junior doctors and the sole care is if 
the nurses to ring on-call doctors with problems.

We saw patient observations (blood pressure, pulse, temperature, respirations) were recorded on 
the new electronic system on two wards. Staff told us that the system required WIFI signal to be 
able to load the patient’s record and record it successfully. All staff we spoke with told us that there 
were on-going problems with the WiFi signal and it was not always possible to use the electronic 
system.

E-observations were initially piloted at the Cumberland Infirmary in July 2017. During the pilot, 
both issues and suggestions were collated from the staff who were using the system.

Subsequently, between January and July 2018, the system was rolled out across 24 areas taking 
a phased approach. This included West Cumberland Hospital. Looking at NEWS audits before 
implementation of e-observations in these areas, 18 out of 24 miscalculated the NEWS score in 
one or more of the patients being audited. Post-implementation, all areas now have 100% correct 
NEWS scores as demonstrated through our audits except for four areas that have not yet been 
audited.

In July 2018, the IT department carried out an audit of WiFi coverage. It found that WIFI coverage 
was well above required levels, however the department wanted to encourage and remind staff to 
report any issues with WiFi and e-Observations straight away to the IT Service Desk or the out-of-
hours on-call IT team. This reminder was well-publicised to all staff.

We saw concerns about deteriorating patients had been escalated in accordance with guidance 
and the national early warning score (NEWS) system. During our inspection we saw that 
deteriorating patients had evidence of appropriate escalation and intervention recorded. We 
observed stickers adhered to medical and nursing notes where clinicians confirmed NEWS trigger 
deviation to meet individual patient need such as an elevated NEWS baseline.

We were informed by staff that the trust no longer employed resuscitation officer. Staff felt that this 
increased patient risk. However, no evidence of risk was observed during the inspection.

Patients who triggered a sepsis care bundle were monitored through audit, to check whether 
treatment and anti-biotics were given appropriately. The sepsis care pathway flowchart provided 
guidance in treating severe sepsis, management plan documentation, critical care considerations
and observation monitoring. We saw the sepsis pathway being followed during the inspection and saw that there was a sepsis escalation plan in place for patients requiring immediate review.

The sepsis audit for West Cumberland Hospital showed that for Q1 (quarter) 17/18 67% of patients were screened; Q2 17/18 showed 87% of patients were screened; and in Q3 17/18 there were 71% of patients screened. This was an improvement on Q4 16/17 where only 38% had been screened appropriately. We saw within the same data Q1 17/18 83% of patients treated within one hour; Q2 17/18 showed 60% of patients; and in Q3 17/18 there were 75% of patients were treated within one hour. This was an improvement on Q4 16/17 were only 33% patients were treated within one hour.

Risks associated with falls, pressure ulcers, venous thromboembolism (VTE), catheter and urinary infections were assessed on a monthly basis using the NHS safety thermometer.

The trust operates a Telestroke system integrating staff from six trusts to mount an acute stroke service.

At the time of our inspection, stroke patients were thrombolysed in the emergency department and then transferred to Coronary Care Unit (CCU) for initial monitoring. Staff told us that from October 2018 patients would be thrombolysed at Cumberland Infirmary.

At weekends, the wards have no consultants or junior doctors and the sole care is if the nurses ring the on-call doctors with problems. All staff told us availability of doctors at the weekend was limited.

**Nurse staffing**

The trust has reported their staffing numbers below as at March 2018 and April 2018 for medicine by site:

<table>
<thead>
<tr>
<th>Location</th>
<th>Mar-18</th>
<th>Apr-18</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Cumberland Infirmary Hospital</td>
<td>278.0</td>
<td>333.8</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>122.2</td>
<td>161.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>400.2</strong></td>
<td><strong>495.6</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) –P16)

Nurse staffing was managed by each Clinical Care Group and uses both an e-roster tool along with the SafeCare module which managed a range of parameters which were in line with the most recent NHSI publication (Safe, sustainable and productive staffing - An improvement resource for adult inpatient in acute care).

We were informed that the trust utilised SafeCare to enable coordination of staffing levels and skill mix to the actual patient demand. Safe Care provided visibility which enables acuity based daily staffing processes to improve productivity and safeguard patient safety.
The trust acknowledged that the collection of acuity and dependency data helped senior nurses and operation teams to get an organisation-wide view of staffing levels and staffing needs. This enabled proactive and informed decision making, to redeploy staff to areas of high demand to provide a safe establishment based on patient acuity/dependency levels.

Census data was pulled through via ‘Health Roster’ for staffing levels and ‘Real-time’ for patient acuity. This was a change for adult wards to the original process of staff inputting acuity data two times a day directly in to the SafeCare tool. The trust audit advised that morning data entry must take place between 06.30 and 08.00 ideally at 07.00 handover. Night data entry must take place between 18.30 and 20.00, ideally at the 19.00 handover.

The audit report represented data collected for acuity levels across inpatient areas for the trust in quarter 1, 2018 by using data from ‘Real-time’. Data was scored using the ‘Shelford Safer Nurse Tool for Acuity’.

The audit highlighted that in April 14% (66) of patients of 463 did not have acuity scores recorded. When reviewing the data for non-recording of acuity it was identified the longest period since the acuity had been recorded for an individual patient was 21 days, this was found to be the same across five wards. There was no data to support the reason for this failure to record the acuity.

In May 14% (60) patients of 420 did not have acuity scores recorded. The longest period since acuity had been reviewed for an individual patient was 90 days; however, there were five wards who had not reviewed scores for over 21 days and this was repeated across five wards.

In June 17% (74) patients of 436 did not have acuity scores recorded. The longest period since acuity had been reviewed for an individual patient was eight weeks and this was evident on two wards.

It was further highlighted that the interface between Real-time and SafeCare had been unreliable and the trust were informed by Allocate that this was a technical problem which was being resolved in the next upgrade of the system which would be monitored by the E-Roster Clinical Lead.

Recommendations from the audit emphasised that support was to be offered to all wards with low participation in acuity scoring, education and continue to support SafeCare users was to be provided and SafeCare relaunch to commence when issues were resolved between the Real-time and SafeCare interfaces. This was expected at the end of July 2018.

We were informed that red flags were used to highlight concerns and were logged on the system to be viewed by line managers and Matrons to identify problems are and implement actions to resolve the issues.

We saw the trusts comprehensive escalation policy which clearly identified the role and responsibility for all staff, management team and executive team.

The trust work to three levels of escalation; level one required no action as planned rosters were achieved without gaps, skill mix and qualified nurse to patient ratio achieved. Level two escalation meant that the fill rate was below 80% but two qualified staff were on duty. The response required
for level two escalation was to initially review patient acuity and dependency. Nonetheless, the ward may manage to provide the correct level of care and no further action would be required. If additional ‘red flags’ were identified then staffing must be increased based on professional judgement. Level three escalation would occur when a ward had less than two qualified nurses; the shift fill rate was below 80% and there were patients with increased level of acuity. The trust stated that the required response to a level three escalation would be to provide an additional qualified nurse or decide to close beds. Patient dependency and acuity would be reviewed by the ward manager and Matron.

We saw that the trust had implemented standard operating procedure for the utilisation of nursing staff out of hours (OOH). This SOP is to guide the reallocation of existing nursing staff for defined periods of time when safe staffing levels cannot be met from within the allocated resource across our wards. This paper outlines the principals for the movement of staff being cognisant of the NMC Code of Practice, Rule 13 Preserve Safety. During times of exceptional and unexpected staffing shortfalls the absolute minimum standard required on any ward documented as two registered nurses.

The SOP stated that staff based on wards may be requested to relocate to ensure skills mix and safe staffing levels are maintained across all patient areas. Wherever possible these moves should have been identified and agreed by Matrons in the operational staffing plan by 17:00. However, this plan may require review out of hours should circumstances change; this revised plan was made by the site coordinator.

We were advised that all staff were given training on acuity and dependency scoring, which was tested on an ad-hoc basis by senior nurses and Matrons to ensure the accuracy of the data entered. At the morning matrons meeting, if a ward appeared to have higher or lower acuity and dependency data than would be expected the matron went to the ward and reviewed the data with the ward sister.

Matrons and senior staff use the tool to make regular reallocation of nursing resources every morning and several times throughout the day and therefore ensure the data is as contemporaneous as possible.

Managers had identified nurse staffing as an issue within the medical division and this appeared on the services risk register. We saw nursing vacancies on all wards that we visited.

Planned and actual numbers of staff were displayed on the walls as you entered the wards. None of the wards we visited had the planned number of staff they required.

There was evidence of health care assistants being used to support gaps in nurse care and this action was included as part of the trusts agreed actions within the monthly staffing reports.

Several wards noted that additional staff was not always available once concerns had been escalated to the Matrons. Wards also noted that despite having patients with complex needs, particularly on the emergency assessment unit, additional staff support was not always available. Such patients required one to one support, behavioural problems including aggressive tendencies. We were informed that there had been occasions when patients assessed as requiring one to one care, would lose the one to one support if the nurse was required elsewhere.
The trust had developed a policy to ensure staffing needs were met for patients requiring non-invasive ventilation (NIV). The British Thoracic Society recommended a minimum staffing ratio of one nurse to two patients, within the first 24 hours and policy guidance was reflective of this.

**Vacancy rates**

From April 2017 to March 2018, the trust reported a vacancy rate of 25.9% in medicine. This was higher than the trust target of 5%.

A breakdown by site is shown below:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total vacancies (WTE)</th>
<th>Total number of staff establishment (WTE)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>1,010.8</td>
<td>3,983.9</td>
<td>25.4%</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>395.6</td>
<td>1,439.7</td>
<td>27.5%</td>
</tr>
<tr>
<td>Total</td>
<td>1,406.4</td>
<td>5,423.6</td>
<td>25.9%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

All wards we visited told us they had vacancies. The trust ran an on-going job advert for nursing staff and some ward sisters told us that vacancies were being filled. We were told ‘We fill the vacancies but then another member of staff leaves. Recruitment is on-going’.

**Turnover rates**

From May 2017 to April 2018, the trust reported a turnover rate of 11.5% in medicine. This was lower than the trust target of 13%. West Cumberland Hospital met the trust target with a turnover rate of 10.5%, while Cumberland Infirmary had a turnover rate of 53.8%, much higher than the trust target, although this equates to only 1.3 WTE staff members leaving the trust.

A breakdown per site can be seen in the table below:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total leavers (WTE)</th>
<th>Average number of staff establishment (WTE)</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Cumberland Hospital</td>
<td>11.3</td>
<td>2.4</td>
<td>53.8%</td>
</tr>
<tr>
<td>Cumberland Infirmary</td>
<td>1.3</td>
<td>107.4</td>
<td>10.5%</td>
</tr>
<tr>
<td>Total</td>
<td>12.6</td>
<td>109.8</td>
<td>11.5%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Matrons and ward sisters we spoke with acknowledged the high turnover rate and told us that on-going advertisements were in place.

We did not see evidence of any learning from staff exit interviews or any trends identified by the trust, when staff left the trust.

**Sickness rates**
From May 2017 to May 2018, the trust reported a sickness rate of 4.9% in medicine. This was higher than the trust target of 4%.

A breakdown per site can be seen in the table below:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total absence days</th>
<th>Total WTE days available</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>4,275.9</td>
<td>88,256.2</td>
<td>4.8%</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>1,797.7</td>
<td>34,483.0</td>
<td>5.2%</td>
</tr>
<tr>
<td>Total</td>
<td>6,073.6</td>
<td>122,739.2</td>
<td>4.9%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

We did not see evidence of any learning following sickness review meetings. Staff we spoke with told us that staff “exhaustion” was common place.

Bank and agency staff usage

From April 2017 to March 2018, the trust reported that 27.1% of qualified nursing shifts in medicine were filled by bank staff.

The trust was unable to provide comparable data for agency and shifts left unfilled, due to system restrictions.

The breakdown by site is shown in the table below.

<table>
<thead>
<tr>
<th>Site</th>
<th>Bank shifts</th>
<th>Total shifts</th>
<th>Bank shifts as a proportion of total shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>1,172</td>
<td>4,274</td>
<td>27.4%</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>465</td>
<td>1,761</td>
<td>26.4%</td>
</tr>
<tr>
<td>Total</td>
<td>1,637</td>
<td>6,035</td>
<td>27.1%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Ward staff told us that an internal nursing bank was used. Occasionally staff were sought from an external nursing agency, when no internal staff were available.

Medical staffing

The trust has reported their staffing numbers below as at March 2018 and April 2018 for medicine.
Medical rota shortfalls were managed and reinforced by advanced clinical practitioners on a 24/7 basis. The division had also implemented the ‘hospital at night’ programme to support clinical presence on site during night hours and the critical care outreach team (CCOT) who worked 24/7.

**Vacancy rates**

From April 2017 to March 2018 the trust reported a vacancy rate of 22.8% in medicine. This was higher than the trust target of 20%. Cumberland Infirmary reported a vacancy rate of 18.8% lower than the trust target of 20%, while West Cumberland Hospital reported a vacancy rate of 63.8%, much higher than the trust target.

A breakdown per site can be seen below:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total vacancies (WTE)</th>
<th>Total number of staff establishment (WTE)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>251.7</td>
<td>1,336.9</td>
<td>18.8%</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>81.6</td>
<td>128.0</td>
<td>63.8%</td>
</tr>
<tr>
<td>Total</td>
<td>333.3</td>
<td>1,464.9</td>
<td>22.8%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

From May 2017 to April 2018, the trust reported a turnover rate of 28.2% in medicine. This was higher than the trust target of 13%. West Cumberland Hospital had a turnover rate of 16.0%, although this relates to only one WTE staff member leaving the trust.

A breakdown per site is shown in the table below:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total leavers (WTE)</th>
<th>Average number of staff establishment (WTE)</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>17.9</td>
<td>60.9</td>
<td>29.4%</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>1.0</td>
<td>6.3</td>
<td>16.0%</td>
</tr>
<tr>
<td>Total</td>
<td>18.9</td>
<td>67.1</td>
<td>28.2%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Turnover tab)
Sickness rates

From May 2017 to May 2018, the trust reported a sickness rate of 2% in medicine. This was lower than the trust target of 4%.

A breakdown per site can be seen in the table below:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total absence days</th>
<th>Total WTE days available</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>564.1</td>
<td>22,108.7</td>
<td>2.6%</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>0.0</td>
<td>1,916.0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total</td>
<td>564</td>
<td>24,025</td>
<td>2.3%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

The trust was unable to provide this data broken down by site or core service, due to system restrictions under the previous recording method.

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

We spoke to a number of locum consultants across the medical directorate at West Cumberland Hospital. Consultants were concerned about the safety of the service. Consultants told us there had been several recent occasions when the medical staff had amounted to one consultant and one Senior House Officer (SHO) for the 30 beds. Staff told us of one occasion, when there was just one consultant until another SHO came later in the day. Junior doctors told us there was a lack of continuity with different locums appearing each day and unfamiliarity with the cases. This unfamiliarity led to needless repetition of work or tests which had already been completed.

Staffing skill mix

In January 2018, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.

Staffing skill mix for the 99 whole time equivalent staff working in medicine at North Cumbria University Hospitals NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>35%</td>
<td>43%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>4%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>19%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>42%</td>
<td>22%</td>
</tr>
</tbody>
</table>
^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

Source: NHS Digital - Workforce statistics (01/01/2018 - 31/01/2018)

Records
Staff within medicine recorded relevant clinical patient information in paper records and a number of core documents were completed on the electronic patient record (EPR).

We reviewed seven of patient records and saw these were collated consistently and well organised. Records were up-to-date with evidence of on-going review, diagnosis and management plans and patient involvement. Staff stored these safely in portable locked cabinets or in areas manned by staff, for example at the rear of the patient’s bed.

The division had developed a number of care bundles and specialist care pathway documentation following best practice guidelines, such as sepsis and chronic obstructive respiratory disease.

Regular annual case note audits were conducted across the various wards and departments. Ten sets of patient notes (paper) were then randomly selected for audit.

Overall, the findings against the key clinical content indicators were good however there were some poor administrative content shortfalls concerning responsible lead and printed name designation. We saw actions required following each audit undertaken.

We saw patients at higher risk of deteriorating had a red sticker on their file to indicate a high NEWS score (5†).

Medicines
Medical wards at WCH accessed a dedicated clinical pharmacy service and pharmacists were integrated into the multi-disciplinary team, attending handovers and ward meetings.

All wards at WCH received quarterly medicines safety data at ward level to identify individual ward actions to encourage learning and support improvement.
Medicines audits were completed ‘15 steps’. We reviewed the overall results for the six months prior to inspection and saw that 100% compliance was recorded in only one of the six months (August 2017). 87% which was the lowest score was recorded in November 2017.

Medicines requiring refrigeration were stored securely. Staff completed daily fridge temperatures checks to ensure these medicines were safe to administer. The trust policy however, did not state staff should record minimum and maximum temperatures for medicines refrigerators, and staff we spoke to were not aware of this requirement. Therefore, we could not be assured medicines requiring cold storage had been stored at the recommended temperature and were safe to use.

We reviewed six medication charts and saw medical and nursing staff completed the charts legibly with the names of the prescribed medication clearly written along with accompanying start and end dates where appropriate.

Controlled Drugs were managed appropriately in relation to storage and administration; however, we found staff were not adhering to trust policy in relation to recording of balance adjustments.

On EAU, the division used the Omnicell system (providing individual patient medication at the bedside which then followed the patient throughout their period of hospitalisation) to improve medicines management and reconciliation. The ward pharmacist and pharmacy technician managed the system.

Non-medical prescribers (nurses and pharmacists) at WCH supported patient medication discharge processes.

Prescriptions were reviewed and we saw three of the six (50%) of the charts we saw did not meet the trust’s own standards. For example, on one chart, no dose was stated for Alendronic Acid. The tablet had been due that morning but not administered. Another example showed the patient was prescribed 1g paracetamol po/IV when required. Trust policy is for the prescriber to write a separate entry for each route of administration (for all drugs) stating either/or.

Ambiguous prescriptions may lead to medicine administration errors by nursing staff.

**Incidents**

**Never Events**

Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each Never Event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event.

The trust reported no never events at West Cumberland Hospital.

The division reported incidents through the trust electronic reporting system and graded incidents according to risk rating and severity of harm in accordance with their incident management policy (including the management of serious incidents), which was published in in February 2016.
All staff spoken to knew of the Duty of Candour (DoC) requirements and of the trust’s ‘being open’ policy.

All incidents were routinely investigated in line with trust policy. Any lessons learnt were discussed at divisional meetings and managers shared learning and cascaded key information to their staff at safety huddles, ward meetings, through the patient safety newsletter, on the intranet, and with direct staff communications.

The division held monthly mortality and morbidity review meetings. The meeting considered case summaries, reviewed outcomes and identified key lessons.

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 19 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from June 2017 to May 2018.

Of these, the most common types of incident reported were:

- Treatment delay meeting SI criteria with six (32% of total incidents).
- Surgical/invasive procedure incident meeting SI criteria with four (21% of total incidents).
- Abuse/alleged abuse of adult patient by staff with two (11% of total incidents).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with two (11% of total incidents).

Note: the incidents above include the one never event at Cumberland Infirmary Hospital.

Site specific information can be found below:

- Cumberland Infirmary: 15 incidents.
- West Cumberland Hospital: four incidents.

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within ten days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 17 new pressure ulcers, 29 falls with harm and 41 new urinary tract infections in patients with a catheter from April 2017 to April 2018 for medical services.

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

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at North Cumbria University Hospitals NHS Trust

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
Catheter acquired urinary tract infection level 3 only

Medicine reported 17 new pressure ulcers. Over the period numbers varied month on month with no pressure ulcers reported in April, June, August, November 2017 and April 2018. The highest numbers reported were during May (four), July 2017 (three) and in March 2018 (three). During September and October 2017 one pressure ulcer per month was reported. In the winter months from December 2017 March 2018, between one to three pressure ulcers were reported consecutively.

In April 2017 the highest number of seven falls were reported, numbers decreased to two in May although increased again to four in June while decreasing month on month from three in July to no falls reported in September 2017. Three falls were again reported in October and no falls in November 2017. During the winter months of December 2017, four falls were reported, numbers decreased to one fall reported in January 2018, although increased once more to four falls reported in February 2018. In March and April 2018 no falls were reported. The overall trend, although there were variances month on month, showed a decrease in the number of falls reported.

A high number of 41 UTIs were reported. With the exception of April 2018, from one to six UTIs were reported month on month. In April 2017 five UTIs were reported, numbers decreased to three in May, although increased again to six per month in June and July 2017. From August 2017 to January 2018, numbers stabilised with one to two ulcers reported per month. In February six UTIs were again reported after which numbers decreased to four in March and none in April 2018.

We saw the trust monitored the correlation of patient harm against reduced qualified staffing numbers.

Source: Safety thermometer - Safety Thermometer

Is the service effective?

Evidence-based care and treatment

Staff were aware of the various policies and care pathways which were based on NICE and Royal College of Physicians guidelines. Two ward staff demonstrated access through the trust intranet site.

We reviewed a number of clinical guidelines on the intranet and all were current, identified author/owner and had review dates.

The medical division were actively involved in local and national audit programmes collating evidence to monitor and improve care and treatment. The division compiled an Annual Clinical Audit Report of activity that specified a range of completed, planned and on-going evidence-based reviews. We saw the trust had developed action plans following these audits to support evidence based care and treatment.
In line with NICE Quality Standards, the division was involved in data collection activity for numerous national audits and during 2016 to 2017 the division participated in 18 of the 20 eligible national HQIP Quality Account Clinical audits and completed 095 local audits. These audits included falls and fractures, chronic obstructive pulmonary disease (COPD), inflammatory bowel disease, diabetes, acute coronary syndromes and the national audit of dementia.

The division had developed a number of care pathways, such as stroke, deep vein thrombosis (DVT), cellulitis, rapid access chest pain and sepsis in place. These were evidenced based and specific to the condition.

All endoscopic procedures were carried out in accordance with recognised best practice and professional guidelines. The unit was working towards JAG (Joint Advisory Group) accreditation.

The division had a designated audit lead, and business units were active in the trust clinical audit group.

Nutrition and hydration

Medical staff recognised the importance of good nutrition, hydration and enjoyable meal times as an essential part of patient care and we saw protected meal times in place on the majority of wards that we visited.

Three patients told us “They keep telling me to drink more”. One patient told us they would like a choice of drinks rather than just water.

We saw a new initiative on three of wards we visited. Visitors could ask for a ‘carer’s pass’ which enabled specific members of the patients family or friends to visit and offer personal care or assistance. This could include assistance with eating and drinking.

All six records we reviewed during inspection, included malnutrition universal screening tool (MUST) risk assessment (equating to 100% compliance). Staff implemented care plans for those patients who required support and assistance with eating and drinking, such as soft diets.

We observed nutrition and hydration recorded on fluid and food charts which were kept by the patient bedside and updated during the course of the day. Overall completion of these charts was good.

We spoke 14 patients and most said the food was good, menus were varied and they could ask for food at all times. One patient told us “Food is good, sadly I don’t have much appetite yet”. Another told us “Always lots of choice and enough to eat”. The quality and quantity of food was monitored through patient led assessments of the care environment (PLACE) which show an overall satisfaction with food provided. WCH recorded a 94.91% satisfaction rate, which was better than national average of 88% in 2016.

Staff told us they accessed support from dietetics and speech and language therapy service (SaLT) specifically allocated to their ward to support those patients who required additional input to maintain their nutritional status.
Pain relief

We reviewed four care plans for pain management and saw pain assessments were carried out and recorded. Pain relief was provided as prescribed and there were systems in place to ensure additional pain relief could be accessed through medical staff.

Patients had no concerns about how their pain was controlled and staff checked that pain relief administered had been effective. We were assured about the assessment of pain for those patients who were unable to communicate they were in pain.

Staff considered the use of analgesia alongside the patient’s clinical condition and particular need and used a pain-scoring tool to assess patient’s pain levels and recorded the assessment within paper and electronic records.

The division also took part in face-to-face and real time surveys where patients were asked to comment upon quality indicators overlapping and extending upon the ‘two minutes of your time’ survey such as pain control, medicines and noise at night. All wards at WCH reported consistently positive feedback and scores overall were in excess of 9.5 out of 10.

The trust took part in the National Cancer Patient Experience Survey (NCPES) 2016. Patients were asked if hospital staff definitely did everything to help control pain. On a scale of zero (very poor) to 10 (very good). Respondents gave an average rating of 89% against a national average of 84%.

We found all patients had access to prescribed analgesia. We found analgesia prescribed on a regular basis and on an as required basis. Patients informed us staff asked them if they had any discomfort or if they required any pain relief.

Staff within medicine accessed the trust pain team if required.

Patient outcomes

Relative risk of readmission

Trust level

From January 2017 to December 2017, patients at the trust had a slightly higher than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

Elective Readmissions

- Patients in clinical oncology (previously radiotherapy) had a slightly higher than expected risk of readmission for elective admissions.
- Patients in gastroenterology had a similar than expected risk of readmission for elective admissions.
- Patients in clinical haematology had a higher than expected risk of readmission for elective admissions.
Non-Elective Readmissions

- Patients in general medicine and cardiology had a lower than expected risk of readmission for non-elective admissions.
- Patients in geriatric medicine had a much lower than expected risk of readmission for non-elective admissions.

Elective Admissions – Trust Level

![Graph showing ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is considered positive, and a value above 100 is negative. Top three specialties for specific trust based on count of activity.]

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

Non-Elective Admissions – Trust Level

![Graph showing ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is considered positive, and a value above 100 is negative. Top three specialties for specific trust based on count of activity.]

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

(Source: HES - Readmissions (01/01/2017 - 31/12/2017))

West Cumberland Hospital

From January 2017 to December 2017, patients at West Cumberland Hospital had a higher than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

Elective Readmissions

- Patients in clinical oncology (previously radiotherapy) had a higher than expected risk of readmission for elective admissions.
- Patients in gastroenterology had a lower than expected risk of readmission for elective admissions.
- Patients in clinical haematology had much a higher than expected risk of readmission for elective admissions.

Non-elective Readmissions
- Patients in general medicine had a lower than expected risk of readmission for non-elective admissions.
- Patients in cardiology had a much higher than expected risk of readmission for non-elective admissions.
- Patients in gastroenterology had a much lower than expected risk of readmission for non-elective admissions.

**Elective Admissions - West Cumberland Hospital**

![Elective Admissions Chart]

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

**Non-Elective Admissions - West Cumberland Hospital**

![Non-Elective Admissions Chart]

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

**Sentinel Stroke National Audit Programme (SSNAP)**

West Cumberland Hospital

West Cumberland Hospital takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved an overall SSNAP level of grade C from August to November 2017.

The team-centred total key indicator level remained unchanged at level C in April to July 2017 and August to November 2017. Scanning was upgraded from level C to level B, while the stroke unit was upgraded from level D to level C. Thrombolysis was upgraded from level E to level D and specialist assessments were upgraded from level E to level C. Physiotherapy was downgraded from level A to level B and speech and language therapy from level B to level C.

The patient-centred total key indicator level was upgraded from level C in April 2017 to July 2017.
to level B in August to November 2017. Scanning was upgraded from level C to level B, thrombolysis from level E to level D and specialist assessments from level E to level C. Physiotherapy was downgraded from level A to level B.

### Team centred performance

<table>
<thead>
<tr>
<th>Team centred performance</th>
<th>Jan-Mar 16</th>
<th>Apr-Jul 16</th>
<th>Aug-Nov 16</th>
<th>Dec 16 - Mar 17</th>
<th>Apr 17 - Jul 17</th>
<th>Aug 17 - Nov 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: Scanning</td>
<td>B↑</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>C↓</td>
<td>B↑</td>
</tr>
<tr>
<td>Domain 2: Stroke unit</td>
<td>D↓</td>
<td>C↑</td>
<td>C</td>
<td>D</td>
<td>D</td>
<td>C↑</td>
</tr>
<tr>
<td>Domain 3: Thrombolysis</td>
<td>D</td>
<td>E↓</td>
<td>C↑↑</td>
<td>C</td>
<td>E↓↓</td>
<td>D↑</td>
</tr>
<tr>
<td>Domain 4: Specialist assessments</td>
<td>D</td>
<td>B↑↑</td>
<td>B</td>
<td>D</td>
<td>E</td>
<td>C↑</td>
</tr>
<tr>
<td>Domain 5: Occupational therapy</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 6: Physiotherapy</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>B↓</td>
</tr>
<tr>
<td>Domain 7: Speech and language therapy</td>
<td>A↑</td>
<td>A</td>
<td>B↓</td>
<td>B</td>
<td>B</td>
<td>C↓</td>
</tr>
<tr>
<td>Domain 8: Multi-disciplinary team working</td>
<td>C</td>
<td>B↑</td>
<td>C↓</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Domain 9: Standards by discharge</td>
<td>B</td>
<td>A↑</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 10: Discharge processes</td>
<td>C↑↑</td>
<td>D↓</td>
<td>D</td>
<td>D</td>
<td>D</td>
<td>D</td>
</tr>
</tbody>
</table>

**Team-centred Total Key Indicator Level**

|               | B↑ | B | B | B | C↓ | C |

### Patient centred performance

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: Scanning</td>
<td>B↑</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>C↓</td>
<td>B↑</td>
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<td>D↓</td>
<td>C↑</td>
<td>C</td>
<td>D</td>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td>Domain 3: Thrombolysis</td>
<td>D</td>
<td>D</td>
<td>C↑↑</td>
<td>C</td>
<td>E↓↓</td>
<td>D↑</td>
</tr>
<tr>
<td>Domain 4: Specialist assessments</td>
<td>D</td>
<td>B↑↑</td>
<td>B</td>
<td>D</td>
<td>E</td>
<td>C↑</td>
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<tr>
<td>Domain 5: Occupational therapy</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 6: Physiotherapy</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 7: Speech and language therapy</td>
<td>B</td>
<td>A↑</td>
<td>B↓</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 8: Multi-disciplinary team working</td>
<td>C</td>
<td>B↑</td>
<td>C↓</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Domain 9: Standards by discharge</td>
<td>B</td>
<td>A↑</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 10: Discharge processes</td>
<td>C↑↑</td>
<td>D↓</td>
<td>D</td>
<td>D</td>
<td>D</td>
<td>D</td>
</tr>
</tbody>
</table>

**Patient-centred Total Key Indicator Level**

|               | C          | B↑         | B | B | C↓ | B↑ |

### Overall scores
Overall Scores

<table>
<thead>
<tr>
<th></th>
<th>Jan-Mar 16</th>
<th>Apr-Jul 16</th>
<th>Aug-Nov 16</th>
<th>Dec-Mar 16</th>
<th>Apr-Jul 17</th>
<th>Aug-Nov 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSNAP level</td>
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<td>B↑</td>
<td>B</td>
<td>B</td>
<td>C↓</td>
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<tr>
<td>Case ascertainment band</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Audit compliance band</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Combined Total Key Indicator level</td>
<td>C</td>
<td>B↑</td>
<td>B</td>
<td>B</td>
<td>C↓</td>
<td>C</td>
</tr>
</tbody>
</table>

(Source: Royal College of Physicians London, SSNAP audit)

Heart Failure Audit

The trust did not take part in this audit.

(Source: NICOR - Heart Failure Audit (01/04/2014 - 31/03/2015))

National Diabetes Inpatient Audit

West Cumberland Hospital

The 2017 National Diabetes Inpatient Audit identified 37 in patients with diabetes at West Cumberland Hospital, 88.3% of patients with diabetes reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which places this site in quartile 3. In comparison with 2016 scores the percentage of patients that were satisfied or very satisfied with overall in hospital care improved from 84.9% to 88.3% in 2017, although the site remained in quartile 3 in comparison with national scores.

(Source: NHS Digital)

Myocardial Ischaemia National Audit Project (MINAP)

All hospitals in England that treat heart attack patients submit data to MINAP by hospital site (as opposed to trust).

From April 2015 to March 2016, 55.5% of nSTEMI patients were admitted to a cardiac unit or ward at West Cumberland Hospital and 93.1% were seen by a cardiologist compared to an England average of 55.8% and 96.2% respectively.

The proportion of nSTEMI patients who had angiography at West Cumberland Hospital was 74.6% compared to an England average of 83.6%.

<table>
<thead>
<tr>
<th></th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
At West Cumberland Hospital percentages for patients seen by a cardiologist deteriorated between 2014/15 and 2015/16 from 96.0% to 93.1% in 2015/16. The proportion of patients admitted to a cardiac unit or ward decreased from 61.2% to 55.5%, while patients receiving an angiogram before discharge deteriorated from 85.6% to 74.6%.

(Source: National Institute for Cardiovascular Outcomes Research (NICOR))

Lung Cancer Audit

The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 86.8%, which did not meet the audit minimum standard of 90%. The 2016 figure was 71.8%

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 17.5%. This is within the expected range. The 2016 figure was not significantly different to the national level. The audit national standard of 17%* was met for this metric.

The proportion of fit patients with advanced (NSCLC) receiving Systemic Anti-Cancer Treatment was 52.7%. This is within the expected range. The 2016 figure was not significantly different to the national level. The national audit standard of 65%* was not met for this metric.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 65.5%. This is within the expected range. The 2016 figure was not significantly different to the national level. The national audit standard of 70%* was not met for this metric.

The one year relative survival rate for the trust in 2017 is 33.9%. This is within the expected range. The 2016 figure was not significantly different to the national level.

* Audit standard based on NICE guideline

(Source: National Lung Cancer Audit)
National Audit of Inpatient Falls 2017

The national aspirational standard is 100% for all measures, the trust failed to meet this standard for all indicators.

The crude proportion of patients who had a vision assessment (if applicable) was 5%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 17%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 32%.

The crude proportion of patients with a call bell in reach (if applicable) was 83%.

(Source: Royal College of Physicians)

Competent staff

Appraisal rates

Trust wide

From April 2017 to March 2018, 93% of staff within medicine at the trust received an appraisal compared to a trust target of 95% for nursing staff and 90% or higher for medical staff.

Nursing staff did not meet the trust target with a completion rate of 93%, while medical staff met the trust with a completion rate of 97%. Medical staff within gastroenterology had the lowest completion rate of 50%, although this relates to only one of the two staff members not receiving an appraisal.

It should however be noted that in the 2017 staff survey, quality of appraisals were within the worst 25% of trusts nationally. The quality of appraisals should be investigated further during inspection.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required</th>
<th>Appraisals complete</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>316</td>
<td>293</td>
<td>93%</td>
</tr>
<tr>
<td>Medical and dental staff</td>
<td>36</td>
<td>35</td>
<td>97%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>352</td>
<td>328</td>
<td>93%</td>
</tr>
</tbody>
</table>

West Cumberland Hospital

From April 2017 to March 2018, 95% of staff within medicine at the trust received an appraisal compared to a trust target of 95% for nursing staff and 90% or higher for medical staff. Nursing staff at Cumberland Infirmary Hospital met the trust target with a completion rate of 95%, while medical staff met the trust with a completion rate of a 100%. Medical staff within elderly
care had a 100% completion rate, although this relates to only one staff member receiving an appraisal.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required</th>
<th>Appraisals complete</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>81</td>
<td>77</td>
<td>95%</td>
</tr>
<tr>
<td>Medical and dental staff</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>82</strong></td>
<td><strong>78</strong></td>
<td><strong>95%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

All staff employed by the trust and working in the division were required to meet their professional continual development obligations.

Ward staff told us that training was delivered either as face to face sessions or electronic modules. The division provided a number of electronic on-line courses and specialist courses in house for staff to attend. Some staff told us that they could access the electronic courses at home.

All staff we spoke with told us that there was no time to complete learning during working hours. However, if they came in to complete courses during days off, they would be paid for this time.

All newly qualified staff employed were subject to a period of preceptorship and supervision which varied according to the area worked and subject to competency sign-off.

Junior medical staff maintained close links with the Deanery as part of their clinical placements and post rotations and spoke positively about the support from the trust.

All staff we spoke with told us that appraisals were conducted but often time was limited due to busy nature of the ward environment.

We saw a number of specialist nurses within medicine such as diabetes. These nurses provided training sessions to all grades of staff and the link nurse programme was in force across medical wards. The trust told us that that there were no dementia specialist nurses however, but offer a reach in service to help support patients with delirium. This was a recently introduced service.

Junior nursing and medical staff were supported by their senior colleagues who they described as approachable and willing to share. Some junior doctors told us that locum consultants changed and occasionally there was a lack of consistency around support.

**Multidisciplinary working**

We saw well attended informal and structured multidisciplinary team meetings (MDT) throughout our visit. Staff worked collaboratively to ensure patient outcomes were planned and delivered.

Other health professionals such as physiotherapists and dieticians confirmed there was good multidisciplinary working and they also offered training, such as the management of dysphagia to nursing staff where appropriate. We saw clear referral pathways to therapy and psychiatric services.
We reviewed patient records and saw formal documented input from the MDT recorded in the medical records. Information included care and treatment planning, discharge processes and social considerations. There was evidence of patient and family involvement in the process.

Strong relationships were evident with community colleagues particularly in emergency assessment and short stay wards.

All staff told us they worked as a team and described focused working even during particularly busy times.

**Seven-day services**

The trust monitored its current working scheme against NHS Services, Seven Days a Week Clinical Standards.

The division engaged in the trust seven-day service standards (7DS) audit published in March 2017. The data showed weekday to weekend difference in relation to patient reviews. Those patients who required a daily review showed a -40% difference in review. Those patients who required a twice daily review showed a -10% review. An action plan was in place to improve these figures by April 2018.

Endoscopy services offered weekday working (to 7pm) but plans had recently been approved to support seven day working, which was due to start in November 2018.

On-call consultants covered weekends and nights. Other medical out-of-hours cover was provided by one agency registrar, and two foundation year two doctors. The agency registrar told us there were no foundation year one doctors and some of the time is spent carrying out basic tasks. As there is no phlebotomy service, additional time is spent taking bloods.

There was availability of physiotherapy and occupational therapy staff Monday to Friday and physiotherapists covered weekends on a rota system to deliver interventions to identified patients on a basis of need.

All ward staff said they had access to mental health and psychiatry support 24 hours per day, seven days per week.

‘Reach-Out’ was a new delirium service with two staff grade six nurses and support workers. The service operated seven days per week and had several key elements; prevention, effective screening, support, treatment, liaising with other services to support discharge and education.

Health professionals worked with patients who are at risk of developing delirium. Reach-Out provided education and practical support to other hospital staff aimed to improve awareness and recognition of delirium.

The dietitians and speech and language therapy (SaLT) service was available from Monday to Friday only.
Health promotion

Staff on specialist units gave patients and their families discharge booklets which provided medical information, treatment details, contact information and signposting for further support and guidance.

Patients said staff gave them advice on smoking cessation, healthy eating, weight loss, wound care and infection prevention on all wards.

Patient leaflets were available throughout the hospital, prominently displayed on communication boards within wards and corridors and available for patients to take with them.

We did not see patient information leaflets in languages other than English but were assured they were available on request.

Three patients’ we spoke with told us that doctors advised them of healthy lifestyle choices, specific to their condition.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

At West Cumberland Hospital we found that ward managers had a good knowledge of the Mental Capacity Act, although the rest of the nursing staff still lacked a clear understanding. None of the other ward staff we spoke with, was clear about the Mental Health Act or the rules in relation to this. Ward managers had ensured that capacity assessments were only carried out when required, although Deprivation of Liberty Safeguards applications were not being completed correctly.

Mental health understanding was supported by the mental health leads, which covered wards at both sites as required.

Staff in the emergency assessment unit had a good knowledge of the Mental Capacity Act and were also aware of the Mental Health Act and the fundamental rules in relation to the Act.

Of four patients who required capacity assessments completion, only one appeared to have had a documented capacity assessment, although this was not recorded in the patient’s care record. This related to carrying out a medical procedure, which the doctor felt the patient was unable to understand. A best interest decision had been made in relation to the procedure and the consent form noted that the patient was unable to comprehend the information.

Capacity assessments had not been carried out for the remaining three patients due to a perceived lack of capacity which relatives or carers had advised staff of when they were admitted. Staff we spoke with told us they were not aware they were required to carry out a capacity assessment as one had previously been completed. None of these patients had a Deprivation of Liberty Safeguards application submitted.

We did, however, find that applications had been submitted for patients who were required to have food and fluid through nasal gastric tubes, needed drips and the use of clinical mitts which were
used to prevent patients pulling these out. Deprivation of Liberty Safeguards applications were not required in these circumstances.

Staff in the emergency assessment unit, had a good knowledge of the Mental Capacity Act and were also aware of the Mental Health Act and the fundamental rules in relation to the Act.

**Trust level**

The trust reported that as at March 2018 Mental Capacity Act (MCA) training was completed by 89% of staff in medicine compared to the trust target of 95%.

Note: Mental Capacity Act training includes both level 1 and level 2.

A breakdown per staff group is shown in the table below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental staff</td>
<td>75</td>
<td>49</td>
<td>65%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>369</td>
<td>344</td>
<td>93%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>444</td>
<td>393</td>
<td><strong>89%</strong></td>
<td><strong>95%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

Nursing staff fell just short of the trust target with 93% of staff having completed the training.

Over the same period deprivation of liberty safeguards training was completed by 78% of staff within medicine compared to the trust target of 95%.

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental staff</td>
<td>27</td>
<td>19</td>
<td>70%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>66</td>
<td>54</td>
<td>82%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>93</strong></td>
<td><strong>73</strong></td>
<td><strong>78%</strong></td>
<td><strong>95%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

**West Cumberland Hospital**

The trust reported that as at March 2018 Mental Capacity Act (MCA) training was completed by 84% of staff at West Cumberland Hospital in medicine compared to the trust target of 95%.

A breakdown per staff group is shown in the table below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental staff</td>
<td>12</td>
<td>5</td>
<td>42%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>85</td>
<td>76</td>
<td>89%</td>
<td>95%</td>
<td><strong>Yes</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>97</strong></td>
<td><strong>81</strong></td>
<td><strong>84%</strong></td>
<td><strong>95%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>
Over the same period deprivation of liberty safeguards training was completed by 90% of staff at West Cumberland Hospital within medicine compared to the trust target of 95%. Medical staff had a 100% completion rate with both staff members eligible for this training completing the modules.

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental staff</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
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<td>7</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
<td>9</td>
<td>90%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Trust Provider Information Request P14/P49)

**Is the service caring?**

**Compassionate care**

**Friends and Family test performance**

The Friends and Family test response rate for medicine at the trust was 29% which was better than the England average of 25% from April 2017 to March 2018.

West Cumberland Hospital had a response rate of 37%, above the England average of 25%.

**Friends and family Test – Response rate between 01/04/2017 to 31/03/2018 by site.**

![Friends and family test - Wards (% recommend)](image-url)
Emotional support

All staff we spoke with placed patients at the forefront of everything they did. Staff spoke passionately about their patients and the standards of care that they wished them to receive.

We saw staff explaining and involving patients in their care and treatment in a calm and caring manner and this remained consistent during the busiest of times. Three patients told us they had been assisted with “a lovely wash. I will get a shower later”.

One patient told us “I came in last night. I’ve had excellent care. Doctors have checked in on me regularly. Very little waiting”.

Care was delivered in a compassionate, person centred way taking into account personal preference, physical, emotional and social considerations. We observed clinical staff from all disciplines involved in providing care.

All staff we saw delivering care explained what they were doing and sought permission from patient’s before delivering care.

One patient we spoke with had recently been seen by one of the physiotherapists. They told us ‘I felt very safe with her’.

Staff on medical wards and units spoke positively about links with the mental health services and liaison staff who visited regularly to see patients with mental health needs and gave advice to staff on issues such as managing challenging behaviour.

The hospital had a multi-faith chaplaincy service and a bereavement service which staff could access to support patients or carers who needed.
We spoke with 14 patients who told us, “I was frightened when I came I arrived, but have been made to feel confident and comfortable by the doctors and nurses”. Another patient told us, “I suffer with cancer. Everything has been explained to me. All staff have been lovely”. One patient told us, “Oh they are marvellous. Staff couldn’t be better, and go out of their way to help”.

The division took part in the National Cancer Patient Experience Survey (NCPES) 2016 receiving 409 responses. Patients were asked to rate their care on a scale of zero (very poor) to 10 (very good). Respondents gave an average rating of 8.3. 74% of respondents said that they were definitely involved as much as they wanted to be in decisions about their care and treatment. 88% said that overall, they were always treated with dignity and respect while they were in hospital.

We spent time observing care interactions between staff and patients and carried out a close observational exercise in which a small group of patients were monitored for an hour. During this time, we saw staff were genuinely warm and attentive and took time to listen to the patient.

One patient told us “First class, always around, press buzzer and they arrive quickly”. Another said, “If you can’t do something for yourself, they will help you to do it”.

**Understanding and involvement of patients and those close to them**

Patients spoke positively about information provided to them by staff. Care and treatment plans, risks and benefits were all explained and patients were given time to discuss any concerns or anxieties.

We observed patients visited by rehabilitation and therapy staff and heard the benefits explained. of the same explained to them. Family members were actively encouraged to get involved in any aspect of care they felt able and carer’s passes were offered to families whom were able to assist with eating and drinking assistance and personal hygiene needs.

Staff assessed patients and used clinical judgment to identify those who may require additional support in understanding care and treatment plans. Staff gave examples of interpreters, specialist practitioners, the use of supporting documents and by way of family presence.

In the recent friends and family test 96% of inpatients within the hospital said they would recommend the hospital.

One patient told us, ‘Not seen a doctor but saw a nurse practitioner and they were very helpful’.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The division supported the trust in planning services to meet the needs of the people of Cumbria in conjunction with the local clinical commissioning group (CCG) and senior managers attended meetings with local CCG representatives to ensure services were aligned to the needs of local people.
It was acknowledged by the divisional management team that developing future services would better position it to respond to the demands upon it, namely the needs of its population, geography, local infrastructure, and recruitment issues.

The trust employed one stroke physician who took part in a Telestroke system integrating staff from six trusts to mount an acute stroke service and there was a specialist stroke nurse based at the hospital. The division had appointed a number of specialist nurses and developed a number of specialist clinics. There were no dementia specialist nurses at the time of inspection.

Patients at WCH had access to a nurse led ambulatory care service (with EAU consultant oversight). The service provided care to patients meeting ‘referral criteria’, (such as atrial fibrillation, cellulitis, low risk chest pain and pulmonary embolism) to avoid unnecessary admission where safe to do so. Additionally, the service hosted a number of specialist clinics such as transient ischaemic attack (TIA) and infusion treatments.

**Meeting people’s individual needs**

The divisional managers confirmed that, when planning services, the needs of all patients, irrespective of age, disability, gender, race, religion, or belief were considered.

The trust had chaplains who provided access to major faiths within their communities. Staff accommodated faith preferences, and this was facilitated by the chaplaincy service or at the bedside.

The trust was working with the Learning Disability lead to implement ‘easy read’ leaflets for patient appointments and admissions. In addition to this, the trust was considering how they ensured learning disability patients were offered reasonable adjustments for appointments, such as, being offered appointments at the beginning of clinics and extended clinic slots to support patients’ complex needs.

During the inspection we observed various dementia initiatives in place to improve care. These included dementia care bundles, John’s campaign, Forget-me-not and the butterfly scheme which discreetly identified dementia patients.

We were advised that patients with a learning disability were catered for dependant on needs. For example, early this year, a patient was very anxious in a ward of other people. As a result, it was arranged, with patient and family involvement to move into an individual cubicle.

Staff stated that they could access support from the learning disability and most patients had a ‘This is me’ passport. The passport detailed personal preferences, likes/dislikes, anxiety triggers, and interventions which were helpful in supporting them during difficult periods.

Staff informed us that they had ease of access/referral into psychiatric services for those patients requiring this care, when needing MCA/DoLS guidance.

All wards displayed information for patients and carers on a variety of topics such as trust information, quality standards, disease/condition specific information, ward/staff contact details, a who’s who of staff on the ward, and general useful signposting on where to get further information such as Patient Advice and Liaison Services (PALS), and complaints.
One patient told us, “Staff have been so positive, no waiting and the doctors explained everything to me”.

We observed translation service signage as you entered wards which included foreign language access 24 hours per day. Telephone interpreters were available as well as face to face translation for deaf and blind patients. We were advised that Patient Advice Liaison Service (PALS) leaflets were available in five languages.

Staff we spoke with explained that they could access bariatric equipment via equipment storage when this was required. There was a dedicated purpose built bariatric room on one of the wards we visited.

Letters to patients were provided in a larger font for patients with impaired sight. We found that text and telephone calls were used to remind patients about appointments and elective admissions.

The trust was working with the learning disability lead to implement ‘easy read’ leaflets for patient appointments and admissions. In addition to this, the trust was considering how they ensured learning disability patients were offered reasonable adjustments for appointments, such as, being offered appointments at the beginning of clinics and extended clinic slots to support patients complex needs.

**Average length of stay**

**Trust Level**

From February 2017 to January 2018 the average length of stay for medical elective patients at the trust was 2.1 days, which is much lower than the England average of 5.8 days.

For medical non-elective patients, the average length of stay was 5.9 days, which is lower than the England average of 6.4 days.

**Average length of stay for elective specialties:**

- Average length of stay for elective patients in cardiology and gastroenterology is lower than the England average.
- Average length of stay for elective patients in nephrology is much lower than the England average.

**Elective Average Length of Stay – Trust Level**

- This trust
- England Average
Note: Top three specialties for specific trust based on count of activity.

**Average length of stay for non-elective specialties:**

- Average length of stay for non-elective patients in general medicine, cardiology and geriatric medicine is similar to the England average.

**Non-Elective Average Length of Stay – Trust Level**

![Bar chart showing average length of stay for non-elective patients in different specialties at West Cumberland Hospital and England average.]

**West Cumberland Hospital**

From February 2017 to January 2018 the average length of stay for medical elective patients at West Cumberland Hospital was 4.6 days, which is lower than England average of 5.8 days. For medical non-elective patients, the average length of stay was 6.4 days, which is the same as the England average.

**Average length of stay for elective specialties:**

- Average length of stay for elective patients in gastroenterology and general medicine is similar to the England average.
- Average length of stay for elective patients in pain management is much lower than the England average.

**Elective Average Length of Stay - West Cumberland Hospital**

![Bar chart showing average length of stay for elective patients in different specialties at West Cumberland Hospital and England average.]
Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine is similar to the England average.
- Average length of stay for non-elective patients in gastroenterology is lower than the England average.
- Average length of stay for non-elective patients in stroke medicine is much higher than the England average.

Non-Elective Average Length of Stay - West Cumberland Hospital

Access and flow

Referral to treatment (percentage within 18 weeks) - admitted performance

Referral to treatment times followed a stable trend over the period April 2017 to March 2018. Trust performance was on average 3% better than the England average for eight of the twelve months. In August and September 2017, trust rates were 8% and 4% respectively lower than the England average. During the winter months of November 2017 and January 2018 trust rates were 3% and 5% respectively lower than the England average.
Referral to treatment (percentage within 18 weeks) – by specialty

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric medicine</td>
<td>100%</td>
<td>97.5%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>100%</td>
<td>93.1%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>95.5%</td>
<td>94.1%</td>
</tr>
<tr>
<td>Neurology</td>
<td>0%</td>
<td>91.5%</td>
</tr>
</tbody>
</table>

Three specialties, general medicine, rheumatology and thoracic medicine were above the England average for admitted RTT (percentage within 18 weeks).

<table>
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<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
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<td>100%</td>
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</tr>
<tr>
<td>Thoracic medicine</td>
<td>100%</td>
<td>93.1%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>95.5%</td>
<td>94.1%</td>
</tr>
</tbody>
</table>

One specialty, neurology was below the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurology</td>
<td>0%</td>
<td>91.5%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

The trust provided us with sight of medical outliers (medical patients being cared for on non-medical wards) bed occupancy data at West Cumberland Hospital. Between January 2018 and June 2018, the number of patients classified as being medical outliers ranged were 2,184.

Staff on the non-medical wards confirmed that medical outliers remained under the care of their admitting medical team and that these patients were reviewed regularly. Staff confirmed that these patients were discussed at bed meetings in order to facilitate return to their base ward and vacate the surgical bed.

Wards with medical outliers were paired with specific teams to look after medical patients. Consultants did early rounds Monday to Friday based on early morning emails with patient lists. Junior doctors from the base ward undertake the daily tasks. We were informed that new admissions or listed complex patients were reviewed, but this was not always possible at weekends.
The trust held local and cross-site bed meetings during the day to address access and flow issues. Division senior nursing staff, matrons, and business managers attended to record bed occupancy and availability, discharges, and pending admissions.

All wards held daily board rounds and staff worked with pharmacy colleagues to obtain patient medications to take home in a timely manner.

We spoke with the integrated discharge team (IDT) and found that different types of multidisciplinary team meetings were needed to achieve successful discharge of complex patients, using the discharge screening tool (DST). Each meeting, involving family, social worker, occupational therapist, physiotherapist, nursing staff and doctor, could take 90 minutes to two hours to complete. The discharge screening tool used by the IDT was not anticipatory and came into operation when the patient was medically fit, which might involve a wait of two weeks or more. There had been no mixed sex breaches in the division in the previous 12 months.

There was an electronic system of appointing social workers to individual cases. Staff have found delays in finding a social worker and inefficiencies with several different social workers visiting the wards at the same time to see different patients. Staff told us that the old system of a ward based social worker was better.

The discharge team based at the hospital supported patients requiring care into the community. Staff told us resources in the community were in short supply and delays in discharge were not unusual, whilst services were sought. We spoke with a senior member of staff from the discharge team who told us that discharge assistants were deployed across medical wards.

Some patients can spend time in the on-site residential home where the trust has purchased for 15 step-down beds. There is no medical input into this home. Patients who spend this time in other community hospitals would have the benefit of GP ward rounds each morning.

**Patient moving wards per admission**

Information provided by the trust stated that data is captured on the daily Situation Reports (Sit Reps) but the system does not have the ability to extract data to provide a longer term overview. The trust indicated that the above can be evidenced at inspection if required.

*(Source: Trust Routine Provider Information Request – Ward moves)*

**Patient moving wards at night**

Information provided by the trust stated that data is captured on the daily Situation Reports (Sit Reps) but the system does not have the ability to extract data to provide a longer-term overview.

**West Cumberland Hospital**

From May 2017 to April 2018, there were 386 patients moving wards at night at West Cumberland Hospital. Ward moves at night followed a fairly stable trend over the period with an average of 32 ward moves per month. During the winter period of December 2017 to March 2018 numbers increased to an average of 46 ward moves per month. Numbers decreased in April.
2018 to 25, below the overall average of 32 ward moves.

We saw there were 31 patient moves after 10p.m at West Cumberland Hospital in the four months leading up to inspection. 13 were related to capacity, 10 due to clinical need, seven due to staff availability and one due to infection prevention.

Staff told us that moves after 10p.m were not ideal but due to capacity issues were essential.

(Source: Trust Routine Provider Information Request – Moves at night)

Learning from complaints and concerns

Summary of complaints

Trust level

From April 2017 to March 2018 there were 66 complaints about medical care. The trust took an average of 31 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be, responded to and closed within 30 working days.

Medical staff received the highest number of complaints of 51 (77%) followed by nursing staff with 12 complaints (18%). The most complaint about service area was elderly care (frailty unit) with 13 (20%) complaints, respiratory received the second highest number of seven (11%) complaints.

The trust did not allocate a site to two complaints received.

A breakdown of complaints per subject is shown in the table below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment / care - inpatient</td>
<td>42</td>
<td>64%</td>
</tr>
<tr>
<td>Treatment / care - outpatient</td>
<td>15</td>
<td>23%</td>
</tr>
<tr>
<td>Attitude of staff</td>
<td>4</td>
<td>6%</td>
</tr>
<tr>
<td>Appointment issues</td>
<td>3</td>
<td>5%</td>
</tr>
<tr>
<td>Information &amp; communication</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>Lost property and expenses</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Grand total</strong></td>
<td><strong>66</strong></td>
<td></td>
</tr>
</tbody>
</table>

West Cumberland Hospital

West Cumberland Hospital received 17 complaints, of these ten (59%) were about inpatient treatment and care and five (29%) about outpatient treatment and care. Nine complaints (53%) were partially upheld, four (24%) upheld and four (24%) refuted.

A breakdown of complaints per subject is shown in the table below:

<table>
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<tr>
<th>Subject</th>
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</tr>
<tr>
<td><strong>Grand total</strong></td>
<td><strong>17</strong></td>
<td></td>
</tr>
</tbody>
</table>
Treatment / care - inpatient | 10 | 59%
Treatment / care - outpatient | 5 | 29%
Appointment issues | 1 | 6%
Attitude of staff | 1 | 6%
Grand total | 17

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

We saw that the trust had a complaint policy and staff were aware of it. Staff discussed feedback from complaints and lessons learnt at ward meetings.

The wards we visited displayed leaflets and posters outlining the complaints procedure, escalation processes, and how to access further support from PALS.

**Number of compliments made to the trust**

The trust was unable to provide data broken down per core service.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

**Is the service well-led?**

**Leadership**

The division of medicine (emergency medicine, general internal medicine, medical specialties, rehabilitation and elderly medicine) had a ‘triumvirate’ management structure in place with clear lines of responsibility and accountability. The division was led by an associate medical director, an associate chief operating officer and a chief matron. The management team covered all sites.

These were further supported by respective heads of service, service managers and matrons.

Ward managers and sisters said they had constructive and positive relationships with directorate matrons and told us that they visited wards on a daily basis. Staff felt that managers communicated well with them and kept them informed about the management of the wards and service changes. Staff did not believe the senior team were as visible as they could be.

Junior doctors were well supported by senior colleagues and supervision from a mentor for each activity as well as an education supervisor. Some doctors told us that the number of locum’s consultants and registrars across the directorate was high and this lead to inconsistencies in the support that was available.

We reviewed divisional operational board (EMOB) monthly meeting minutes from April 2018 The agenda covered strategic, operational, divisional and business unit items. The Chair updated action plans after the meeting and these were revisited as a standing agenda item at subsequent meetings. We saw a number of concerns were discussed in relation to sepsis pathways and delays in treatment specific to stroke patients. These meetings were very well attended by the divisional leadership across both sites and were networked by way of video conferencing facilities.
Vision and strategy

The trust had developed clear objectives and aims for 2018 to 2019 in the ‘this is us – aims for the future document’. The document outlined four headings relating to staff, system working, service quality and sustainable finances and under each heading showed the priorities for the next twelve months.

We saw the trust website displayed the vision, mission and values and the medical division operational strategy was developed to align with the trust strategy which identified quality priorities, why they had been chosen and plans for improvement.

The trust’s values were: Patients first, safe and high quality care, responsibility and accountability, everyone’s contribution counts and respect.

Staff were clear about the vision and strategy for the service. There were displays of the trust vision (‘…to deliver nationally recognised high quality, cost effective, sustainable healthcare for the people we serve with staff who are proud to recommend our services’) and strategy within the division.

Culture

Staff at all levels spoke passionately about their work, and about the quality of care delivered. Staff spoke openly about some of the staffing difficulties faced on the wards but described their commitment to deliver the best possible care at all times.

We observed staff working together on the wards and a sense of ‘pulling together’ to get the job done. We saw with staff from a variety of specialisms and grades of staff working together effectively.

Staff morale was variable and staff expressed concern for colleagues working in particularly demanding wards due to staffing difficulties. Staff considered these issues to be national and generally described their managers as supportive and hard working. Recruitment efforts were recognised and teams were aware of progress being made where possible to fill vacancies.

The NHS staff survey outcomes for 2017 showed a 54.4% return rate for the trust and reflected some of these feelings expressed by staff. The survey was made up of 88 questions separated under five themes. We found that compared to 2016, out of 88 questions the trust had 13 questions showed outcomes which were significantly better, 72 showed no change and three areas were significantly worse.

The top three findings from the NHS staff survey outcomes for 2017 compared to other acute trusts were the ‘percentage of staff appraised’, the ‘percentage of staff working extra hours’ and the ‘percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months’.

The lowest three findings from the NHS staff survey outcomes for 2017 compared to other acute trusts were ‘quality of appraisals’, ‘support from immediate managers’ and ‘percentage of staff reporting good communication between senior management and staff’.
Staff did not always feel their contribution was recognised and valued by senior leaders and many of the staff told us they had not seen senior executive staff.

**Governance**

We saw the division had clear governance processes which were linked into the wider organisational management structure. Governance systems were clinically driven with multi-specialism input.

The senior management team told us divisional management meetings, operational team meetings and clinical governance meetings took place each month. The risk register, incidents, complaints and lessons learned were discussed. Matrons and ward managers disseminated information to ward staff through ward meetings, communication books and notices on staff boards. We reviewed monthly divisional governance, safety and quality board meeting minutes for January and February 2018, which corroborated this.

Several weaknesses in governance and performance exist within the trust with respect to medicines use, as stated on the medicines optimisation strategy 2014 to 2019. There had been some recent and early signs of improvement but further significant change and action is required to deliver the level of care that patients need. The trust recognised that a fundamental requirement will be to have a safe and effective system for managing medicines to ensure that all patients received the medicines that they need, when they need them and irrespective of location within the Trust. The strategy outlines the seven strategic challenges required over the next five years to ensure delivery of the safe and effective use of medicines.

We saw that the divisional clinical audit reporting arrangements flow from the monthly dashboard into the emergency care and medicine operational board, to the safety and quality committee before presentation at the trust board.

In the March 2017 Safety and Quality Committee Nurse Staffing Assurance Report we saw a number of wards which were highlighted as having a less than 80% registered nurse fill and as a result of this were being closely monitored by the senior management team. This included the emergency assessment unit (EAU) at West Cumberland Hospital.

Within the same paper we saw where fill rates were less than 80% a review was completed to show the possible correlation of patient harm when compared to reduced numbers of registered nurses. EAU was reported as an area of exception for February and March as the fill rate on duty for registered nurses was 72.0% below the 80% threshold. The impact of the reduced registered nurse staffing was correlated with patient harm in February and March 2018 resulting in twenty three patient falls, two hospital acquired pressure ulcers one grade two, and two medication errors.

Staff working in this area were aware of the incidents and felt managers were providing staff as best they could on a day to day basis.

Senior staff were motivated and enthusiastic about their roles and had clear direction with plans in relation to improving patient care.
Ward managers, senior managers and clinical leads showed knowledge, skills, and experience. A clear responsibility and accountability framework had been established. Staff at all levels were clear about their roles and understood their level of accountability and responsibility.

The division actively contributed to the trust Quality Improvement Plan (QIP) which drew together organisational objectives and improvement plans.

The division were involved in reviewing procedures caught within the National Safety Standards for Invasive Procedures (NatSSIPs) agenda. The team had identified local invasive practices by business unit based on core NatSSIPs and were reviewing procedures locally to standardise practice, referred to as LocSSIPs. Division leads were working with the NatSSIPs Steering Group to prioritise specific procedures for development.

**Management of risk, issues and performance**

We were provided with sight of the divisional risk register dated 19 June 2018. Divisional managers confirmed the risk register was a live document with on-going review, actions taken and progress. However, we were advised that numerous items had remained on the risk register for several years.

The registers contained a risk descriptor, risk controls, control assurances, risk grading and reviewed progress against each. The on-going risks listed in the June 2018 register included a number of trust wide matters.

We found those risks which attracted a rating of 12 or more included nurse staffing cover and impact, slip, trips and falls, failure to consistently to meet cancer targets, no substantive middle grade doctor in haematology-oncology, lack of consultant oncologist capacity, patient flow as well as education and training of the workforce.

Whilst detailed in terms of risk description, the register appeared unreliable, duplicating many common themes and lacking detail in terms of actions taken and progress over the period of time since the risk was identified. There were several examples of wards not knowing what the risk register was. Additionally, ward managers were unable to voice what risks were on it.

There was internal clinical audit activity and monitoring of performance and quality within the division. Senior staff recorded local and national measures and outcomes which fed into divisional activity.

The top risk identified by ward staff was lack of registered nurse cover. This risk specific EAU was included on the divisional register but was rated amber, scoring 12 at the time of inspection, despite incidence of patient harm due reduced qualified nurse numbers.

**Information management**

Information provided (end of March 2018) by the trust showed 88% compliance for nursing staff and 80% compliance with medical staff with information governance training across the division. This was below the trusts target of 95% compliance.
Although staff said there was difficulty in accessing computers, policies and clinical guidelines were available on the trust intranet. We observed staff trying to log into the system and we saw delays in obtaining information.

Some staff told us that access to the electronic observation platform was intermittent and baseline observations such as blood pressure and temperatures were recorded on paper and then transferred to the electronic system at a later time.

These electronic patient observations and information were accessible to authorised staff through the input of a password. Some doctors told us that the system was not as up to date as it should be due to these issues.

We were notified, post inspection, that a recent WiFi upgrade has significantly improved coverage and performance and on 31 July, the e-observations software was upgraded to NEWS2 and monitoring data has showed that staff were using the system and all issues were being reported. The trust had 12 issues logged to date, all of which were resolved. An action plan was in place in order to ensure there was ongoing monitoring of WiFi performance and any issues reported to the service desk.

Staff informed us that discharge-planning considerations commenced on admission with input from the discharge team. We found that general practitioners (GPs) were informed of patient discharge in writing and always made themselves available in the event of any GP telephone queries.

Community services and ongoing care needs were identified by staff prior to the patients discharge and involved the patient, his or her family, and the service providers in the discharge planning.

Staff on specialist units gave patients and their families discharge booklets which provided medical information, treatment details, contact information, and signposting for further support and guidance.

**Engagement**

The division sought the viewed of patients and their families provided views and feedback through the friends and family test, the ‘two minutes of your time’ survey, ‘face-to-face and real time surveys. Patients could also leave feedback on comment cards and staff told us that opportunities to take feedback during hospital stay were made.

Wards displayed information for patients and their families on ways in which they could provide commentary about their experiences in a more confidential setting such as accessing PALS.

We saw local information was gathered relating to volunteer organisations, charities and national support groups. Staff told us they maintained strong local links with the various organisations.

The senior leadership team arranged staff forums and drop-in sessions and the chief executive held cross-site roadshows. Staff we spoke with were aware of these sessions but told us it could be difficult to leave the ward.
Staff were provided with updates via the trust intranet, email, and team meetings. Many of the ward sisters told us it was difficult arranging staffing meetings and often held update chats following patient huddles.

Staff had developed good links with external professional colleagues, support organisations and volunteer groups.

One member of staff told us ‘I feel valued and part of the team. I am happy to cover the hospital when needed’.

Friends and family test score: staff showed that 57 staff recommend this trust as a place to work. There were 251 responses out of 4,100 staff who work at this trust.

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Learning, continuous improvement and innovation

- The trust provided us with detail of divisional innovations within the last two years. They reported a joint project with the University of Cumbria to develop and appoint allied nurse practitioners (occupational therapists) to support the nursing compliment across the division.
- The stroke team were part of the North-West network which provided telemedicine (Telestroke) services across the region.
- The endobronchial ultrasound service implemented and successfully moved to core biopsy improving diagnostic rates.
- The ambulatory lung biopsy vent improved the lung cancer pathway.
- The trust had recruited sleep specialist nurses to provide continuous positive airway pressure (CPAP) service and in due course plan to introduce an in-house sleep diagnostic service.
- We were advised that the new exhaled nitric oxide analysers purchased were improving asthma care.
- A subspecialist interstitial lung disease clinic has been developed (with same day gas transfer testing, and embedded specialist nurse with palliative care skillset).
• Local safety standards for invasive procedures (LocSSIPs) had been introduction and embedded in cardio catheterisation lab.

• The trust was top in UK for patient reported experience measures survey for kidney care.

• We were informed that the home therapists were shortlisted for a national award.

• The peritoneal dialysis nursing team at the trust were nominated for a Burdett Award (The Burdett trust for nursing).

• The trust host and participate in Regional Upper GI Endoscopy training

• A hyper-acute stroke unit business case was approved and the implementation process has commenced.

• We were informed that the frailty service had received a HSJ nomination.

• There were joint appointments agreed with the University of Central Lancashire and professor of medicine, senior lecturers and clinical fellows.

• We were advised of secondment of community heart failure nurses to acute and developing single services.

• A business case for a cancer centre within a large North-East hospital had been approved

• The trust was providing scientific immunology at a large North-East hospital.

• We saw that pathology services within the trust had received ISO (15189) Accreditation.

• A consultant of the week had been implemented to provide clear direction to staff and patients across the directorate.

• A new sleep apnoea service had been introduced and the introduction of sleep specialist nurses were due to be appointed at the hospital in the future.

• Additional respiratory nurses to be introduced the support the ward based pleural service. The COPD care bundle had been updated and a new asthma bundle created. This included the purchase of new exhaled nitric oxide analysers to use improve asthma care

• The introduction of specialist interstitial lung disease clinic developed (with same day gas transfer testing, and embedded specialist nurse with palliative care skillset) and now participating in regional MDT work.

• A cardiologist lead for the directorate agreed and improved cardiologist cover for the hospital. Heart failure nurses appointed.

• The trust had recently purchased new dialysis machines and the renal department commenced expansion within this service.

• We were informed that the trust has purchased a fibro scan and that staff training had completed

• During the inspection were informed of approval to progress to a seven-day endoscopy service in the near future.

• The trust had appointed advanced care practitioners.
Facts and data about this service

The trust provides both emergency and elective surgical intervention at two sites Cumberland Infirmary and West Cumbria Hospital. Surgical service is split into a number of specialities as listed below:

- General surgery (lower GI, upper GI, breast)
- Urology
- Theatres & anaesthetics
- Critical care & High dependency unit
- Trauma & orthopaedics
- Rheumatology
- Head & neck (ENT, oral surgery, orthodontics)
- Ophthalmology
- Vascular
- Radiology

Trauma is carried out at Cumberland Infirmary with the one list of minor trauma procedures carried out weekly at West Cumberland Hospital.

Emergency surgery is provided primarily at Cumberland Infirmary and a clinical pathway is in place for patients presenting at West Cumberland Hospital requiring emergency surgical intervention.

The trust has seven surgical wards with 157 inpatient beds.

(Source: Routine Provider Information Request (Acute RPIR) – Info about service)

The trust had 25,605 surgical admissions from January to December 2017. Emergency admissions accounted for 7,388 (29%), 15,122 (59%) were day case, and the remaining 3,095 (12%) were elective.

(Source: Hospital Episode Statistics)

Following a comprehensive inspection in 2016, the trust was required to complete the following actions:

- Ensure the peri-operative improvement plan is thoroughly embedded and debrief sessions are undertaken;
- Improve compliance against 18 week RTT standards for oral surgery, trauma and orthopaedics, urology and ophthalmology;
- Improve rate of short notice cancellations for non-clinical reasons, specifically ENT, orthopaedic and general surgery; and
- Must ensure patients whose operations are cancelled are treated within 28 days.
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The trust set a target of 95% for completion of mandatory training.

Trust level

A breakdown of compliance for mandatory training courses as at March 2018 at trust level for qualified nursing staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving &amp; handling level 1 non clinical (3 yearly)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, trips and falls level 1</td>
<td>362</td>
<td>354</td>
<td>98%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk management</td>
<td>362</td>
<td>350</td>
<td>97%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>361</td>
<td>342</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Duty of candour</td>
<td>362</td>
<td>341</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>362</td>
<td>340</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety</td>
<td>362</td>
<td>340</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>362</td>
<td>340</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>362</td>
<td>337</td>
<td>93%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent level 1&amp;2</td>
<td>362</td>
<td>327</td>
<td>90%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia</td>
<td>335</td>
<td>302</td>
<td>90%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines management</td>
<td>350</td>
<td>308</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control level 2</td>
<td>362</td>
<td>308</td>
<td>85%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Calculating drug doses</td>
<td>347</td>
<td>290</td>
<td>84%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health records management</td>
<td>362</td>
<td>301</td>
<td>83%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Hand hygiene (clinical)</td>
<td>362</td>
<td>287</td>
<td>79%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>BLS (adults)</td>
<td>72</td>
<td>56</td>
<td>78%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; handling level 2</td>
<td>361</td>
<td>278</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>News</td>
<td>312</td>
<td>213</td>
<td>68%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 04</td>
<td>14</td>
<td>9</td>
<td>64%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>ILS (adults)</td>
<td>268</td>
<td>168</td>
<td>63%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 01</td>
<td>327</td>
<td>200</td>
<td>61%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 02</td>
<td>334</td>
<td>192</td>
<td>57%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>ILS (paediatrics)</td>
<td>147</td>
<td>82</td>
<td>56%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>134</td>
<td>73</td>
<td>54%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Understanding end of life</td>
<td>361</td>
<td>179</td>
<td>50%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk management (board and senior management)</td>
<td>47</td>
<td>22</td>
<td>47%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
In surgery the 95% target was met for one of the 28 mandatory training modules for which qualified nursing staff were eligible. Blood safety 04 had a completion rate of 64%, although this equates to only five staff members that did complete the training. Apart from the four training modules that met the 95% trust target a further seven modules had completion rates of 90% and above. Moving & handling level 1 non clinical (3 yearly) had a 100% completion rate, although only one staff member was eligible for this training.

A breakdown of compliance for mandatory training courses as at March 2018 at trust level for medical staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand hygiene (non clinical)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>NG tubes</td>
<td>65</td>
<td>58</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>147</td>
<td>130</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Duty of candour</td>
<td>147</td>
<td>123</td>
<td>84%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prompt</td>
<td>12</td>
<td>10</td>
<td>83%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, trips and falls level 1</td>
<td>147</td>
<td>121</td>
<td>82%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk management</td>
<td>147</td>
<td>120</td>
<td>82%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>147</td>
<td>117</td>
<td>80%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Hand hygiene (clinical)</td>
<td>146</td>
<td>115</td>
<td>79%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>147</td>
<td>113</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; handling level 1 clinical (3 yearly)</td>
<td>147</td>
<td>112</td>
<td>76%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety</td>
<td>147</td>
<td>111</td>
<td>76%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent level 1&amp;2</td>
<td>147</td>
<td>110</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>147</td>
<td>109</td>
<td>74%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Trust doctors patient safety programme</td>
<td>146</td>
<td>108</td>
<td>74%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia</td>
<td>124</td>
<td>89</td>
<td>72%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Calculating drug doses</td>
<td>138</td>
<td>97</td>
<td>70%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control level 2</td>
<td>147</td>
<td>100</td>
<td>68%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines management</td>
<td>139</td>
<td>93</td>
<td>67%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>ALS (adults)</td>
<td>3</td>
<td>2</td>
<td>67%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>BLS (paediatrics)</td>
<td>29</td>
<td>19</td>
<td>66%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>BLS (adults)</td>
<td>92</td>
<td>59</td>
<td>64%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health records management</td>
<td>147</td>
<td>90</td>
<td>61%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>News</td>
<td>109</td>
<td>66</td>
<td>61%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 01</td>
<td>124</td>
<td>59</td>
<td>48%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>ILS (adults)</td>
<td>5</td>
<td>2</td>
<td>40%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>13</td>
<td>5</td>
<td>38%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 02</td>
<td>18</td>
<td>6</td>
<td>33%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In surgery the 95% target was met for one of the 28 mandatory training modules for which qualified nursing staff were eligible.
medical staff were eligible. ALS (adults) had a completion rate of 67% and ILS (adults) had a completion rate of 40%, this equates to only one and three staff members respectively that did not complete the training. Hand hygiene (non clinical) had a 100% completion rate, although only one staff member was eligible for this training.

**West Cumberland Hospital**

A breakdown of compliance for mandatory training courses as at March 2018 for qualified nursing staff in the surgery department at West Cumberland Hospital is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk management</td>
<td>94</td>
<td>93</td>
<td>99%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, trips and falls level 1</td>
<td>94</td>
<td>93</td>
<td>99%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Duty of candour</td>
<td>94</td>
<td>92</td>
<td>98%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>94</td>
<td>92</td>
<td>98%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety</td>
<td>94</td>
<td>92</td>
<td>98%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>94</td>
<td>92</td>
<td>98%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>94</td>
<td>91</td>
<td>97%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>94</td>
<td>91</td>
<td>97%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent level 1&amp;2</td>
<td>94</td>
<td>91</td>
<td>97%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia</td>
<td>80</td>
<td>76</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control level 2</td>
<td>94</td>
<td>89</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines management</td>
<td>94</td>
<td>89</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Calculating drug doses</td>
<td>94</td>
<td>85</td>
<td>90%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health records management</td>
<td>94</td>
<td>81</td>
<td>86%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>23</td>
<td>19</td>
<td>83%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Hand hygiene (clinical)</td>
<td>94</td>
<td>77</td>
<td>82%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>News</td>
<td>93</td>
<td>73</td>
<td>78%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; handling level 2</td>
<td>94</td>
<td>70</td>
<td>74%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>BLS (adults)</td>
<td>14</td>
<td>10</td>
<td>71%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk management (board and senior management)</td>
<td>7</td>
<td>5</td>
<td>71%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>ILS (adults)</td>
<td>77</td>
<td>54</td>
<td>70%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 02</td>
<td>93</td>
<td>63</td>
<td>68%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 01</td>
<td>79</td>
<td>53</td>
<td>67%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>ILS (paediatrics)</td>
<td>45</td>
<td>30</td>
<td>67%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 04</td>
<td>14</td>
<td>9</td>
<td>64%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Understanding end of life</td>
<td>94</td>
<td>60</td>
<td>64%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, trips and falls level 2</td>
<td>35</td>
<td>19</td>
<td>54%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

At West Cumberland Hospital the 95% target was met for twelve of the 27 mandatory training modules for which qualified nursing staff were eligible.

Risk management (Board and senior management) had a completion rate of 71%; this equates to only two staff members that did not complete the training.
Apart from the twelve training modules that met the 95% trust target, a further one module had a completion rate of 90%.

Staff we spoke with told us they had completed their mandatory training mainly online but with some classroom-based training. Staff told us that finding time to complete training was an issue but they had more time during night shifts.

At this inspection, the completion rate for role specific mandatory training was 65% and for core training it was 85%. The matron was placing reminder signs in the staff room requesting staff to complete certain courses; i.e. targeting the lowest completion rate course. Staff were also encouraged to identify career development opportunities.

A breakdown of compliance for mandatory training courses as at March 2018 for medical staff in the surgery department at West Cumberland Hospital is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALS (adults)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Hand hygiene (clinical)</td>
<td>34</td>
<td>31</td>
<td>91%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NG tubes</td>
<td>19</td>
<td>17</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Duty of candour</td>
<td>34</td>
<td>30</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk management</td>
<td>34</td>
<td>30</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, trips and falls level 1</td>
<td>34</td>
<td>30</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>34</td>
<td>29</td>
<td>85%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>34</td>
<td>28</td>
<td>82%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia</td>
<td>27</td>
<td>22</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>BLS (adults)</td>
<td>16</td>
<td>13</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>34</td>
<td>27</td>
<td>79%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety</td>
<td>34</td>
<td>27</td>
<td>79%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent level 1&amp;2</td>
<td>34</td>
<td>27</td>
<td>79%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Trust doctors patient safety programme</td>
<td>34</td>
<td>27</td>
<td>79%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Calculating drug doses</td>
<td>33</td>
<td>26</td>
<td>79%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; handling level 1 clinical (3 yearly)</td>
<td>34</td>
<td>26</td>
<td>76%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prompt</td>
<td>4</td>
<td>3</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>34</td>
<td>25</td>
<td>74%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control level 2</td>
<td>34</td>
<td>24</td>
<td>71%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines management</td>
<td>34</td>
<td>24</td>
<td>71%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>BLS (paediatrics)</td>
<td>6</td>
<td>4</td>
<td>67%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health records management</td>
<td>34</td>
<td>19</td>
<td>56%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 01</td>
<td>30</td>
<td>14</td>
<td>47%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>News</td>
<td>27</td>
<td>11</td>
<td>41%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>ILS (adults)</td>
<td>5</td>
<td>2</td>
<td>40%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 02</td>
<td>7</td>
<td>2</td>
<td>29%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
At West Cumberland Hospital the 95% target was met for one of the 26 mandatory training modules for which medical staff were eligible. Prompt and BLS (paediatrics) had completion rates of 75% and 67% respectively, this equates to only one and two staff members that did not complete the training.

Apart from the one training module that met the 95% trust target a further one module had a completion rate of 90%.

ALS (adults) had a 100% completion rate, although only one staff member was eligible for this training.

(Source: Routine Provider Information Request (RPIR) – P40)

The current completion rate for mandatory training was 65% for all courses and 85% for core training courses, below the trust’s target of 95% compliance. The matron was striving to increase the compliance rate by placing reminder signs in the staff room requesting staff to complete outstanding mandatory training. The matron was targeting the courses with the lowest completion rates first.

Senior managers explained that staff shortages had contributed to the lower than expected compliance rates and it would take time for staff to catch up with their mandatory training. At ward level, ward managers told us their staff were either booked to receive training or had been encouraged to complete as soon as practicable. Staff we spoke with confirmed that training completion was discussed at annual appraisals and throughout the year.

The divisional senior management team had initiated action to increase the levels of compliance for mandatory training. This included reimbursing staff for undertaking training during their own time and linking the completion of mandatory training to salary progression.

**Safeguarding**

The trust set a target of 95% for completion of safeguarding training.

**Trust level**

A breakdown of compliance for safeguarding training courses as at March 2018 at trust level for qualified nursing staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 3 (specialist)</td>
<td>14</td>
<td>13</td>
<td>93%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>313</td>
<td>281</td>
<td>90%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>362</td>
<td>315</td>
<td>87%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 3 (core)</td>
<td>35</td>
<td>30</td>
<td>86%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In surgery the 95% target was met for none of the safeguarding training modules for which
qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses as at March 2018 at trust level for medical staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 2</td>
<td>128</td>
<td>93</td>
<td>73%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>147</td>
<td>103</td>
<td>70%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 3 (core)</td>
<td>19</td>
<td>12</td>
<td>63%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In surgery the 95% target was met for none of the three safeguarding training modules for which medical staff were eligible.

West Cumberland Hospital

A breakdown of compliance for safeguarding training courses from as at March 2018 for qualified nursing staff in the surgery department at West Cumberland Hospital is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 2</td>
<td>58</td>
<td>56</td>
<td>97%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 3 (specialist)</td>
<td>14</td>
<td>13</td>
<td>93%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>94</td>
<td>84</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 3 (core)</td>
<td>22</td>
<td>18</td>
<td>82%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

At West Cumberland Hospital the 95% target was met for one of the safeguarding training modules for which qualified nursing staff were eligible. Safeguarding children level 3 (specialist) had a completion rate of 93%, this equates to only one staff member not completing this training.

A breakdown of compliance for safeguarding training courses as at March 2018 for medical staff in the surgery department at West Cumberland Hospital is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 2</td>
<td>27</td>
<td>22</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 3 (core)</td>
<td>7</td>
<td>5</td>
<td>71%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>34</td>
<td>22</td>
<td>65%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

At West Cumberland Hospital the 95% target was met for none of the three safeguarding training modules for which medical staff were eligible. Safeguarding children level 3 (core) had a
completion rate of 71%; this equates to only two staff members not completing this training.

(Source: Routine Provider Information Request (RPIR) – P40)

We were not assured that safeguarding training was delivered in accordance with ‘Adult Safeguarding Levels and Competencies for Healthcare, Intercollegiate guidance (2016)’. This recommends level two training for clinical staff and level three for staff responsible for the review of alerts.

Training data submitted by the trust prior to inspection, showed that all staff appear to be completing level one adults safeguard training. This included managers investigating safeguarding alerts.

The trust’s adults safeguarding policy stated that all clinical staff working with adults should complete level two adults safeguarding training. Staff were instructed to inform their line managers when raising alerts, but the policy did not provide guidance for line managers to support any further action and no additional training was provided.

The divisional senior management team had initiated action to increase the levels of compliance for safeguarding training. This included reimbursing staff for undertaking training during their own time and linking the completion of training to salary progression.

The trust had systems and processes in place to protect patients from abuse and staff had been trained in safeguarding and were aware of how to get help so that safeguarding was everyone’s responsibility. We saw that the trust had an up to date safeguarding policy that staff accessed through the trust’s intranet.

The trust had a lead nurse for adult and children safeguarding. The safeguarding sub-group reported to the safety and quality committee which reported to the board.

Cleanliness, infection control and hygiene

At this inspection, we found the wards and departments visited were visibly clean and tidy. The trust had an infection, prevention and control policy, this directed staff to other policies and protocols for guidance about cleaning, decontamination and personal protective clothing.

We saw information displayed on the wards and departments we visited recording the number of days since the last hospital acquired Clostridium difficile (C. diff) and Methicillin-resistant staphylococcus aureus (MRSA) isolate.

The infection prevention team conducted audits at random and they sent their results to the matron and ward manager. The audit results had been 90% or greater. The directorate held infection prevention meetings once a month where infection prevention audits were discussed. Environmental audits were completed on a weekly basis. The latest audits gave compliance results for nursing (100%), domestic (99%) and estates (100%) areas – a combined total of 100% compliance.

During the inspection, we observed that staff were compliant with hand hygiene policies, including ‘bare below the elbows’ and personal protective clothing policies. Hand washing advice was
clearly displayed and facilities for hand hygiene were available. Hand hygiene compliance data was displayed on wards we visited. We observed staff decontaminating their hands appropriately. Staff had access to at the point of use alcohol gel. Isolation rooms were available for patients identified at risk of infection.

Staff we spoke with said that they had access to appropriate personal protective clothing (PPE). We observed staff using gloves and aprons appropriately.

**Environment and equipment**

The ward consisted of 32 single bedrooms with en-suite facilities. The bedrooms were large in size with soft lighting making a comfortable experience for patients. The corridors were wide, clean and free from clutter. The ward was divided in to three areas; i.e. 1A, 1B and 1C. The area known as 1A contained 13 beds. At the time of inspection, all of these beds were occupied.

Ward 1B had four bedrooms for patients recovering from surgery and ward 1C had 15 beds for all trauma repatriation; i.e. patients who have had trauma orthopaedic emergency surgery at Cumberland Infirmary. Once they are well enough to travel by ambulance they are transferred to West Cumberland Hospital.

All three wards were visibly clean and tidy with alcohol hand sanitisers throughout the ward. Aprons and gloves were available outside each bedroom. We saw staff using the gel on their hands and wearing aprons and gloves when attending to patients’ needs. Also, staff wore uniforms that were bare below the elbow.

The domestic and linen rooms were clean and tidy with all items neatly stored on shelves. The chemicals were locked in metal storage cupboards in the domestic rooms. All the equipment in the staff room and pantry were labelled with PAT testing stickers apart from the toaster in the pantry. The trust told us that all equipment was subject to routine planned preventative maintenance as defined by the equipment manufacturer and we saw that equipment had been maintained and were safety checked. We saw that resuscitation trolleys had all been checked on a daily basis.

**Assessing and responding to patient risk**

The surgical division had systems and processes in place to support staff in wards and theatres to assess and respond to patient risk. An example of this was the development of a standard operating procedure for the management of critical care patients who were nursed in recovery areas within theatres that ensured specialist critical care nurses were available.

Within the electronic patient record there were a series of prompts built in to support staff in managing risks posed to individual patients. For example, automatic drug alerts, dose alerts, allergy alerts, venous thromboembolism alerts and care bundles such as for pressure ulcers or falls.

Information gathered from the electronic patient record was used to help the trust assess and respond to patient risks. Staff, using the electronic patient record, recorded patient observations using the national early warning score (NEWS) system. In addition, we saw that each ward displayed posters about the risk of sepsis. All staff we spoke with were able to describe what they
would do to treat and escalate sepsis. Staff also had access to an outreach team if NEWS scores were abnormal and staff required additional help.

The trust had a sepsis policy in place to provide best practice guidance to all staff involved in the care of patients presenting with sepsis. The policy covered initial management of patients with sepsis and was based on recommended research based evidence. Emphasis was placed on actions within the first hour and reflected NICE guidance issued in July 2016.

The policy required all ill or deteriorating patients to be screened for sepsis, using bedside observations, clinical skills, blood tests (including lactate) and imaging where appropriate. All patients with an elevated NEWS score were considered for screening and escalation to senior medical staff. Further management, such as the use of the sepsis care bundle and antibiotics were implemented.

We saw that patient observations were recorded appropriately on the electronic system and concerns about deteriorating patients were escalated in accordance with guidance and the NEWS system. During our inspection we saw that deteriorating patients had evidence of appropriate escalation and intervention recorded.

Risks associated with falls, pressure ulcers, VTE, catheter and urinary infections were assessed on a monthly basis using the NHS safety thermometer.

In theatres staff used the World Health Organisation’ (WHO) surgical safety checklist. This was supplemented by the perioperative improvement plan (POIP) to ensure all debrief sessions were undertaken as part of the checklist to reduce the risk of never events.

The trust had taken action to ensure the POIP was embedded and that all debrief sessions were undertaken as part of the WHO checklist to reduce the risk of never events. The perioperative improvement plan was shared on the trust intranet and was a live document continually monitored and updated. Within the division, the POIP was discussed at the safety and quality board and surgical away days and also at relevant directorate meetings. LocSSIP audits were carried out on a monthly basis, each audit reviewed 10 patient episodes and a draft summary report on audits conducted to date was awaiting final approval.

The national safety standards for invasive procedures (NatSSIPs) incorporated the contents of the WHO surgical safety checklist. These required the checklist to be completed for every patient undergoing a surgical procedure (including local anaesthesia).

We saw that audits of completion of the checklist were carried out for all theatres. Staff told us the audit also identified whether the sign-in, time-out and sign-out had been completed for each patient. The audits provided by the trust showed completion of the checklist had been ‘poor’ and had not been completed for every patient.

The audit identified areas of good practice (compliance with the safety checklist, excluding debrief, was good; ‘no’ responses were less than 1%) and areas for improvement (compliance with the audit; omissions in the safety process were not always escalated). The audit outcomes were to be presented to the board in August 2018. Observation of procedures during this inspection showed the WHO checklist was appropriately completed.
**Nurse staffing**

The trust has reported their staffing numbers below for the period as at March 2018 and April 2018.

<table>
<thead>
<tr>
<th>Location</th>
<th>Mar-18</th>
<th></th>
<th>Apr-18</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
<td>Fill rate</td>
<td>Actual WTE staff</td>
</tr>
<tr>
<td>Cumberland Infirmary</td>
<td>219.3</td>
<td>226.8</td>
<td>96.7%</td>
<td>216.6</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>91.5</td>
<td>102.9</td>
<td>88.9%</td>
<td>90.4</td>
</tr>
<tr>
<td>Total</td>
<td>310.8</td>
<td>329.7</td>
<td>94.3%</td>
<td>307.0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16)

**Vacancy rates**

From April 2017 to March 2018, the trust reported a vacancy rate of 10.0% in surgery. This was higher than the trust target of 5%.

A breakdown for each site is as follows:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total vacancies (WTE)</th>
<th>Total number of staff establishment (WTE)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>231.0</td>
<td>2,890.7</td>
<td>8.0%</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>187.6</td>
<td>1,291.1</td>
<td>15.0%</td>
</tr>
<tr>
<td>Total</td>
<td>419.5</td>
<td>4,181.7</td>
<td>10.0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

From May 2017 to April 2018, the trust reported a turnover rate of 7.3% in surgery. This was better than the trust target of 13%.

A breakdown for each site is as follows:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total leavers (WTE)</th>
<th>Average number of staff establishment (WTE)</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>8.1</td>
<td>104.3</td>
<td>7.8%</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>6.2</td>
<td>90.5</td>
<td>6.9%</td>
</tr>
</tbody>
</table>
Sickness rates

April 2017 to April 2018, the trust reported a sickness rate of 5% in surgery. This was higher than the trust target of 4%.

A breakdown for each site is as follows:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total absence days</th>
<th>Total WTE days available</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>3,710.0</td>
<td>79,785.0</td>
<td>5.0%</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>1,550.4</td>
<td>33,028.0</td>
<td>5.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5,260.4</strong></td>
<td><strong>112,813.0</strong></td>
<td><strong>4.7%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

From April 2017 to March 2018, the trust reported a bank usage rate of 22% in surgery.

The trust was unable to provide comparable data for agency and shifts left unfilled, due to system restrictions.

At West Cumberland Hospital, general theatres (96%) reported the highest agency staff use.

The breakdown by site is shown in the table below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Bank shifts</th>
<th>Total shifts</th>
<th>Bank shifts as a proportion of total shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>361</td>
<td>1,906</td>
<td>19%</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>71</td>
<td>83</td>
<td>86%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>432</strong></td>
<td><strong>1,989</strong></td>
<td><strong>22%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

We saw nurse staffing figures were displayed in each ward and planned staffing numbers matched actual numbers in each ward we visited. However, practice within the trust was for matrons and the operational matron to undertake meetings on a daily basis to identify wards most at risk of running at less than optimal staff numbers. This frequently resulted in staff being moved from surgical wards and areas to cover shortages on medical wards. Although, surgical wards had reduced numbers of staff we did not observe unsafe numbers or practice. During particular periods of staff pressures matrons worked operationally on wards.

We spoke with the operational matron who confirmed that staffing levels were reviewed across the trust as a whole based on staffing numbers, the use of an acuity tool ((safer nursing care tool (SNCT)) and professional judgement. Some ward staff were uncomfortable with moving wards at
short notice and were unsure how effectively decisions had been made, e.g. the use of the SNCT. We attended the bed meetings and saw that daily staffing levels were escalated and discussed by the operational matron and the matrons for the division. Staff were moved between wards to reach an acceptable staffing. Theatre staffing levels were planned according to the lists on a daily basis.

Staffing was on the division’s risk register because the senior management team recognised that, while it achieved safe staffing levels, the position was only maintained with daily close monitoring. The risk register identified that there was insufficient staff to meet the needs of patients across the trust. Within the division there were 24 whole time equivalent qualified vacancies across both sites and 0.8 healthcare assistant vacancies.

A number of actions had been identified to address staffing vacancies, e.g. recruitment plans for current vacancies, robust sickness monitoring, the use of bank nurses, overtime, daily board rounds prioritising care and monitoring of staff rota. Longer term plans had also been developed, such as vacancies advertised and international recruitment, implementation of the e-roster, escalation processes in place through the matron, business manager and chief matron, daily situation reports (‘sitreps’ x4).

The trust had also implemented the ‘allocation safe care programme’ that reviewed nurse staffing against patient acuity and facilitated the appropriate movement of staff between wards. The trust used situation, background, action, result (SBAR) notes for handovers which reduced patient risk.

The trust had initiated a student nurse apprenticeship programme (‘grow your own’), a four year programme that enabled healthcare assistants within the organisation to be seconded and trained.

**Medical staffing**

The trust has reported their staffing numbers below for the period as at March 2018 and April 2018.

<table>
<thead>
<tr>
<th>Location</th>
<th>Mar-18</th>
<th></th>
<th>Fill rate</th>
<th></th>
<th>Fill rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
<td>Fill rate</td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Cumberland Infirmary</td>
<td>141.6</td>
<td>162.8</td>
<td>87.0%</td>
<td>141.6</td>
<td>167.0</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>21.6</td>
<td>37.8</td>
<td>57.1%</td>
<td>22.6</td>
<td>36.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>163.2</strong></td>
<td><strong>200.6</strong></td>
<td><strong>81.4%</strong></td>
<td><strong>164.2</strong></td>
<td><strong>203.8</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16)

**Vacancy rates**

As from April 2017 to March 2018, the trust reported a vacancy rate of 14.7% in surgery. This
was lower than the trust target of 20%.

A breakdown for each site is as follows:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total vacancies (WTE)</th>
<th>Total number of staff establishment (WTE)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>221.5</td>
<td>2,005.4</td>
<td>11.0%</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>140.0</td>
<td>453.9</td>
<td>30.8%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>361.6</strong></td>
<td><strong>2,459.2</strong></td>
<td><strong>14.7%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

From May 2017 to April 2018, the trust reported a turnover rate of 15.9% in surgery. This was above the trust target of 13%.

A breakdown for each site is as follows:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total leavers (WTE)</th>
<th>Average number of staff establishment (WTE)</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>19.2</td>
<td>103.3</td>
<td>18.6%</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>1.0</td>
<td>24.1</td>
<td>4.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>20.2</strong></td>
<td><strong>127.4</strong></td>
<td><strong>15.9%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**

From April 2017 to April 2018 the trust reported a sickness rate of 2% in surgery. This was better than the trust target of 4%.

A breakdown for each site is as follows:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total absence days</th>
<th>Total WTE days available</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>820</td>
<td>37,442</td>
<td>2%</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>258</td>
<td>8,977</td>
<td>3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,078</strong></td>
<td><strong>46,419</strong></td>
<td><strong>2%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Bank and locum staff usage**

The trust was unable to provide this data broken down by site or core service, due to system
restrictions under the previous recording method.
(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

**Staffing skill mix**

From January 2018 to January 2018, the proportion of consultant staff reported to be working at the trust was slightly higher than the England average and the proportion of junior (foundation year 1-2) staff was about the same.

**Staffing skill mix for the whole time equivalent staff working at North Cumbria University Hospitals NHS Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>52%</td>
<td>49%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>16%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>19%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>12%</td>
<td>11%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Medical cover was available on-site 24 hours a day and the division of surgery made use of a number of on call rotas. Consultants were supported at ward level by foundation year one doctors assigned to each ward. We spoke with consultants in the theatres and noted there were no concerns raised about medical cover.

Junior doctors were assigned to each ward and trust data showed the trust was above the England average for junior doctors. Junior doctors out of hours could call for consultant support. Predominantly this would be by phone with the option to attend site for emergency theatre, emergency procedures or diagnostic procedures. At weekends the rota was shared and the team of consultants gave telephone advice, ward rounds and emergency procedures out of hours.

Following an inspection in January 2018 the foundation school reported concerns about the adequacy of training and experience of foundation programme doctors in surgery and intends to remove recognition for training from August 2019. The division had developed an action plan to address these concerns which included providing a supportive environment for learning, improved induction, handover, re-organised ward cover and a regular teaching programme that meets stipulated educational standards. Additionally, the introduction of the consultant surgeon of the week model, reorganisation of ward and patient cover had been completed.
Post-operative ward rounds were completed daily. We were told medical outliers on a surgery ward awaiting a bed on a medicine ward were seen by consultants from medicine usually before midday each day.

Where locums were used the booking team checked the suitability of the locum to work in the trust according to set criteria which included obtaining references. According to data submitted by the trust the anaesthetics team made most use of locums.

Anaesthetists spoken with said they believed the inability to recruit to the hospital was due to the downgrading of the service and the criteria for patients (ASA 1 and ASA 2), leading to less attractive learning and experience for newly qualified anaesthetists.

The inability to recruit permanent anaesthetic staff to maintain a sustainable anaesthetic care model at the hospital had been addressed at the time of inspection. Recruitment had been made to three middle grade posts (surgical care practitioners) and offers made to staff grade posts.

Records
The trust had introduced an electronic patient record supported by paper records for each patient as well as integrated patient assessment and bed management systems.

Nursing and medical records within the ward were consistent with care plans and risk assessments. These were completed accurately and updated regularly and included nutrition, fluid balance, turning charts and hydration charts and do not attempt cardiopulmonary resuscitation (DNACPR) forms.

Ward managers and staff confirmed that the quality of record keeping was emphasised within the trust and matrons and ward sisters carried out documentation audits on records in all wards; these were used to identify learning and improvement. We saw that records were consistent, fully completed and learning needs were addressed with relevant staff. Common issues were shared with all staff at ward meetings.

Medicines
The trust had an up to date medicine policy that detailed the safe storage and management of medicines, including controlled drugs. All medicines and intravenous fluids were stored behind keypad locked doors and the nurse in charge carried the keys to gain access to the locked controlled drugs cabinet and locked drugs fridge.

Pharmacy colleagues found inconsistent practice across wards regarding the management of medicines. Although trust policy identified arrangements for monitoring medicines which required refrigeration, maximum and minimum temperatures were not recorded on a daily basis.

The trust ensured appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance. We saw all patients had been appropriately assessed for the risk of Venous Thromboembolism (blood clots) and appropriate prophylaxis had been prescribed where this was indicated.
Incidents

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From June 2017 to May 2018, the trust reported one incident classified as a never event for surgery.

The incident, classed as a surgical/invasive procedure incident meeting SI criteria, occurred at West Cumberland Hospital. The incident took place on 9 March 2018 and was reported on 13 March 2018. This incident involved a patient who was to have a SLN injection in the left breast prior to breast surgery. The injection was given in error in the right breast.

(Source: Strategic Executive Information System (STEIS))

A root cause analysis of the never event confirmed the never event had been fully investigated and identified lessons learnt. Procedures had been improved to ensure a further similar incident could not happen, check lists had been updated and all staff were aware of the incident.

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 14 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from June 2017 to May 2018. The never event mentioned above is included in this figure.

The most reported incident types were:

- Treatment delay meeting SI criteria with four incidents (29%)
- Sub-optimal care of the deteriorating patient meeting SI criteria with two incidents (14%)
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with two incidents (14%)
- Medical equipment/devices/disposables incident meeting SI criteria with two incidents (14%)
Site specific information can be found below:

- Cumberland Infirmary: 11 incidents
- West Cumberland Hospital: Three incidents

(Source: Strategic Executive Information System (STEIS))

There were systems in place for reporting, monitoring and learning from incidents. The trust had an incidents policy, which staff accessed through the intranet. This provided staff with information about reporting, escalating and investigating incidents. The trust also had an electronic reporting system in place for reporting incidents.

Staff we spoke with were conversant with the trust’s incident reporting policy and could accurately describe how they would report incidents. Staff informed us that they would report incidents on the electronic recording system which then sent an email to the sisters and deputy sisters. Feedback was given via email or verbally but it wasn’t always received.

Previous recurring incidents were patients coming back from Carlisle Infirmary at 1 a.m., especially elderly patients; the trust informed us that this practice had now stopped.

If the incident was serious, a report was compiled after a full investigation and all staff had to read and sign this report to confirm that they had read the contents. The ward manager would then discuss the contents of this report with staff on an individual basis. Incidents were also discussed weekly at governance meetings with matrons, chief matrons and head of patient safety. Emerging themes were fed back to staff verbally and through a newsletter.

Lessons were learned from incidents and these were implemented; for example, patients not being discharged for some time period. This was resolved by placing patients from theatres overnight in to one area of the ward so that they could be discharged the next day 9-11 a.m. so that their beds became available from 12 p.m. when the next batch of patients arrived from theatres.
Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

During the inspection, we saw safety boards displayed on the wards we visited, these showed the results from the safety thermometer audits. The safety thermometer was completed the third Wednesday of every month. This collected data for pressure ulcers, falls and MRSA.

Data from the Patient Safety Thermometer showed that the trust reported 13 new pressure ulcers, 14 falls with harm and nine new catheter urinary tract infections from April 2017 to April 2018 for surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at North Cumbria University Hospitals NHS Trust

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

From April 2017 to April 2018 surgery reported 13 pressure ulcers. From April to August 2017 two pressure ulcers were reported, one in April and one in June 2017. From September 2017 to
January 2018 one to two pressure ulcers per month were reported consecutively. Pressure ulcers reported escalated sharply from none reported in February to five in March 2018. Pressure ulcers reported decreased with no pressure ulcers reported in April 2018.

No falls were reported from April to October 2017. In November 2017 three falls were reported, numbers escalated sharply with ten falls being reported in December 2017. One fall was reported in January 2018 and no falls from February to April 2018.

From April to July 2017 no CUTIs were reported. Two infections were reported in August and none in September and October 2017. During the winter months of November 2017 to February 2018, one to three infections per month were reported, reaching the highest number of three in December 2017. After February no CUTIs were reported up until April 2018.

(Source: NHS Digital)

Safety thermometer results were on display to the public on each ward. These included staffing levels, days since the occurrence of pressure ulcers, falls and CUTIs as well as medication errors, hand hygiene and cleaning audits. Compliance rates for the assessment of venous thromboembolism and the provision of patient information and the completion rates for mandatory training and appraisals were also displayed.

Each ward displayed their friends and family test results as well as ‘two minutes of your time’ feedback.

Is the service effective?

Evidence-based care and treatment

Trust policies and pathways were based on guidance from the Royal College of Surgeons and the National Institute for Health and Care Excellence (NICE). New guidance was monitored through clinical governance meetings and we saw evidence of this through a review of clinical governance reports.

The division had care plans and pathways for a number of conditions including stroke, deep vein thrombosis (DVT), cellulitis, rapid access chest pain and sepsis based on the acute toolkit, screening tool and care protocols.

Staff accessed policies, procedures and other guidance through the trust intranet. We reviewed policies and found them to be in date with version control and a named author. Integrated pathways were in use for patients undergoing day surgery procedures including documentation to assess risk such as venous thromboembolism (VTE). Enhanced recovery pathways were in place, for example for patients undergoing elective joint replacement surgery.

Audits were undertaken for the completion and accuracy of care bundles, the use of NEWS, medication and documentation such as those which related to infection prevention and control. Results showed good levels of compliance. Ward sisters completed trust-wide nursing audit programmes and we saw results and action plans in ward files.
The division participated in a number of national audits including the national hip fracture database and the national bowel cancer audit programme. Staff records reflected training initiated and completed. Medical staff undertook clinical audits and these were discussed at clinical governance meetings.

Nursing staff completed a number of audits on patient experience and outcomes, these audits were completed internally and were completed by observation or review of documents. These audits included medicines administration, environment and hand hygiene.

**Nutrition and hydration**

We reviewed electronic and paper care plan documentation and risk assessments were fully completed and fluid, food and rounding charts were completed appropriately.

The electronic patient record enabled staff to identify patients at risk of malnutrition, weight loss or requiring extra assistance at mealtimes. Protected meal times were in place and we saw patients being supported to eat and drink. Drinks were readily available and were in easy reach of patients.

Most patients said food was good and menus were varied. The quality and quantity of food was monitored through patient led assessments of the care environment (PLACE) which showed an overall satisfaction with food provided.

Policies were in place regarding fasting times and intravenous fluids in line with best practice. We saw records in notes for patients who received nutrition via nasogastric tubes, including the day and reason for insertion, the type of tube, measurement, aspirate pH and a confirmation that consent had been obtained.

**Pain relief**

We reviewed care plans related to pain management. Pain assessments were carried out and recorded in patient notes and the electronic patient record. Pain relief was provided as prescribed and there were systems in place to make sure that additional pain relief was accessed through medical staff, if required.

Patients we spoke with had no concerns about how their pain was controlled and staff checked that pain relief administered had been effective. We were assured about the assessment of pain for those patients who may not be able to communicate when in pain.

Staff used a pain-scoring tool to assess patient’s pain levels; staff recorded the assessment on paper and electronic records. We saw evidence of pain scores in patient documentation reviewed. Staff informed us that when patients were admitted to the hospital, the electronic patient record had a section for religion and dietary requirements. Staff also completed the malnutrition universal screening tool (MUST) documentation for every patient. Depending on the score, appropriate action was taken by staff.

The ward had a pain assessment chart with scores between 1 – 3. For dementia patients, if the family had completed ‘this is me’ bundle, staff used this to identify signs of pain. For learning disability patients, staff spoke to their support worker. The hospital also had a specified pain team
consisting of two nurses available 9 a.m. – 5 p.m., five days a week. Staff used the disability distress assessment tool for patients with communication difficulties.

There were dedicated staff in the kitchen who reported to nursing staff if patients had not eaten. Dieticians and supplements were also available for patients. Staff completed fluid balance charts for post-operative patients, sepsis patients or those eating or drinking very little. Menus covering variety of religions were available in the kitchen and these were given to patients for them to select meals.

Protected mealtimes were promoted on the wards. Patients told us they were satisfied with the quality and choice of meals.

**Patient outcomes**

**Relative risk of readmission**

**Elective admissions – trust level**

From January 2017 to December 2017, all patients at the trust had a slightly lower expected risk of readmission for elective admissions when compared to the England average.

General surgery patients at the trust had a similar expected risk of readmission for elective admissions when compared to the England average.

Trauma & orthopaedics and urology patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.

![Graph](image)

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity*  

**Non-elective admissions – trust level**

All patients at the trust had a slightly higher expected risk of readmission for non-elective admissions when compared to the England average.

General surgery patients at the trust had a higher expected risk of readmission for non-elective admissions when compared to the England average.

Trauma & orthopaedics patients at the trust had a lower expected risk of readmission for non-elective admissions when compared to the England average.
Urology patients at the trust had a similar expected risk of readmission for non-elective admissions when compared to the England average.

**Elective admissions - West Cumberland Hospital**

From January 2017 to December 2017, all patients at West Cumberland Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.

General surgery patients at West Cumberland Hospital had a much lower expected risk of readmission for elective admissions when compared to the England average.

Urology and trauma & orthopaedics patients at West Cumberland Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.

**Non-elective admissions - West Cumberland Hospital**

All patients at West Cumberland Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

General surgery patients at West Cumberland Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.
Trauma & orthopaedics patients at West Cumberland Hospital had a higher expected risk of readmission for non-elective admissions when compared to the England average.

Urology patients at West Cumberland Hospital had a much higher expected risk of readmission for non-elective admissions when compared to the England average.

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics)

We discussed the higher than expected risk of readmission for trauma and orthopaedics and urology for non-elective admissions when compared to the England average with the divisional management team.

The division’s senior management team were aware of the readmission rates and told us the issue was being addressed by a review to identify the causes of the elevated expected risks of readmissions and methodologies for bringing the risks of readmission in line with England averages.

National Hip Fracture Database – trust level

In the 2017 National Hip Fracture Database, the risk-adjusted 30-day mortality rate was 5.1% (England average 6.7%) which was within the expected range. The 2016 figure was 6.7%.

The proportion of patients having surgery on the day of or day after admission was 69.8% (England average 70.6%), which failed to meet the national standard of 85%. This was within the middle 50% of trusts. The 2016 figure was 68.9%.

The perioperative medical assessment rate was 93.4% (England average 88.7%), failed to meet the national standard of 100%. This was within the middle 50% of trusts. The 2016 figure was 94.4%.

The proportion of patients not developing pressure ulcers was 96.7% (England average 95.6%), failed to meet the national standard of 100%. This was within the middle 50% of trusts. The 2016 figure was 97.4%.

The overall length of stay was 16.1 days, which falls within the top 25% of trusts. The 2016 figure was 17.1 days.
The case ascertainment rate was 93% in 2017, a slight improvement in comparison with 2016 the 2016 rate of 92%. Rates however were below the national aggregate of 95% and failed to meet the 100% aspirational standard.

(Source: National Hip Fracture Database 2017)

The trust had introduced a full time orthogeriatrician and the ‘consultant of the week’ working model which had improved co-ordination, review and consistency of care. The trust also participated in the Northern Region tissue viability collaborative which had increased focus and improvement methodology for the reduction of pressure ulcers.

The reduction in the 30 day mortality rate was attributed to the input from the ward based orthogeriatrician, a holistic orthopaedic and geriatrician approach, supported by specialist nurses and nurse practitioners.

Bowel Cancer Audit

In the 2017 Bowel Cancer Audit, 80.3% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national aggregate.

The risk-adjusted 90-day post-operative mortality rate was 0% (England average 3.2%) which was within the expected range. The 2016 figure was 5.4%.

The risk-adjusted 2-year post-operative mortality rate was 21.3% which was within the expected range. The 2016 figure was 20.9%.

The risk-adjusted 30-day unplanned readmission rate was 16.6% (England average 9.9%) which was within the expected range. The 2016 figure was not reported.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 52.6% which was within the expected range. The 2016 figure was 42.7%.

The 2017 case ascertainment rate of 69.8% was lower than the 2016 rate of 82.1% and national aggregate of 95.0%, although in comparison to other hospitals the trust had a fair (50%-80%) ascertainment rate.

(Source: National Bowel Cancer Audit)

National Vascular Registry

In the 2017 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 3% for abdominal aortic aneurysms which was within the expected range. The 2016 figure was 2.9%.

Within Carotid Endarterectomy, the median time from symptom to surgery was 14 days, equal to the audit aspirational standard of 14 days.
The 30-day risk-adjusted mortality and stroke rate was 0% (England average 2.2%) this was within the expected range.

The trust had a 100% case ascertainment rate, better than the national aspirational standard of 90%. Rates improved from 82% in 2016 to 100% in 2017.

(Source: National Vascular Registry)

**Oesophago-Gastric Cancer National Audit**

In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 9.9%, this was a positive outlier in comparison to other trusts. Patients diagnosed after an emergency admission are significantly less likely to be managed with curative intent. The audit recommends that overall rates over 15% could warrant investigation. The 2015 figure was 9.5%.

The trust was not eligible for the 90-day post-operative mortality rate.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 34.2%. This was significantly lower than the national aggregate.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres); the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results.

The case ascertainment rate at the trust was between 81% to 90%, which was better than the national aggregate.

(Source: National Oesophago-Gastric Cancer Audit 2016)

**National Emergency Laparotomy Audit – trust level**

The National Emergency Laparotomy audit awards three ratings for each indicator. Green ratings indicate performance of over 80%, amber ratings indicate performance between 50% and 80% and red ratings indicate performance under 50%.

In the 2016 National Emergency Laparotomy Audit (NELA), the trust achieved an amber rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 102 cases.

The trust achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 73 cases.

The trust achieved a green rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 53 cases.
The trust achieved an amber rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 37 cases.

The risk-adjusted 30-day mortality for the trust was within the expected range. This was based on 102 cases.

(Source: National Emergency Laparotomy Audit)

**Patient Reported Outcome Measures**

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

In 2016/17 performance on groin hernias was generally worse than the England average. The proportion of patients in England that reported improvement was 45% compared to the trust proportion of 35%. At the trust, 25% of patients reported an improvement for EQ VAS compared to an England figure of 39%. The EQ-5D Index at the trust was 46% compared to the England figure of 50%.

For varicose veins, performance was generally better than the England average. The proportion of patients in England that reported improvement was 58% compared to the trust proportion of 61%. The Aberdeen varicose vein score for the trust was slightly lower than England scores, 80% compared to 81%. At trust level, 49% of patients reported an improvement for EQ VAS compared to an England figure of 40%. The EQ-5D Index at the trust was 54% compared to the England figure of 52%.
For hip replacements, performance was similar to the England average. The proportion of patients in England that reported improvement was 84% compared to the trust proportion of 85%. The Oxford hip score for the trust was 98% similar to England average, of 96%. At trust level, 67% of patients reported an improvement for EQ VAS, the same as the England figure. The EQ-5D Index at the trust was 90% similar to the England average of 89%.

For knee replacements performance was similar to the England average. The proportion of patients in England that reported improvement was 77% compared to the trust proportion of 78%. The Oxford knee score for the trust was the same as than England score, of 94%. At trust level the EQ VAS score was 55% similar to the England figure of 58%. The EQ-5D Index at the trust was by 84% similar to the England figure of 81%.

(Source: NHS Digital)

Competent staff

Appraisal rates - trust level

From April 2017 to March 2018, 93% of staff within surgery at the trust received an appraisal compared to a trust target of 95%.

Appraisal rates for medical staff were in line with the trust target, the speciality with the lowest completion rate was trauma and orthopaedic with a completion rate of 85%. All other specialities met or exceeded the trust target of 90% for medical staff.

Nursing staff had a 92% appraisal completion rate, lower than the trust target of 95%. Appraisal rates for nine of the 16 specialities did not meet the trust target, with endoscopy, oral surgery and vascular surgery having a completion rate of 0%. Apart from the specialities that had a completion rate of 0%, Anaesthetics (25%), Otolaryngology (50%) and urology (67%) had the lowest completion rates.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required</th>
<th>Appraisals completed</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>328</td>
<td>302</td>
<td>92%</td>
</tr>
<tr>
<td>Medical &amp; dental Staff</td>
<td>122</td>
<td>116</td>
<td>95%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>450</td>
<td>418</td>
<td>93%</td>
</tr>
</tbody>
</table>

West Cumberland Hospital

From April 2017 to March 2018, 97% of staff within surgery at West Cumberland Hospital received an appraisal compared to a trust target of 95%.

Appraisal rates for medical staff were higher than the trust target; the speciality with the lowest completion rate was trauma and orthopaedics (83%). All other specialities exceeded the trust target of 90% for medical staff.

Nursing staff at West Cumberland Hospital had an appraisal completion rate of 98%, higher than the trust target of 95%. Appraisal rates for two of the seven specialities did not meet the trust target. Anaesthetics (50%) and the day case unit (90%) had the lowest completion rates. All other
specialities met or exceeded the trust target.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required</th>
<th>Appraisals completed</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>100</td>
<td>98</td>
<td>98%</td>
</tr>
<tr>
<td>Medical &amp; dental Staff</td>
<td>28</td>
<td>26</td>
<td>93%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>128</td>
<td>124</td>
<td>97%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

The senior management team had issued instructions that appraisals had to be completed by September 2018 to ensure staff within the division complied with trust targets for appraisal.

**Multidisciplinary working**

Staff we spoke with told us multidisciplinary team meetings were held where different specialities attended, for example radiologists, speech and language therapy and consultants. Staff we spoke with told us there was one stop clinic which involved a dietician, speech and language therapy, for example.

Nursing and medical staff reported good multidisciplinary working and all surgical wards participated in multidisciplinary ward rounds. This resulted in a co-ordinated approach to treatment plans and decisions.

Multidisciplinary team (MDT) meetings for discussion of patients on specific pathways or with complex needs had been established and included attendance from consultants, physiotherapists, matrons and occupational health. Staff we spoke with said that teams from all staff disciplines were supportive and they had positive working relationships. The discharge co-ordinator led on patient discharge but nurses discharged the actual patient and would delay this if it wasn’t an appropriate time of the day. The matron informed us that GPs were able to ring consultants for advice regarding ongoing care of patients.

Specialist nurses were available to review patients in specialties, such as respiratory and diabetes, physiotherapy, speech and language, pharmacy, child and adolescent and adult mental health liaison. Specialists were also available to support staff groups with training and to participate in multidisciplinary meetings to discuss patient care and treatment.

Allied Health Professionals confirmed there was good multidisciplinary working and also offered training to nursing staff where appropriate. Dieticians completed daily reviews of those patients referred for their input.

**Seven-day services**

The trust monitored its working scheme against NHS Services, Seven Days a Week Clinical Standards. At the time of inspection, the surgical division met NHS England’s seven day services priority standards; i.e. time to first consultant review.
Consultants provided seven-day cover for surgical wards and assessment unit. On-call consultants covered weekends and nights. Daily consultant ward rounds took place and we saw evidence of reviews at weekends and patients confirmed this.

There was availability of physiotherapy and occupational therapy staff Monday to Friday and physiotherapists covered weekends on a rota system to deliver interventions to identified patients on a priority of need basis.

The mental health, physiotherapy and critical care services were delivered over seven days, 24-hours, which meant patients who required these services could access them at any time. Dementia services were available seven days a week during office hours and occupational health was available five days a week.

The surgical consultants were available all weekend with pharmacists available six days a week with on call cover on Sundays. Pharmacy input was available via the telephone out of hours and at the weekends. Diagnostic services were available seven days a week, 24-hours; this resulted in critical imaging and reporting available within one hour, urgent imaging and reporting within 12 hours and all non-urgent imaging and reporting available within 24 hours.

**Health promotion**

Staff gave patients advice on smoking cessation, healthy eating, weight loss, wound care and infection prevention on all wards when appropriate.

Patient leaflets were available throughout the hospital, prominently displayed on communication boards within wards and corridors and available for patients to take with them.

We did not see patient information leaflets in other languages than English but were assured they were available on request.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

**Mental Capacity Act and Deprivation of Liberty training completion - trust level**

The trust reported that as at March 2018 Mental Capacity Act (MCA) training was completed by 86% of staff in surgical care compared to the trust target of 95%.

A breakdown by staff group can be seen below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental staff</td>
<td>287</td>
<td>218</td>
<td>76%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>410</td>
<td>384</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Over the same period Deprivation of Liberty Safeguards training was completed by 75% of staff within surgical care compared to the trust target of 95%.

A breakdown by staff group can be seen below:
West Cumberland Hospital

West Cumberland Hospital reported that as at March 2018 Mental Capacity Act (MCA) training was completed by 90% of staff in surgical care compared to the trust target of 95%.

A breakdown by staff group can be seen below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental staff</td>
<td>100</td>
<td>67</td>
<td>67%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>46</td>
<td>43</td>
<td>93%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Over the same period Deprivation of Liberty Safeguards training was completed by 77% of staff within surgical care compared to the trust target of 95%.

A breakdown by staff group can be seen below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental staff</td>
<td>68</td>
<td>55</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>99</td>
<td>96</td>
<td>97%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

(Source: Trust Provider Information Request P40- Training)

Staff spoken with demonstrated an understanding of consent, mental capacity and ‘best interest’ decisions and accessed training through e-learning. Staff had accessible guidance and information and knew who to contact for advice and support, if needed.

During discussion staff had an understanding of how to assess capacity and when this should be done and by whom. Support was provided throughout the division by the delirium team.

We reviewed patient records and saw that Mental Capacity Act (MCA) assessments had been undertaken by the doctor responsible for the patient’s care. Nursing records with DoLS in place showed the appropriate paperwork had been completed. We observed staff providing explanations and obtaining consent prior to completing procedures.

Staff told us best interest meetings were held for patients who lacked capacity to make decisions for themselves.
Staff showed a good understanding of mental capacity and referred to it as being decision and time specific. Staff had a good understanding of DoLS and used both the emergency and standard authorisation appropriately.

Mental health colleagues visited surgical wards at both Cumberland Infirmary and West Cumberland Hospital and found that staff in both locations had a good understanding of the Mental Capacity Act.

At West Cumberland Hospital there were no patients who had capacity assessments in place. Patients were seen prior to surgery and capacity assessments were discretely completed as part of the pre-operative assessment. If there was a concern the patient would be required to return at a later date for a further assessment when it would be decided if the patient was able to make a decision about treatment.

If patients were due to have surgery and it was felt they lacked capacity, they would have their operation delayed, or if this was not possible, a best interest decision would be made and recorded on patient care records. Staff were clear about what capacity assessments were and how they fitted in with day to day work. If they had concerns they knew who they could speak to.

Staff at both sites were aware that patients who had received a general anaesthetic would have full capacity for 24 hours and advised patients of this.

**Is the service caring?**

**Compassionate care**

**Friends and Family test performance**

The Friends and Family Test response rate for surgery at North Cumbria University Hospitals NHS Trust was 28% which was the same as the England average from April 2017 to March 2018.

A breakdown of response rate by site can be viewed below.

**Friends and family test response rate at North Cumbria University Hospitals NHS Trust, by site.**
Friends and family test scores per site and ward is shown in the table below:

<table>
<thead>
<tr>
<th>Ward</th>
<th>Total Resp</th>
<th>Ave Resp rate</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Sep-17</th>
<th>Oct-17</th>
<th>Nov-17</th>
<th>Dec-17</th>
<th>Jan-18</th>
<th>Feb-18</th>
<th>Mar-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Intensive</td>
<td>270</td>
<td>29%</td>
<td>97%</td>
<td>87%</td>
<td>90%</td>
<td>100%</td>
<td>100%</td>
<td>95%</td>
<td>100%</td>
<td>81%</td>
<td>80%</td>
<td>95%</td>
<td>91%</td>
<td>93%</td>
</tr>
<tr>
<td>GD</td>
<td>410</td>
<td>29%</td>
<td>96%</td>
<td>96%</td>
<td>96%</td>
<td>96%</td>
<td>94%</td>
<td>90%</td>
<td>99%</td>
<td>96%</td>
<td>98%</td>
<td>100%</td>
<td>95%</td>
<td>96%</td>
</tr>
<tr>
<td>DDS</td>
<td>320</td>
<td>9%</td>
<td>0%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>95%</td>
<td>100%</td>
<td>96%</td>
</tr>
<tr>
<td>ENDO</td>
<td>654</td>
<td>15%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>100%</td>
<td>99%</td>
<td>99%</td>
<td>96%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
</tr>
<tr>
<td>LD</td>
<td>359</td>
<td>23%</td>
<td>98%</td>
<td>95%</td>
<td>99%</td>
<td>100%</td>
<td>98%</td>
<td>98%</td>
<td>100%</td>
<td>99%</td>
<td>100%</td>
<td>99%</td>
<td>100%</td>
<td>99%</td>
</tr>
<tr>
<td>MB</td>
<td>251</td>
<td>5%</td>
<td>0%</td>
<td>9%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>NC</td>
<td>430</td>
<td>83%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>OPDU</td>
<td>324</td>
<td>19%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>DCU</td>
<td>1426</td>
<td>46%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>ENDO</td>
<td>430</td>
<td>43%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>OPH                1</td>
<td>952</td>
<td>53%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>WC1</td>
<td>609</td>
<td>28%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
<td>100%</td>
<td>98%</td>
<td>98%</td>
<td>100%</td>
<td>98%</td>
<td>98%</td>
<td>100%</td>
<td>98%</td>
<td>98%</td>
</tr>
</tbody>
</table>

* Data only includes hospitals with total responses above 100; Top 12 wards shown per site

(Source: NHS England Friends and Family Test)

Friends and family test data (January to March 2018) we saw on the ward showed that 98% were extremely likely or likely to recommend the ward to friends and family. The quarter four January 2018 to March 2018 friends and family test data for the day case unit showed that 99% of respondents were extremely likely or likely to recommend the department to friends and family. We spoke patients on the ward, the majority of patients we spoke with were happy with their care. On the ward we observed staff caring for patients and found they were compassionate and reassuring. We heard staff introducing themselves by name and explaining the care and treatment they were delivering.

Patients told us staff treated them with respect and dignity and respected their privacy by closing bedroom doors and drawing the blind when conducting medical examinations. We observed staff closing blinds and doors whilst delivering personal care. Patients we spoke with said that staff answered buzzers quickly and during the inspection we did not hear buzzers ringing for long periods of time. Staff responded promptly to call bells or requests for assistance and had enough time for patients and they introduced themselves. All patients seen looked clean and well cared for and able to move around, with staff assistance where necessary.

**Emotional support**

There was a range of clinical nurse specialists at the trust and patients and staff spoke positively about their input. For example, diabetes and respiratory nurse specialists provided a high level of emotional support and practical advice.

Staff on the ward spoke positively about links with the delirium, mental health services and liaison staff who visited regularly to see patients with mental health needs and give advice to staff on issues such as managing challenging behaviour.

We saw that ward managers were visible on wards and departments we visited, and patients and relatives could speak with them. Patients we spoke with said that staff were available to talk to them as required. Patients said that staff kept them informed about care they were delivering and
the rationale behind the type of care. They also stated that doctors and surgeons explained to them the risks and benefits of their surgical procedures.

A multi-faith chaplaincy room was available for patients to offer them religious and spiritual support.

**Understanding and involvement of patients and those close to them**

Patients told us they knew what was happening with their care and what their treatment plans were. Almost all patients said they had been kept informed in a way they could understand so that they felt involved in their care.

The ward involved relatives in the care of patients where possible and with the permission of the patient. Although there were set visiting times, all wards were flexible and provided information regarding current care and treatment. Wards told us they were planning to pilot ‘open visiting’ times.

Patients we spoke with told us that staff explained their care to them including the risks and benefits of treatment. Patients we spoke with said that they were aware of their plans of care and they had been given the time for questions and felt listened to. Patients we spoke with said that they were aware of who to approach if they had any issues regarding their care, and they felt able to ask questions. The majority of patients we spoke with informed us that they knew how to raise a complaint about the service.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

**Elective average length of stay – trust level**

From February 2017 to January 2018, the average length of stay for all elective patients at the trust was 2.9 days, which was lower compared to the England average of 3.9 days.

The average length of stay for trauma & orthopaedics elective patients at the trust was 3.1 days, which was lower compared to the England average of 3.9 days.

The average length of stay for general surgery elective patients at the trust was 3.4 days, which was similar compared to the England average of 3.9 days.

The average length of stay for urology elective patients at the trust was 1.9 days, which was lower compared to the England average of 2.5 days.
Non-elective average length of stay – trust level

The average length of stay for all non-elective patients at the trust was 4.1 days, which was slightly lower compared to the England average of 4.9 days.

The average length of stay for general surgery non-elective patients at the trust was 2.6 days, which was lower compared to the England average of 3.8 days.

The average length of stay for trauma & orthopaedics non-elective patients at the trust was 7.4 days, which was lower compared to the England average of 8.7 days.

The average length of stay for ENT non-elective patients at the trust was 2.2 days, which was the same as the England average.

Elective average length of stay - West Cumberland Hospital

From February 2017 to January 2018 the average length of stay for all elective patients at West Cumberland Hospital was 2.2 days, which is lower compared to the England average of 3.9 days.

The average length of stay for trauma & orthopaedics elective patients at West Cumberland Hospital was 2.5 days, which is lower compared to the England average of 3.9 days.

The average length of stay for general surgery elective patients at West Cumberland Hospital was 2.0 days, which is lower compared to the England average of 3.9 days.

The average length of stay for urology elective patients at West Cumberland Hospital was 1.8 days, which is lower compared to the England average of 2.5 days.
The average length of stay for all non-elective patients at West Cumberland Hospital was 0.9 days, which is lower compared to the England average of 4.9 days.

The average length of stay for general surgery non-elective patients at West Cumberland Hospital was 0.8 days, which is lower compared to the England average of 3.8 days.

The average length of stay for trauma & orthopaedics non-elective patients at West Cumberland Hospital was 4.1 days, which is lower compared to the England average of 8.7 days.

The average length of stay for urology non-elective patients at West Cumberland Hospital was 3.3 days, which is higher compared to the England average of 2.9 days.

(Source: Hospital Episode Statistics)

Meeting people’s individual needs

There was a variety of patient information leaflets available in wards; however, there were no leaflets available in different languages. The ward had access to translation services.

The electronic assessment system had an area for communication where hearing problems, sign language and interpreter required were documented. Staff we spoke with told us these assessments were completed upon admission to the hospital. The electronic system on wards allowed staff to see whether patients had been referred to a social worker.
Staff identified patients who had additional care needs at handovers and safety huddles, for example patients living with dementia, learning disabilities or mental health conditions. Staff we spoke with told us they referred patients on to a variety of teams at the trust, for example the tissue viability team and the pain team. Staff referred patients to the adult psychiatry team if required and there was a mental health team available for support and advice. There was regular pharmacy attendance on the surgical wards.

Patients living with dementia were identified to staff by a butterfly symbol to enable them to provide additional support. Patients we spoke with said that staff respected their privacy and dignity by closing curtains and doors as necessary.

Patients’ religious needs, dietary requirements and hearing, sight or language difficulties were identified through structured assessments. Patients were provided with information leaflets on their surgical procedures.

The ward and departments were accessible for patients with limited mobility and people who use a wheelchair. There was one room for bariatric patients on ward 1C and there was such a room in every ward in the new build hospital. Specialised equipment for bariatric patients was available on the ward.

**Access and flow**

The trust had supported a two year training programme of a nurse hysteroscopist, which enabled the service to reduce the number of inpatient admissions and costs. There had been a 50% increase in clinics for hysteroscopy which enabled the trust to ensure referral to treatment and diagnosis and cancer standards had been achieved.

A reduction in patient breaches, treatment without an admission to hospital, reduced wait for diagnosis and treatment plans and less hospital visits had been achieved through the support and training for a specialist nurse and specialist doctor colposcopist and delivering the urodynamic service at both sites.

The ward received medical outliers due to pressure on beds in other areas. At the time of inspection, there were seven medical outliers with three empty beds on ward 1C.

**Referral to treatment (percentage within 18 weeks) - admitted performance**

From April 2017 to March 2018 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was consistently worse than the England average. Trust rates were on average 17% lower than the England average. Over the period trust performance worsened from 53% of patients referred for treatment within 18 weeks in April 2017 to 33% in March 2018.
At the time of inspection (June, 2018), the trust’s referral to treatment time (RTT) for admitted pathways for surgery had improved to 43%, although this was still below the England average of patients treated within 18 weeks (64%).

**Referral to treatment (percentage within 18 weeks) – by specialty**

A breakdown of referral to treatment rates for surgery by specialty is below. Of these, two specialties, urology and ENT, were above the England average and three of specialties were below the England average.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>89%</td>
<td>77%</td>
</tr>
<tr>
<td>ENT</td>
<td>72%</td>
<td>64%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>39%</td>
<td>61%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>39%</td>
<td>71%</td>
</tr>
</tbody>
</table>

We discussed the RTTs with the senior management team. Improving RTTs had been set as a priority within the division and at the time of inspection, national data (NHS England, May 2018) showed referral to treatment times had improved for these specialties:

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>93%</td>
<td>87%</td>
</tr>
<tr>
<td>ENT</td>
<td>93%</td>
<td>86%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>58%</td>
<td>84%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>78%</td>
<td>89%</td>
</tr>
</tbody>
</table>

The trust was meeting the operational national standard of 92% for urology and ENT. National data (NHS England, May 2018) also showed referral to treatment times for general surgery (88%) and oral surgery (91%) were both above England averages (84% and 84% respectively).

**Cancelled operations**

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of
the standard and the patient should be offered treatment at the time and hospital of their choice.

Patients who had their operations cancelled and not treated within 28 days were higher than the England average in Q1 and Q2 2016/17. Percentages improved and were lower than the England average from Q3 2016/17 to Q2 2017/18. Percentages however increased again to higher than the England average in Q3 and Q4 2017/18.

Percentage of patients whose operation was cancelled and were not treated within 28 days - North Cumbria University Hospitals NHS Trust

Over the two years, the percentage of cancelled operations at the trust was higher than the England average in Q1 and Q2 2016/17. From Q3 2016/17 to Q2 2017/18 percentages improved to below the England average although percentages increased again in Q3 and Q4 2017/18 to above the England average.

Cancelled operations as a percentage of elective admissions only includes short notice cancellations. Trust rates were consistently worse than the England average with the worst performance in Q3 and Q4 2017/18. Trust performance improved from Q2 to Q4 2017/18 although rates remained higher than the England averages.

(Source: NHS England)

During this inspection, staff told us they often had medical outliers on the ward due to pressures on beds in other wards. The number of outliers affected the number of beds available for surgical patients.
At the time of inspection national data (May 2018) showed the trust cancelled 1.5% of elective operations against a national average of 1.3%.

The inability to recruit permanent anaesthetic staff to maintain a sustainable anaesthetic care model at the hospital had been the cause of some cancellations. The senior management team confirmed this had been addressed through the recruitment to three middle grade posts and offers made to staff grade posts.

**Learning from complaints and concerns**

**Trust level**

From April 2017 to March 2018 there were 102 complaints about surgical care. The trust took an average of 31 days to investigate and close complaints. This is not in line with their complaints policy, which states complaints, should be responded to and closed within 30 working days.

Medical staff received the most complaints, 76%, followed by nursing staff with 13%. The orthopaedic department received the most complaints, 33%, followed by general surgery with 28%.

One complaint (1%) was fully upheld, 22 (22%) complaints were upheld, 37 (36%) were partially upheld, two (2%) were reviewed to do a moderate root cause analysis, three (3%) were transferred to serious incidents and 37 (36%) of complaints were refuted.

A breakdown of complaints per subject is shown in the table below:

<table>
<thead>
<tr>
<th>Subjects</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment / care - inpatient</td>
<td>51</td>
<td>50%</td>
</tr>
<tr>
<td>Treatment / care - outpatient</td>
<td>25</td>
<td>25%</td>
</tr>
<tr>
<td>Attitude of staff</td>
<td>11</td>
<td>11%</td>
</tr>
<tr>
<td>Information &amp; communication</td>
<td>9</td>
<td>9%</td>
</tr>
<tr>
<td>Appointment issues</td>
<td>5</td>
<td>5%</td>
</tr>
<tr>
<td>Lost property and expenses</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>102</strong></td>
<td></td>
</tr>
</tbody>
</table>

**West Cumberland Hospital**

West Cumberland Hospital received 27 complaints. Seven (26%) complaints were upheld, nine (26%) were partially upheld, nine were refuted and two were transferred to serious incidents.

A breakdown of complaints per subject is shown in the table below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment / care - inpatient</td>
<td>14</td>
<td>52%</td>
</tr>
<tr>
<td>Treatment / care - outpatient</td>
<td>6</td>
<td>22%</td>
</tr>
<tr>
<td>Attitude of staff</td>
<td>5</td>
<td>19%</td>
</tr>
<tr>
<td>Appointment issues</td>
<td>2</td>
<td>7%</td>
</tr>
<tr>
<td>-------------------</td>
<td>---</td>
<td>----</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>27</td>
<td></td>
</tr>
</tbody>
</table>

No site was allocated for a further seven complaints received within surgical care.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Feedback from complaints was given to staff through team meetings or displayed as information on staff boards. Staff on the ward confirmed that feedback from complaints would be provided to staff at staff meetings.

**Is the service well-led?**

**Leadership**

The surgical division had a management structure in place with clear lines of responsibility and accountability. The division was managed by an overall senior leadership team which included a consultant, chief operating officer and chief matron. Each ward visited had a ward sister in place, deputy ward sister and a matron. The team was supported by heads of service, business and service managers and matrons. The senior management team had a clear and comprehensive understanding of the current risks, challenges and pressures impacting on service delivery and patient care.

Staffing levels were planned so that ward sisters were given management time with other senior nurses in their teams. All ward sisters said they were supported well by the senior management team and that members of the board were visible and matrons regularly visited the wards. During this inspection we saw matrons regularly on wards; some matrons had undertaken clinical duties to cover staff shortages.

At ward level staff said they were well supported by their matrons who provided clear leadership. Ward sisters said they had constructive and positive relationships with matrons and that they visited wards on a daily basis.

Staff we spoke with said the senior management team was supportive and visible on the wards and departments, particularly the associate director of nursing. Staff also told us that the chief executive was seen mainly at meetings but he did visit the surgical ward.

We found ward mangers on the wards and departments we visited knowledgeable and professional. They appeared visible and approachable for junior members of staff they supported.

**Vision and strategy**

The trust had a mission statement and values. These values were displayed on posters on the wall and the values were safe, sustainable, staffing and service improvement.

We asked senior managers about the vision and strategy for the service and we were told that the surgery reconfiguration was the current strategy across the different hospital sites. This was designed to provide services on an elective and acute basis, reconfigured over the two sites.
Cumberland Infirmary was the designated ‘hot’ site for surgery and West Cumberland Hospital was used for increased levels of elective procedures. Emergency pathways were in place and all emergency orthopaedic procedures were expected to be carried out at Cumberland Infirmary.

The senior management team acknowledged the difficulties in covering the anaesthetic rota at West Cumberland Hospital and informed us that recruitment had recently been made ensuring the rota would be covered within the next few weeks.

**Culture**

At this inspection, staff told us they felt supported and valued. The division had ‘freedom to speak up’ guardians who encouraged staff to speak up about unsafe practices and enabled staff to raise concerns without fear of negative repercussions.

Staff we talked with said they felt valued by their patients, ward leaders and the trust. They said that morale was good within the ward and staff supported each other in their teams. One member of staff said ‘couldn’t ask for a better team, would rather leave than work elsewhere’. Staff told us that they had not suffered or witnessed bullying or harassment. However, if they did witness such behaviour they would report it to their line manager.

Staff felt supported by their managers and colleagues at ward level. They said that ward managers regularly ‘checked on how they were’. Certificates were given to staff for the number of days without pressure ulcers, bacterium for infection prevention. However, there was no corporate reward scheme in place.

All staff we spoke with during the inspection told us there was good teamwork, openness and morale was generally good.

Staff told us the division had strong leadership and senior managers were visible and engaged with staff. We interviewed a number of staff on an individual basis and held group discussions on the wards when possible. Staff spoke positively about the service they provided for patients and high quality care was a priority. All staff were clear about their roles and responsibilities, patient-focused, and worked well together.

All staff felt they received appropriate support from management to allow them to perform their roles effectively. Although staff reported difficulties with moving to other wards at short notice, they accepted this was necessary for the safety of patients. They all told us they felt able to report these concerns but recognised this was caused by recruitment issues.

We observed senior doctors supporting junior doctors; junior doctors reported feeling very supported and able to ask for advice. However, the foundation school did not feel the training and experience of foundation programme doctors in surgery was adequate during an inspection in January 2018. The intention is to remove recognition for training from August 2019. The team was addressing concerns by providing a supportive environment for learning, improved induction, handover, re-organised ward cover and a regular teaching programme that meet stipulated educational standards.

Nursing staff reported a positive culture and good working relationships between staff groups.
Ward sisters told us that they had appropriate access to senior staff members. This included being able to access support and leadership courses to help them in leading their services.

**Governance**

We asked senior managers about governance arrangements and were told there was a weekly governance meeting for the surgical division. There was a structure of management and governance meetings in the surgical division. For example, there was a divisional meeting which provided information to a care group surgical meeting and then to the clinical management group meeting. Alongside these meetings there was a quality and safety meeting and a weekly referral to treatment performance meeting.

Wards held a daily huddle and staff we spoke with told us they would discuss discharge, safety, staffing and complaints.

Senior staff were motivated and enthusiastic about their roles and had clear direction with plans in relation to improving patient care. Ward managers, senior managers and clinical leads showed knowledge, skills, and experience. A clear responsibility and accountability framework had been established. Staff at all levels were clear about their roles and understood their level of accountability and responsibility.

**Management of risk, issues and performance**

The senior management team confirmed that risks were identified through the electronic incident reporting system and were discussed at the weekly governance meeting, then reported to the quality and safety meeting. The senior management team were able to describe the risks to the services, for example referral to treatment performance. There was a quarterly performance meeting for the surgical division.

The division had a risk register which was detailed and thorough in identifying, recording and managing risks, issues and mitigating actions. Governance meeting minutes showed risk registers were reviewed regularly.

The highest risks identified were the lack of critical care capacity at Cumberland Infirmary, the rate of cancellation of elective patients scheduled for post operative care on ICU, the rate of non-clinical transfers out of ICU due to lack of emergency beds, the removal of foundation doctors from surgery, the inability to recruit permanent anaesthetic staff to maintain a sustainable anaesthetic care model at West Cumberland Hospital and the failure to achieve the referral to treatment standards.

We discussed these with the senior management team who were well informed about the difficulties and had action plans in place to address the risks.

**Information management**

The accessible information standard (AIS) was introduced in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand.
We saw that all patient observations and information was recorded on the electronic patient record system accessible to staff through the input of a password. This gave immediate access to test results, risk assessments and treatment plans for all patients. This ensured patients who had a disability, impairment or sensory loss were given information that they were able to access and understand.

The electronic patient record enabled staff to ask people if they had any information or communication needs. These were clearly recorded and highlighted in the record and covered disabilities, impairment or sensory loss. We saw contact methods, formats (audio, braille, easy read or large print) and support needed (e.g. interpreter, lip-read, hearing aid) were detailed.

**Engagement**

**Public engagement**

People using the service were encouraged to give their opinion on the quality of service they received. And the surgery division carried out ‘two minutes of your time’ surveys to gather feedback on the services from patients. The teams had a weekly team meeting where positive and negative feedback was discussed. The senior management team told us there had been a surgical away day with staff where improvement work was discussed.

Staff were clear about their roles and responsibilities, patient focused and worked well together to engage patients and families.

Leaflets about the friends and family test, and the Patient Advice and Liaison Service were available on all ward and reception areas. Internet feedback was gathered along with complaint trends and outcomes.

Ward sisters were visible on the ward, which provided patients opportunity to express their views and opinions.

Discussions with patients and families regarding decision making was recorded in patient notes. We saw thank you cards and letters displayed at the entrances to wards.

**Staff engagement**

The national NHS staff survey (2017) showed the trust scored 3.62 (out of five) for an overall indicator of staff engagement. This is below average (3.79) when compared with other trusts of a similar type.

We were told that management engaged with staff well and we saw senior managers communicate with staff through the trust intranet, e-bulletins, team briefs and safety huddles. Each ward held staff meetings when possible where issues, particularity service configuration and staffing, were discussed.

All staff were able to voice their opinions and speak with the ward sister, receive feedback and discuss any concerns. Staff we spoke to said they felt appreciated by the ward sister and more senior managers and listened to when they raised concerns.
Learning, continuous improvement and innovation

The division had developed a number of initiatives to improve and enhance care and treatment:

- Emergency surgical assessment unit had participated in ‘Engagement for Improvement Wave 6’, a 26 week process which looked at the environment and fluid balance compliance which is being audited weekly;

- A rapid process improvement workshop had been held with a multidisciplinary approach looking at the patient’s journey from referral to discharge. A number of small changes have been made to improve processes to help improve patient experience;

- As part of a quality improvement project on the surgical ward, a senior nurse provided education around VTE re-assessment which saw a 25% increase in compliance;

- The introduction of a surgical flow co-ordinator, an experienced surgical nurse, has improved flow;

- Introduced a virtual fracture clinic;

- Introduced a golden patient protocol where two trauma patients are identified and reviewed by the anaesthetist the night before the list;

- Nurse practitioner telephone review clinics in place of follow up clinics;

- Trans nasal oesophagoscopy (a flexible oesophagoscopy under local anaesthetic in outpatients) replacing a general anaesthetic procedure for many patients. This is safer, cheaper and much quicker. It also enabled examination in patients who are unfit for an anaesthetic;

- In the process of starting a new laser procedure for a specific swallowing disorder (cricopharyngeal spasm) that will allow a wider range of patients to be treated and thus help reduce the incidence of (potentially fatal) chest infections in these often elderly patients;

- ‘Healing Arts’ group (chaired by the clinical director for head and neck) which runs projects that connect arts to health;

- Introduction of ‘Positive Steps to Safety Newsletter’ which allowed the sharing of key learning from incidents and used to promote positive learning from incidents;

- Engaged with the Cumbria learning and improvement collaborative to embed a culture of learning by training staff to undertake quality improvement work utilising tools to equip teams.
Maternity

We spoke with three women and two people close to them, and looked at six patient records. We spoke with 17 staff including:
Two doctors
One consultant
One associate director of midwifery
Two reception staff
Four midwife managers
Four midwives
Two health care assistants
One maternity support worker

Facts and data about this service

The trust provides consultant led maternity care and midwifery led units at both Cumberland Infirmary Hospital and West Cumberland Hospital. This includes a day assessment centre, antenatal and postnatal inpatient beds, maternity theatre, delivery suite and a number of outpatient clinics on each site.

Services available on both sites include:

- Elective and emergency caesarean sections
- Epidural service
- Bereavement service
- Scanning, diabetic clinics and early pregnancy assessment clinics

At West Cumberland Hospital there is a fetal telemedicine clinic with the Royal Victoria Infirmary at Newcastle. Antenatal clinics are also undertaken in the community which covers the remote rural areas of North Cumbria.

The trust provides a birthing centre at Penrith and there is an active maternity voices partnership.

(Source: Trust Provider Information Request (RPIR) AC1 Context - description of all acute services)

The trust has 41 maternity beds. There are 23 maternity beds at Cumberland Infirmary Hospital, all of which are on the Aspen maternity ward. There are 17 maternity beds at West Cumberland Hospital, six of which are on the delivery suite and 11 are on Honister ward. There is one maternity bed at the Penrith birthing centre.

(Source: Trust Provider Information Request (RPIR) P2 Sites)

From January 2017 to December 2017 there were 2,763 deliveries at the trust, of which 1,208 took place at West Cumberland Infirmary.
A comparison of the number of deliveries at the trust and the national totals during this period is shown below.

**Number of babies delivered at North Cumbria University Hospitals NHS Trust – comparison with other trusts in England**

(Source: Hospital Episode Statistics)

A profile of all deliveries and gestation periods from January 2017 to December 2017 can be seen in the tables below.

<table>
<thead>
<tr>
<th>Profile of all deliveries (January 2017 to December 2017)</th>
<th>North Cumbria University Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Single or multiple births</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>2,371</td>
<td>98.8%</td>
</tr>
<tr>
<td>Multiple</td>
<td>32</td>
<td>1.2%</td>
</tr>
<tr>
<td>Mother's age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 20</td>
<td>108</td>
<td>3.9%</td>
</tr>
<tr>
<td>20-34</td>
<td>2,238</td>
<td>81.0%</td>
</tr>
<tr>
<td>35-39</td>
<td>352</td>
<td>12.7%</td>
</tr>
<tr>
<td>40+</td>
<td>65</td>
<td>2.4%</td>
</tr>
<tr>
<td>Total number of deliveries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>2,763</td>
<td></td>
</tr>
</tbody>
</table>

Note: A single birth includes any delivery where there is no indication of a multiple birth.
Gestation periods (January 2017 to December 2017)

<table>
<thead>
<tr>
<th>Gestation period</th>
<th>North Cumbria University Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Under 24 weeks</td>
<td>0</td>
<td>0.1%</td>
</tr>
<tr>
<td>Pre term 24-36 weeks</td>
<td>No deliveries at the trust had a valid gestation period recorded.</td>
<td>7.9%</td>
</tr>
<tr>
<td>Term 37-42 weeks</td>
<td></td>
<td>91.8%</td>
</tr>
<tr>
<td>Post Term &gt;42 weeks</td>
<td></td>
<td>0.2%</td>
</tr>
</tbody>
</table>

Total number of deliveries with a valid gestation period recorded

| Total | 0 | 492,201 |

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

The number of deliveries at the trust by quarter for the last two years can be seen in the graph below.

Number of deliveries at North Cumbria University Hospitals NHS Trust by quarter

![Bar chart showing quarterly deliveries]

There was a reduction in the number of deliveries for each quarter in 2017 compared to the equivalent quarter in 2016. However, the quarterly trend in 2017 follows the same trend when compared to 2016.

(Source: HES - Deliveries (January 2016 - December 2017))

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or
discriminatory abuse.

**Mandatory training**

**Mandatory training completion rates**

The trust set a target of 95% for completion of mandatory training.

**Trust level**

Nursing and midwifery staff in maternity services had an overall mandatory training compliance rate of 81.1% for April 2017 to March 2018 which was below the trust target. A breakdown of completion of mandatory training courses for nursing and midwifery staff in maternity services is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced life support (adults)</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Basic life support (adults)</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Dementia</td>
<td>14</td>
<td>14</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Slips, trips and falls level 1</td>
<td>174</td>
<td>171</td>
<td>98%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Risk management</td>
<td>174</td>
<td>169</td>
<td>97%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>174</td>
<td>166</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Duty of candour</td>
<td>174</td>
<td>164</td>
<td>94%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Intensive life support (paediatrics)</td>
<td>16</td>
<td>15</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Information governance</td>
<td>174</td>
<td>158</td>
<td>91%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>174</td>
<td>155</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Medicines management</td>
<td>174</td>
<td>155</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Prevent level 1 and 2</td>
<td>174</td>
<td>155</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Calculating drug doses</td>
<td>174</td>
<td>153</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Health and safety</td>
<td>174</td>
<td>153</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Blood safety 04</td>
<td>16</td>
<td>14</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Fire safety</td>
<td>174</td>
<td>149</td>
<td>86%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Hand hygiene (clinical)</td>
<td>174</td>
<td>147</td>
<td>84%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>PROMPT</td>
<td>144</td>
<td>121</td>
<td>84%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Health records management</td>
<td>174</td>
<td>140</td>
<td>80%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Infection control level 2</td>
<td>174</td>
<td>135</td>
<td>78%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Moving and handling level 2</td>
<td>174</td>
<td>124</td>
<td>71%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>NEWS</td>
<td>10</td>
<td>7</td>
<td>70%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Maternity professionals issues day</td>
<td>144</td>
<td>100</td>
<td>69%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Blood safety 02</td>
<td>174</td>
<td>109</td>
<td>63%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Blood safety 01</td>
<td>158</td>
<td>98</td>
<td>62%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>162</td>
<td>99</td>
<td>61%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Slips, trips and falls level 2</td>
<td>15</td>
<td>8</td>
<td>53%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Understanding end of life</td>
<td>174</td>
<td>92</td>
<td>53%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Risk management (board and senior management)</td>
<td>39</td>
<td>16</td>
<td>41%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Prevention of suicide</td>
<td>16</td>
<td>5</td>
<td>31%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>
The maternity service met the trust's mandatory training target in six out of the 30 modules for which nursing and midwifery staff were eligible, however for two of these modules only a small number of staff were eligible to complete the training (nine eligible staff for adults advanced life support and five staff for adults basic life support). A further three training modules had a completion rate of over 90%, which was just below the trust target.

For four of the modules the compliance rate was less than 60%, however for two of these modules only a small number of staff were eligible to complete the training (15 eligible staff for slips, trips and falls level 2 and 16 eligible staff for prevention of suicide).

All medical staff in maternity services were reported as based at Cumberland Infirmary Hospital.

**West Cumberland Hospital**

Nursing and midwifery staff in maternity services at West Cumberland Hospital had an overall mandatory training compliance rate of 79.2% for April 2017 to March 2018 which was below the trust target. A breakdown of completion of mandatory training courses for nursing and midwifery staff in maternity services at West Cumberland Hospital is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic life support (adults)</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, trips and falls level 1</td>
<td>90</td>
<td>88</td>
<td>98%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk management</td>
<td>90</td>
<td>86</td>
<td>96%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Intensive life support (paediatrics)</td>
<td>16</td>
<td>15</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>90</td>
<td>84</td>
<td>93%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Duty of candour</td>
<td>90</td>
<td>82</td>
<td>91%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>90</td>
<td>82</td>
<td>91%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety</td>
<td>90</td>
<td>81</td>
<td>90%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>90</td>
<td>81</td>
<td>90%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Hand hygiene (clinical)</td>
<td>90</td>
<td>79</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent Level 1 and 2</td>
<td>90</td>
<td>79</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 04</td>
<td>16</td>
<td>14</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>90</td>
<td>78</td>
<td>87%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Calculating drug doses</td>
<td>90</td>
<td>77</td>
<td>86%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines management</td>
<td>90</td>
<td>76</td>
<td>84%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health records management</td>
<td>90</td>
<td>75</td>
<td>83%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control level 2</td>
<td>90</td>
<td>75</td>
<td>83%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>PROMPT</td>
<td>70</td>
<td>54</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and handling level 2</td>
<td>90</td>
<td>56</td>
<td>62%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, trips and falls level 2</td>
<td>5</td>
<td>3</td>
<td>60%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 02</td>
<td>90</td>
<td>54</td>
<td>60%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 01</td>
<td>74</td>
<td>43</td>
<td>58%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>85</td>
<td>46</td>
<td>54%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Understanding end of life</td>
<td>90</td>
<td>48</td>
<td>53%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk management (board and senior management)</td>
<td>12</td>
<td>6</td>
<td>50%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Maternity professionals issues day</td>
<td>70</td>
<td>32</td>
<td>46%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevention of suicide</td>
<td>16</td>
<td>5</td>
<td>31%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
The maternity service met the mandatory training target in four out of the 28 modules for which qualified nursing staff were eligible, however for two of these modules only four staff were eligible to complete the training (adults basic life support and dementia). A further six modules had a training completion rate of 90% or more, which was just below the trust target.

For six of the modules the compliance rate was 60% or less, however only 12 staff were eligible to complete risk management for the board and senior management and 16 were eligible to complete the prevention of suicide module.

No medical staff were reported by the trust as being based at West Cumberland hospital

(Source: Routine Provider Information Request (RPIR) – P40)

The service had systems and processes in place to ensure that staff could access mandatory training and staff we spoke with confirmed they had enough time to complete mandatory training.

Staff told us mandatory training compliance was managed by a training lead midwife, responsible for all sites and the current rate was higher than that provided by the Trust. We spoke with staff about the compliance rates with mandatory training shown above and were assured that the compliance figures would improve as the year progressed and so patient safety was not at risk.

Staff we spoke with assured us all staff including midwives, health care assistants, managers and medical staff, were rostered to attend all elements of mandatory training. Courses were held regularly with e-learning modules and classroom based sessions. Those who did not attend received a reminder, copied to their team leader.

The lead consultant at West Cumberland Infirmary organised weekly education sessions for all staff. These were shared across sites using video link.

All maternity staff, including community midwives, completed skills training and emergency drills including birthing pool evacuation and obstetric emergencies. However, staff told us they had not completed a pool evacuation drill for 18 months.

Safeguarding

Safeguarding training completion rates

The trust set a target of 95% for completion of safeguarding training.

Trust level

Nursing and midwifery staff in maternity services had an overall safeguarding training compliance rate of 86.2% for April 2017 to March 2018 which was below the trust target. A breakdown of completion of safeguarding courses for nursing and midwifery staff in maternity services is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 2</td>
<td>14</td>
<td>13</td>
<td>93%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>160</td>
<td>145</td>
<td>91%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>(specialists)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>174</td>
<td>142</td>
<td>82%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

Maternity services did not meet the safeguarding training trust target for any of the three modules.
for which nursing and midwifery staff were eligible. However only one member of staff (out of 14) did not complete the safeguarding children level 2 training module, and over 90% of staff had completed two out of the three modules.

All medical staff in maternity services were reported as based at Cumberland Infirmary Hospital.

**West Cumberland Hospital**

Nursing and midwifery staff in maternity services at West Cumberland Hospital had an overall safeguarding training compliance rate of 86.7% for April 2017 to March 2018 which was below the trust target. A breakdown of completion of safeguarding courses for nursing and midwifery staff in maternity services at West Cumberland Hospital is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 2</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>86</td>
<td>77</td>
<td>90%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>(Specialists)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>90</td>
<td>75</td>
<td>83%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

Maternity services at West Cumberland Hospital met the safeguarding training trust target for one of the three modules for which nursing and midwifery staff were eligible, however only four members of staff were eligible for this module. A further module had a completion rate of 90% which was just below the trust target.

*(Source: Routine Provider Information Request (RPIR) – P40)*

The midwives were moving onto online training for level three safeguarding and told us they understood this was the only route available to them for level three training. The community midwives carried out case reviews when they raised safeguarding issues, but we were told this practice did not take place in the ward areas. However, all midwives we spoke with in the ward areas told us they had spoken with staff at the safeguarding hub who provided support regarding any women identified with safeguarding issues.

The trust had policies, systems and processes in place to protect children and adults from neglect or abuse. Staff we spoke with had undertaken safeguarding training so that safeguarding was everyone’s business. Staff we spoke with understood their responsibilities in identifying and reporting any safeguarding concerns.

Staff were able to give us examples of safeguarding referrals made including domestic abuse, child protection, and female genital mutilation (FGM). The lead consultant at West Cumberland Infirmary was also the FGM lead for the whole service.

Midwives told us they undertook FGM and child sexual exploitation (CSE) training as part of their mandatory training. Staff told us they were not aware of any women who had presented with this. However, staff told us that any case would be shared with the community teams, GP, and health visitors.

There was a clear referral pathway via the community midwives if there were any identified safeguarding issues with expectant mothers, for example mothers who may have had children removed previously, those living with drug and alcohol abuse, and domestic violence. Staff attended a regular core group meeting where all the professionals met to discuss the mothers and plan any further action that may be required. We looked at two cases with
safeguarding issues and found that adequate risks had been assessed and recorded. If there was any risk of the mother absconding due to safeguarding issues, the unit was part of a network and would put alerts out to warn other maternity units nationally. The midwives told us mothers were involved in any decisions about their care and staff would ensure any plans of action would be made clear.

Staff set an alert in the patient administration system in maternity and staff put a red divider in patient paper records to ensure all staff were aware of safeguarding issues for a mother. We saw red cards used in patient records to identify any patient with a reported safeguarding concern. We saw evidence to show the team identified babies at risk at birth due to social issues. Staff told us an alert would also show on any electronic record.

Once the mother was discharged home, staff would tick a box in the perinatal notes to alert any health visitors of risks such as safeguarding. The midwives referred women into the safeguarding HUB and received feedback when required from the social workers.

The trust had a range of specialist midwives for vulnerable women such as young parents, women suffering domestic abuse, women involved in abuse of drugs or alcohol, women living with learning disabilities, and maternity related conditions such as diabetes.

The chief Matron worked with women who wished to develop their birth plan in a way that was outside of best practice guidance. This work ensured that a woman’s wishes were heard and a safe plan was developed. Staff told us the specialist midwives for vulnerable women were involved in development of birth plans and worked closely with the mental health perinatal team.

Staff we spoke with were aware of the trust’s abduction policy and the infant tagging system. Midwives told us if a baby’s tag came off, and this had happened on occasions, sometimes several times a day, it would alarm and alerts would show on the midwife station computer screen. Staff felt this ensured they kept babies safe. However, staff we spoke with could not remember the abduction policy ever being formally tested with drills on site. We observed staff and visitors were compliant with ward security, using passes and challenging visitors.

**Cleanliness, infection control and hygiene**

We found that the environment was visibly clean and that systems and processes were in place to control infection and promote hygiene. We saw the results of monthly cleaning audits displayed in ward areas. Compliance was consistently measured at 100%.

We found cleaning rotas and checklists for all patient areas including delivery rooms, the birthing pool so staff were aware of what was expected of them. Domestics held cleaning rotas for public areas. However, we did not find evidence staff complied with the Health and Safety Executive guidance and ran the hot water in the birthing pool for five minutes daily to reduce the risk of legionella.

Hand washing facilities and antibacterial gel dispensers were available at the entrance of the wards and on corridors. There was clear signage encouraging visitors and staff to wash their hands. We observed staff using personal protective equipment when required, and they adhered to ‘bare below the elbow’ guidance.

Women we spoke to said they had observed all disciplines of staff washing their hands and using hand gel.
Single rooms were available in all areas if a patient needed to be isolated.

We observed staff cleaned equipment after use and used assurance stickers to indicate it was clean and ready for use.

All wards displayed the results of hand hygiene audits. All the wards we visited achieved 100% throughout 2018.

We saw clinical waste and domestic waste was appropriately segregated and disposed of correctly in accordance with trust policy. Separate utility areas were designated for clean and dirty use. Separate bins for clinical and domestic waste were evident throughout all wards visited.

We saw posters offering women flu vaccinations.

Women were screened for Meticillin resistant staphylococcus aureus (MRSA) before undergoing elective caesarean sections as part of the pre-operative assessment.

Environment and equipment

We found the wards were accessible using a buzzer system, with good signage. All main entrances to the delivery suite and antenatal/postnatal ward were locked and admission was only possible via a telecom system. Staff and visitors gained entry and could only exit via a swipe card system.

Staff we spoke with reported having enough equipment that was ready and safe to be used.

Cardiotocography (CTG) equipment was available to enable staff to monitor the fetal heart rate in labour. The trust had a medical devices and equipment policy which set out how checks on equipment were done, how faults or damage were reported and what monitoring was in place.

Planned preventative maintenance was managed between estates and team leaders. Repairs needed earlier could be requested through the estates department. All the equipment we saw had visible evidence of electrical testing indicating safety checks.

The delivery suite was situated on the fourth floor and could be accessed via a lift or stairs.

The delivery suite had ten single labour, delivery, recovery and postnatal (LDRP) rooms. All the delivery rooms had en-suite facilities and a wet room, except for two rooms that shared a bathroom, lockable from either side. Delivery rooms close to the nurses’ station were used for women with higher risk scores and other rooms were used for women at lower risk. There was no separate midwifery led unit. However, staff told us two rooms had been identified to be converted for women wanting midwifery led care. There was no date set for this work to be done.

A birthing pool was available on the delivery suite and a safety net was stored in the room. Staff ran emergency pool evacuation simulation as part of their mandatory training.

There was an antenatal and postnatal ward with three four-bedded bays and a single room. Staff told us the single room was usually used to triage admissions and the bays could be used depending on the type of women admitted, but most often one bay was kept for antenatal women.

There were two dedicated obstetric theatres located just off the delivery suite, this enabled easy access. One theatre was in regular use for elective and emergency use and the second theatre was used rarely and for emergencies only. Theatres were cleaned and fully stocked every day.

Resuscitation trolleys were located on the main corridors in each of the areas we visited. We
checked the resuscitation trolleys in all the clinical areas and found all stocks and supplies were checked in line with best practice in all clinical areas.

There were resuscitaires in LDRP rooms but not in the antenatal or postnatal ward area. This meant that staff had to access SCBU if a baby was in need of urgent resuscitation. SCBU was located through a security door so although it was very close, there was a physical barrier between a sick baby with staff providing care, and the equipment needed.

Community staff we spoke with explained that they carried weighing scales to monitor weight of mums and babies to ensure nutrition was taking place.

Assessing and responding to patient risk

Within the maternity service staff used the modified early obstetric warning score (MEOWS) and the national early warning score (NEWS) respectively to assess the health and wellbeing of women. These assessment tools enabled staff to identify if a patient’s clinical condition was changing. Women on the delivery suite and antenatal/postnatal ward were assessed using the MEOWS score. We reviewed three sets of records and found there was sufficient and regular information recorded for staff to assess women’s conditions and staff understood escalation protocols and interventions.

The Trust used the national sepsis tool to ensure early recognition and action regarding postnatal infection.

Staff used the World Health Organisation (WHO) safety checklist, modified for maternity, for all interventional procedures and staff told us the checklist would be started in the delivery room from the time of decision to proceed. We saw completed checklists and reviewed records of a woman who had been to theatre. All WHO checklists had been completed correctly.

We observed midwife handovers and medical staff communications and saw staff at all levels and grades took part fully in handovers of patient care from one shift to the next. Staff told us if anaesthetists were unable to attend medical handovers they would attend the ward before or afterwards. Staff gave updates on labouring women, transfers to and from other wards or theatre and details of women requiring additional care. We saw staff used a situation, background, action and result (SBAR) framework to transfer women between teams. This appeared to work well.

We saw evidence the unit used the ‘fresh eyes’ approach, a system that required two members of staff to review fetal heart tracings. This indicated a proactive approach in the management of obstetric risk as it reduced the risk of misinterpretation of the heart tracings. We also saw a second midwife attended a birth wherever possible.

Midwives completed risk assessments at booking to identify women with any medical, obstetric, psychological or lifestyle risk factors. This determined if an individual was high or low risk. High risk women were referred to consultant led antenatal clinics. Women referred by their GP or the emergency department attended the ward for assessment.

Medical staff told us clinical information was discussed formally between all levels of medical staff and recorded in handover notes.
Consultant obstetricians were available out of hours for emergency caesarean section and if a patient’s condition gave rise for concern.

The service had an agreement in place with the local ambulance service to attend babies born before arrival of a midwife at home. Community midwives told us they informed the ambulance service before attending any home birth in case an emergency arose.

**Midwifery and nurse staffing**

**Planned vs actual**

Staffing levels were recorded and displayed on noticeboards in ward areas. Most shifts were fully staffed and sometimes overstaffed. Lead midwives were supernumerary on day shift.

There was formal escalation process to manage the unit at busy times including using non-clinical staff or calling in community midwives. Staff told us this happened very infrequently and they were not sure if it was monitored.

Staff were allocated by the lead midwife to specific areas such as delivery suite or the ward at the beginning of each shift. However, staff told us midwife staffing levels were static and did not risk assess daily. The service had used Birthrate Plus to manage and balance risk in 2016 but staffing had not reassessed since then. Staff told us this was mainly due to not being able to plan for the future.

There were two HCAs were on each shift, one on the antenatal and postnatal ward, and the other on delivery suite.

**Vacancy rates**

From April 2017 to March 2018, the trust reported an over-establishment of 4.1% with 63.4 more WTE staff in post than planned. The trust target for vacancy rate is 5%.

Vacancy rates by site are shown below:

- West Cumberland Hospital: 10.9% (overfill)
  
  *(Source: Routine Provider Information Request (RPIR) – Vacancy tab)*

**Turnover rates**

From April 2017 to March 2018, the trust reported a turnover rate of 7.2% in maternity which was lower than the trust target of 13.0% for voluntary turnover (excluding corporate services, junior doctors and FTCs)

Turnover rates by site are shown below:

- West Cumberland Hospital: 8.0%
  
  *(Source: Routine Provider Information Request (RPIR) – Turnover tab)*

**Sickness rates**

From May 2017 to May 2018, the trust reported a sickness rate of 5.2% in maternity which was above the trust target of 4.0%.
Sickness rates by site are shown below:

- West Cumberland Hospital: 4.3%

West Cumberland Hospital had a sickness rate that was just above the trust target.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Bank and agency staff usage**

From April 2017 to March 2018, the trust reported a bank usage rate of 8.6% in maternity.

The trust was unable to provide comparable data for agency and shifts left unfilled specifically for West Cumberland Hospital, due to system restrictions. However, staff told us the service did not use agency staff.

**Midwife to birth ratio**

From January 2017 to December 2017 the trust had a ratio of one midwife to every 23.7 births. This was similar to the England average of one midwife to every 25.5 births and similar to the trust’s previous performance (November 2015 to October 2016) of one midwife to every 24.4 births.

(Source: Electronic Staff Records – EST Data Warehouse)

The service performed better than national benchmark for midwifery staffing set out in the Royal College of Obstetricians and Gynaecologists guidance (Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour) with a ratio of 1:24 against the recommended 1:28. The service had previously used the Birthrate Plus® midwifery acuity tool, however, at the time of inspection the service was working towards the continuity of carer model advocated in Better Births (2017). This meant that the acuity tool would be more appropriate following the implementation of the new way of working.

Between July 2017 and June 2018, the service reported an average 1:1 care in labour rate of 75.8%, however, 14.2% of maternity records showed 1:1 care in labour was not recorded. The service identified 9.9% of women did not receive 1:1 care in labour.

From January 2017 to December 2017 the trust had a ratio of one midwife to every 23.7 births. This was similar to the England average of one midwife to every 25.5 births and similar to the trust’s previous performance (November 2015 to October 2016) of one midwife to every 24.4 births.

(Source: Electronic Staff Records – EST Data Warehouse)

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Between July 2017 and June 2018, the service reported an average 1:1 care in labour rate of 81.9%, however, 15.9% of maternity records showed 1:1 care in labour was not recorded. The service identified 1.6% of women did not receive 1:1 care in labour.
Staff we spoke with told us, they were assured women received safe care through audit and friends and family survey results. We spoke with three women who said they had received one to one care in labour.

**Medical staffing**

There were five consultants employed at each site and they all provided cross cover for obstetrics and gynaecology. The service employed six middle grade trust doctors and four junior doctors including foundation trainees. There were no specialist trainees in obstetrics.

The delivery suite had consultant cover 40 hours per week, this was in line with the safer childbirth (2007) recommendation. Consultants were available within 30 minutes when they were on call. On-call consultants telephoned the acute units every evening at 10pm to ensure staff had all requirements in place. They would attend at any time they were needed. We spoke with consultants and midwives who all confirmed this.

Handovers took place twice a day and staff told us consultants on call made a structured call to the midwife in charge of the maternity units every evening at 10pm to receive information on women, their care and any specific needs.

The medical team were trialling a handover tool to help junior doctors be aware of the current acuity of women on the unit.

Anaesthetic cover was available 24 hours a day and included an epidural service, however there was not a dedicated anaesthetic team for the maternity unit. Anaesthetic cover was shared between the intensive care unit and maternity this meant that there may be a delay woman receiving an epidural. There was a trust shortage of anaesthetists but the trust had mitigated this risk by employing long term locums and existing staff worked flexibly to ensure all departments had adequate cover. The maternity service had not experienced any difficulties in accessing anaesthetists for their women.

The consultants held clinics in the antenatal clinic. However, we were told that it was difficult to get a medical consultant to support the diabetes clinic. There were specialist clinics available for women who had multiple pregnancies, mental health issues.

**Staffing skill mix**

In January 2018, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.

**Staffing skill mix for the 24.5 whole time equivalent staff working in maternity at North Cumbria University Hospitals NHS Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>25%</td>
<td>41%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>30%</td>
<td>9%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>33%</td>
<td>45%</td>
</tr>
<tr>
<td>Junior*</td>
<td>12%</td>
<td>6%</td>
</tr>
</tbody>
</table>
Records

We reviewed six sets of records and found them to be legible, detailed, signed, and safely stored. Records showed each woman had a named midwife responsible for their care. Individualised care plans for pregnancy and labour were documented and venous thromboembolism (VTE) risk assessments were completed.

Patient records were a mix of electronic and paper patient notes (for instance, inpatient notes and nursing care plans were paper based). Paper records were stored securely away from patient areas and maternity used an electronic record so data could be shared with community services.

Women carried their own hand-held records throughout their pregnancy. These were shared with community midwives and GPs. Results from antenatal tests were documented in these records. Antenatal risk assessments were completed at booking to identify any medical, obstetric, or psychological risk factors. Midwives we spoke with told us risk assessments were repeated at each antenatal visit. We saw evidence of this in records we reviewed.

Information relating to discharge was communicated using the SBAR tool to ensure timely communication on discharge from the maternity unit. Information was sent by post to women’s GPs and health visitors. Community midwives could access the information electronically. Staff said if a woman had complex needs they would contact the relevant professional in addition.

All staff could access test results using the trust electronic system. Community staff had electronic access to test results at their hub offices.

Staff we spoke with told us and we saw senior midwives undertook a monthly spot check record audit of records. Any trends or good practice were disseminated to clinical areas.

The ‘fresh eyes’ approach was used to review CTG’s and we saw evidence of this in patient records.
**Medicines**

We checked the storage of medicines on the wards we visited. We found that medicines were stored securely in appropriately locked rooms and stocks were in date. Pharmacy staff checked storage and stocks of medicines weekly. A prescription pad was securely stored within the locked medicines cabinet.

We checked the storage and administration of controlled drugs, which require specific controls, in all clinical areas. We found controlled drugs were appropriately stored with access restricted to authorised staff. Records showed the administration of controlled drugs were subject to a second check. After administration, the stock balance was confirmed to be correct and the balance recorded. We checked records between March and July 2018 and found these had all been completed appropriately. Intravenous fluids were securely stored in all the clinical areas we visited.

Medicines that required refrigeration were stored appropriately in fridges. The drugs fridges were locked and there was a method in place to record daily fridge temperatures. All fridge minimum and maximum temperatures were checked and recorded daily. There were no gaps in recording. Staff we spoke with understood their responsibilities for raising concerns if the fridge temperature went out of range.

Eighty four percent of staff in maternity had completed medicine management training in the last 12 months.

We checked three prescription charts and found these to be comprehensive and completed to a high standard. Women received medicines promptly and any allergies were clearly recorded. Staff documented where prescribed medicines were not administered and the reason why.

All midwives were practising under patient group directions (PGDs). (PGDs provide a legal framework that allows some registered health professionals to supply and/or administer specified medicine(s) to a predefined group of women without them having to see a doctor.) Records showed PDGs were in date and included exemptions.

In the medicine room on the labour suite there was grab box for post-partum haemorrhage (PPH) (on resus trolley – dates recorded when medicines taken out), two suturing boxes containing lignocaine, and five delivery boxes. These each contained medicines that required to be labelled when they were removed from the fridge. Four out of five delivery boxes contained dates on the two different medicines that were required to be labelled. However, in one box one medicine did not contain a date when the medicine was removed. We raised this with the lead midwife who ensured the box was removed and staff were reminded of the correct process.

Community midwives based within the West Cumberland infirmary kept medicines required for homebirth in label boxes in the fridge, and would call into the office on the way to a homebirth to collect them.

Community midwives told us all home birth equipment, including medicines and medical gases, were delivered to the woman’s home from 36 weeks gestation. Community midwives did not carry or transport medical gases at any times.

**Incidents**

The trust had a clear policy for the reporting of incidents, near misses and adverse events. Staff were encouraged to report incidents using the trusts electronic reporting system. The staff we spoke with described the process of incident reporting and understood their responsibilities to report safety incidents including near misses. Staff told us they received a copy of the closure of any incident they reported from the electronic reporting system.
Between May 2017 and June 2017 there were 621 incidents specifically categorised as obstetrics and reported to the National Reporting and Learning System (NRLS). Of these, 231 (37%) related to treatment and procedures and 130 (21%) were reported as concerns around staffing. Staff told us they completed details of actions taken to prevent a recurrence of an incident.

Staff we spoke with said incidents were discussed in weekly, joint (cross-site) core risk meetings. Feedback from incidents was shared in a number of ways including; a “safety message of the week”, case reviews, and face to face feedback. Safety and quality midwives relayed feedback and updates to staff.

The service held monthly perinatal mortality meetings where serious case reviews were discussed. These meetings were attended by gynaecology, obstetric and neonatal staff.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify women (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

Staff we spoke with understood and could describe duty of candour requirements and understood the importance of being open and honest with women. It was evident in the serious incident investigations we reviewed that the duty of candour had been applied.

There were escalation processes to activate plans during internal critical incidents such as shortfalls in staffing levels or bed shortages. However, some staff told us they had reported staff shortages, especially at night, and had been told there would be no additional staff made available.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From June 2017 to May 2018, the trust reported one incident which was classified as a never event for maternity. This was a retained foreign object post procedure and occurred in May 2018.

*(Source: Strategic Executive Information System (STEIS))*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported nine serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from June 2017 to May 2018 including one never event.

The types of incident reported were:

- Maternity/obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant) with six (66.7% of total incidents)
- Maternity/obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant) with one (11.1% of total incidents)
- Maternity/obstetric incident meeting SI criteria: mother only with one (11.1% of total incidents)
- Surgical/invasive procedure incident meeting SI criteria with one (11.1% of total incidents)
Site specific information can be found below:

- West Cumberland Hospital (four)

(Source: Strategic Executive Information System (STEIS))

Staff gave an example of a recent serious incident involving post-natal sepsis and explained the lessons learned and shared and actions taken to help prevent a recurrence.

**Safety thermometer**

The Maternity Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care.

Measurement at the frontline is intended to focus attention on patient harms and their elimination. Data collection takes place one day each month – a suggested date for data collection is given but the service can change this. Data must be submitted within 10 days of suggested data collection date.

The graphs below identify the levels of harm free care for the maternity service.
The graphs show mixed results for the perception of harm free care for the service; however, women reported feeling safe 100% of the time between April 2016 and August 2018.

Is the service effective?

Evidence-based care and treatment

The trust had systems and processes in place to ensure that care was given by the service according to published national guidance such as that issued by National Institute for Health and Care Excellence (NICE) and Royal College of Obstetricians and Gynaecologists (RCOG). All staff we spoke with could access on the trust's intranet, guidelines, policies and procedures relevant to their role.

On a review of clinical pathways and guidelines we found some maternity guidelines and procedures had an author and were within their review date. However, there were many maternity guidelines that were beyond their published review date. We found that of 20 maternity guidelines we reviewed, 17 were out of date, some by up to two years. We spoke with the midwife lead responsible for governance, along with the ADM, to ensure that clinical guidelines were updated in accordance with NICE or RCOG guidelines. Staff told us guideline reviews were underway but there were various reasons for delays including lack of clinical input. There was no clear process or timeline for updating maternity guidelines and staff reported the Trust ratification process was responsible for some of the delays in publishing clinically agreed guidelines.

The service had an annual audit programme. Doctors and midwives were involved in the audit programme. For instance, we saw audits on maternal and fetal monitoring in labour or indication for induction of labour. Actions from audits were discussed and monitored at joint core risk meetings and following presentations at education meetings.

Nutrition and hydration

We found the service met the needs of women having babies, babies and visitors, carers or relatives.

There was a specialist midwife for infant feeding who worked across both sites, who led on the implementation and training associated with the implementing United Nations Children’s Fund (UNICEF) Baby Friendly Initiative standards. The specialist midwife also managed the breastfeeding peer supporters.
The trust had implemented United Nations Children’s Fund (UNICEF) Baby Friendly Initiative standards. The maternity unit in Whitehaven was awarded stage one UNICEF baby friendly accreditation and was assessed for stage two in October 2017 and was in the process of providing additional evidence.

Breastfeeding initiation rates for deliveries that took place in the hospital for June 2017 and May 2018 were reported between 49.5% and 71.1%.

The Maternity ward had a kitchen area where women had open access to hot drinks and cold water.

Women told us they had a choice of meals and these took account of their individual preferences, including religious and cultural requirements.

**Pain relief**

To help women manage their pain we saw that the service could offer a range of options, both medical and non-medical. Women we spoke with did not report any issues with the management of their pain.

Women received information of the pain relief options available to them, this included Entonox (nitrous oxide and oxygen) piped directly into all delivery rooms, and pharmacological methods such as Pethidine and epidural. Between June 2017 and May 2018 between 6.4% (March 2018) and 18.1% (May 2018) of women used epidural as a method of pain relief.

The service promoted normal birth as much as possible, the delivery suite had one birthing pool and had acquired funding for a further birthing pool.

The service did not actively promote alternative therapies such as aromatherapy and hypnobirthing, although staff we spoke with informed us that they had supported women using hypnobirthing techniques.

To help women manage their pain we saw that the service could offer a range of options, both medical and non-medical. Women we spoke with did not report any issues with the management of their pain.

Community staff told us any required pain relief for a home birth would be prescribed by the GP and Entonox would be delivered to the home at 36 weeks gestation.

**Patient outcomes**

The service had systems and processes in place to monitor patient outcomes, such as case reviews, use of a maternity dashboard, maternity safety thermometers, and taking part in a programme of national and local audits, the results from all of which were used to improve the experience of its women.

**National Neonatal Audit Programme**

**West Cumberland Hospital**

In the 2017 national neonatal audit West Cumberland Hospital performance in the two measures relevant to maternity services was as follows:
• Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?

There were 23 eligible cases identified for inclusion and 81.7% of mothers were given a complete or incomplete course of antenatal steroids.

This was within the expected range when compared to the national aggregate where 86.1% of mothers were given at least one dose of antenatal steroids.

The hospital did not meet the audit’s recommended standard of 85% for this measure.

• Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?

Data for this metric was suppressed due to low numbers.

(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)

Standardised caesarean section rates and modes of delivery

From January 2017 to December 2017 the total number of caesarean sections, standardised caesarean section rates and emergency sections were all similar to expected.

<table>
<thead>
<tr>
<th>Type of caesarean</th>
<th>England</th>
<th>North Cumbria University Hospitals NHS Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Caesarean rate</td>
<td>Caesareans (n)</td>
</tr>
<tr>
<td>Elective caesareans</td>
<td>12.4%</td>
<td>311</td>
</tr>
<tr>
<td>Emergency caesareans</td>
<td>15.6%</td>
<td>348</td>
</tr>
<tr>
<td>Total caesareans</td>
<td>28.0%</td>
<td>659</td>
</tr>
</tbody>
</table>

Note: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries.

In relation to other modes of delivery from January 2017 to December 2017 the table below shows the proportions of deliveries recorded by method in comparison to the England average:

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>North Cumbria University Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total caesarean sections¹</td>
<td>659</td>
<td>23.9%</td>
</tr>
<tr>
<td>Instrumental deliveries²</td>
<td>312</td>
<td>11.3%</td>
</tr>
<tr>
<td>Non-interventional deliveries³</td>
<td>1,789</td>
<td>64.7%</td>
</tr>
<tr>
<td>Other/unrecorded method of delivery</td>
<td>3</td>
<td>0.1%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>2,763</td>
<td>100%</td>
</tr>
</tbody>
</table>

¹Includes elective and emergency caesareans
²Includes forceps and ventouse (vacuum) deliveries
³Includes breech and normal (non-assisted) deliveries
The proportion of deliveries by caesarean section at this trust was lower than the England average and the proportion of non-interventional deliveries was higher.

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

Between June 2017 and May 2018, the service reported the total caesarean section between 15.2% (August 2017) and 30.6% (March 2018) with the average being 21.6%. This was better to the regional average of 27% and England average of 28%.

Between June 2017 and May 2018, the service reported an elective caesarean section rate between 6.4% (March 2018) and 19% (November 2018). The average for this timescale was 12.7% which was better than the regional average of 13.3% and equal to the England average of 12.4%.

Between June 2017 and May 2018, the service reported an elective caesarean section rate between 7.3% (February 2018) and 17% (May 2018). The average for this timescale was 10.2% this was better than the regional average of 13.6% and the England average of 15.6%.

Between June 2017 and May 2018, the service reported an induction of labour rate between 26% (June 2017) and 38.8% (April 2018). Additional of those induced labours the service monitored the number of labours which resulted in an emergency caesarean section. The service reported between 5.7% (November 2017) and 27.6% (March 2018) against a target of 22%.

Maternity active outlier alerts

As of May 2018, the trust reported no active maternity outliers.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE UK Audit)

The trust took part in the 2017 MBRRACE audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 4.45.

This is up to 10% lower than the average for the comparator group rate of 4.73 and performance was rated as better than expected.

(Source: MBRRACE UK)

Between June 2017 and May 2018, the service reported the rate of 3rd and 4th degree vaginal tears between 0% (March/April 2018) and 4.5% (October 2017), this was better that the target of less than 5%, however, was worse than the regional average of 1.7%

Between June 2017 and May 2018, the service reported a post-partum haemorrhage of 1500mls rate between 0.0% (March 2018) and 5.6% (March 2018), this was better than the regional average of 5% with the exception of March 2018.

Between June 2017 and May 2018, the service reported a post-partum haemorrhage of 2000mls rate between 0% (September, December 2017, January, February, March, May 2018) and 3.7% (July 2017). The service had undertaken some improvement work around identifying estimated blood loss at delivery.
Competent staff

Appraisal rates

Trust level

From April 2017 to March 2018 97.3% of staff within maternity services at the trust received an appraisal compared to a trust target of 95.0%. A breakdown of staff appraisal completion is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required</th>
<th>Appraisals completed</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to doctors and nursing staff</td>
<td>38</td>
<td>38</td>
<td>100%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>4</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff (Qualified nurses)</td>
<td>141</td>
<td>136</td>
<td>96%</td>
</tr>
</tbody>
</table>

All of the staff groups met the trust target for completion of appraisals.

West Cumberland Hospital

From April 2017 to March 2018 98.8% of staff within maternity services at West Cumberland Hospital received an appraisal compared to a trust target of 95%. A breakdown of staff appraisal completion is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required</th>
<th>Appraisals completed</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>2</td>
<td>2</td>
<td>100%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>17</td>
<td>17</td>
<td>100%</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff (Qualified nurses)</td>
<td>62</td>
<td>61</td>
<td>98%</td>
</tr>
</tbody>
</table>

All four staff groups met the trust target for completion of appraisals.

Junior doctors had cross site teaching with colleagues at Cumberland Infirmary via video conferencing. This included presentations and discussions on recent incidents within the service.

The service ensured that staff were competent in their roles by ensuring staff received an annual appraisal, or through sharing information by email or at team meetings or in a newsletter, and by offering staff additional training, including support for the new professional midwife advocate role.

Staff we spoke with confirmed that they had received an annual appraisal or were booked to receive one.

A midwife training coordinator provided support to both main sites to collate training information and inform staff and managers when mandatory training was required. We were told the Trust training information supplied prior to our inspection was out of date.

Staff told us that there were five trained professional midwife advocates at West Cumberland Hospital, four of whom had undertaken a short course to update from the superseded supervisor.
of midwives role. One midwife who had no previous experience had completed the full course. This role had replaced the supervisor of midwives role. Midwives felt supported, particularly around revalidation.

Student midwives and newly qualified midwives worked through a preceptorship package. Staff told us all newly qualified staff were allocated a preceptor. All staff, except specialist midwives and community midwives, worked on Delivery Suite and the antenatal/postnatal ward to ensure up to date skills and competence in all areas.

The service had a number of midwives occupying specialist roles, such as for young parents, drug and alcohol, diabetes, bereavement, an infant feeding coordinator and a safeguarding midwife.

Staff received training within their department or via video link from West Cumberland Infirmary, led by the consultant lead. This training was multi-disciplinary and attended by all staff.

Junior doctors reported to us that they felt well supported and felt able to approach senior colleagues if advice was needed. The service employed midwifery support workers who told us they completed training modules including annual (PROMPT PRactical Obstetric Multi-Professional Training is an evidence based multi-professional training package for obstetric emergencies). They took part in joint training with staff at Cumbria Infirmary including annual breast-feeding module. Midwifery support workers rotated between delivery suite and the ward to ensure they kept their skills up to date.

**Multidisciplinary working**

We saw different teams and health professionals working together with staff at the service to ensure effective services were delivered to women. All newborn baby checks had been done at the hospital by staff in the adjacent neonatal unit with support from paediatricians, before the baby left. However, all student midwives received NIPE training as standard and the service ensured that at least one midwife per shift had completed NIPE training so baby checks could be carried out on the unit. Between April and June 2018 75% of newborn checks were undertaken by a midwife.

Staff told us handover between shifts was open, with structured, and detailed communication between doctors and midwives. Anaesthetists joined the multidisciplinary handover, or the ward round shortly afterwards, and were made aware of any high-risk women and planned cases for theatre.

Education sessions and joint core risk meetings were open meetings so if any staff member wished to attend they were welcome to do so.

We saw that healthcare assistants were a highly valued part of the team and we saw a display of very positive comments from midwives about midwifery support workers.

A number of clinics that the service ran drew on specialist consultants or other health professionals from outside the service. However, staff told us they had difficulty identifying a medical consultant support for the diabetic clinic.

Specialist midwives worked closely with GPs, social workers, health visitors, and support workers, to ensure that vulnerable women and those with long term conditions received effective care. Staff told us they had good links with the perinatal mental health team who could provide assessment and treatment as necessary.
We were told of one incident where a patient who was pregnant and had mental health needs identified had attended the unit. Staff had assessed they required help and support for their condition. The midwife tried to speak with the MH team to request they see the patient. Staff told us at first the mental health team would not take the referral because the patient was not in the emergency department. Staff had discussed the situation and process for triage and the patient was seen. This incident was shared with the wider team and lessons had been learned as this incident had created further links with the mental health team to explore and understand mental health alongside pregnancy.

**Seven-day services**

There was a specific obstetric theatre team and was always available, out of hours this staffed between by emergency theatres. Anaesthetic cover was available 24 hours a day, however, this was shared with the intensive care unit, therefore there may be a delay in women receiving an epidural.

There was medical staff presence on the labour ward 24 hours a day, with consultant presence 40 hours a week.

Maternity triage was provided on the Antenatal and postnatal ward 24 hours a day. The day assessment unit was available seven days a week and undertook routine day assessments of pregnant women including blood pressure profiles they also triaged all emergency admissions, pre-operation checks.

Ultrasound scans were available Monday to Friday 9.00am to 5.00pm, however, we were told there were not enough slots for urgent scans.

Community midwives provided seven-day cover with antenatal clinics and postnatal visits took place in the home they were available at weekends.

**Health promotion**

Between January 2018 and May 2018, the service reported the rate of women smoking at booking appointment was 8.8% (March 2018) and 21.6% (April 2018), this was worse than the target of less than 11%.

Between January 2018 and May 2018, the service reported the rate of women smoking at delivery was 9.6% (March 2018) and 18.7% (April 2018), this was worse than the target of less than 11%.

The service had a public health midwife manager whose portfolio includes Vaccinations, obesity pathways, infant nutrition, smoking cessation, substance misuse and teenage pregnancy. Each workstream had a specialist midwife lead.

Women had access to aqua aerobics classes.
Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

The trust set a target of 95% for completion of mental capacity act (MCA) and deprivation of liberty safeguarding (DoLS) training.

Trust level

Nursing and midwifery staff in maternity services had an overall MCA and DoLS training compliance rate of 94.8% for April 2017 to March 2018 which met the trust target. A breakdown of completion of MCA and DoLS courses for nursing and midwifery staff in maternity services is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental capacity level 2</td>
<td>37</td>
<td>36</td>
<td>97%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental capacity level 1</td>
<td>174</td>
<td>169</td>
<td>97%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Deprivation of liberty</td>
<td>37</td>
<td>30</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Maternity services met the training trust target for two of the three modules for which nursing and midwifery staff were eligible.

All medical staff in maternity services were reported as based at Cumberland Infirmary Hospital.

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental capacity level 1</td>
<td>84</td>
<td>83</td>
<td>99%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental capacity level 2</td>
<td>27</td>
<td>26</td>
<td>96%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Deprivation of liberty</td>
<td>27</td>
<td>21</td>
<td>78%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Maternity services at Cumberland Infirmary Hospital met the training trust target for two of the three modules for which nursing and midwifery staff were eligible.

Medical staff in maternity services at Cumberland Infirmary Hospital had an overall MCA and DoLS training compliance rate of 70.0% for April 2017 to March 2018 which did not meet the trust target. A breakdown of completion of MCA and DoLS courses for medical staff in maternity services at Cumberland Infirmary Hospital is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental capacity level 1</td>
<td>8</td>
<td>6</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Deprivation of liberty</td>
<td>6</td>
<td>4</td>
<td>67%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Mental capacity level 2</td>
<td>6</td>
<td>4</td>
<td>67%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Maternity services at Cumberland Infirmary Hospital did not meet the training trust target any of the three modules for which medical staff were eligible, however the number of eligible staff for each module was low and there were two staff for each module that had not completed the training.
Nursing and midwifery staff in maternity services at West Cumberland Hospital had an overall MCA and DoLS training compliance rate of 95.5% for April 2017 to March 2018 which met the trust target. A breakdown of completion of MCA and DoLS courses for nursing and midwifery staff in maternity services at West Cumberland Hospital is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental capacity level 2</td>
<td>10</td>
<td>10</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental capacity level 1</td>
<td>90</td>
<td>86</td>
<td>96%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Deprivation of liberty</td>
<td>10</td>
<td>9</td>
<td>90%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Maternity services at West Cumberland Hospital met the training trust target for two of the three modules for which nursing and midwifery staff were eligible. There was a small number of eligible staff (10) for two of the modules (mental capacity level 2 and deprivation of liberty).

Staff knew the importance of gaining consent to treatment and had received training in consent, mental capacity and deprivation of liberty safeguards.

Our discussions with staff and review of patient records showed that consent was written where any medical procedure was carried out, such as a caesarean section, with verbal consent for everyday tasks, such as taking blood pressure. We reviewed two records of women undergoing a medical procedure and noted that consent was properly evidenced in writing in both records. Staff told us women were given relevant background information for procedures involving written consent, for example in a caesarean section preparation clinic. This promoted better understanding and ensured consent was informed consent.

Staff could describe what was meant by Gillick competence, (a test used to assess a young person’s ability to give consent), with staff informing us this was part of their mental capacity training. Staff gave examples of when they would use this.

**Is the service caring?**

**Compassionate care**

**Friends and Family test (FFT) performance**

**Friends and family test performance (antenatal), North Cumbria University Hospitals NHS Trust**

From March 2017 to March 2018 the trust’s maternity FFT (antenatal) performance (%) recommended was generally similar to the England average. In three of the reported months...
100% of patients recommended the trust for antenatal care. Note that no data was published by NHS England for November 2017.

Friends and family test performance (birth), North Cumbria University Hospitals NHS Trust

From March 2017 to March 2018 the trust’s maternity FFT (birth) performance (% recommended) was generally similar to the England average. In five of the reported months 100% of patients recommended the trust for care during birth. Note that no data was published by NHS England for November 2017.

Friends and family test performance (postnatal ward), North Cumbria University Hospitals NHS Trust

From March 2017 to March 2018 the trust’s maternity FFT (postnatal ward) performance (% recommended) was generally better than the England average. The trust scored between 97% and 100% each month compared to the England average of between 94% and 95%. Note that no data was published by NHS England for November 2017.

Friends and family test performance (postnatal community), North Cumbria University Hospitals NHS Trust

From March 2017 to March 2018 the trust’s maternity FFT (postnatal community) performance (% recommended) was generally similar to the England average. In nine of the reported months 100% of patients recommended the trust for care during birth. Note that no data was published by NHS England for November 2017.

(Source: NHS England Friends and Family Test)
CQC Survey of women’s experiences of maternity services 2017

The trust performed better than other trusts for six out of 16 questions in the CQC maternity survey 2017

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>9.4</td>
<td>Best performing trusts</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>8.8</td>
<td>Best performing trusts</td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>9.7</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>8.8</td>
<td>About the same</td>
</tr>
<tr>
<td>Staff during labour and</td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>9.3</td>
<td>About the same</td>
</tr>
<tr>
<td>birth</td>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>8.6</td>
<td>Best performing trusts</td>
</tr>
<tr>
<td></td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>8.9</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>9.6</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If you needed attention during labour and birth, did a member of staff help them within a reasonable amount of time?</td>
<td>9.3</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>9.1</td>
<td>Best performing trusts</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>9.6</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>9.3</td>
<td>About the same</td>
</tr>
<tr>
<td>Care in hospital after the</td>
<td>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</td>
<td>8.0</td>
<td>About the same</td>
</tr>
<tr>
<td>birth</td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?</td>
<td>8.8</td>
<td>Best performing trusts</td>
</tr>
<tr>
<td></td>
<td>Thinking about your stay in hospital, how clean was the hospital room or ward you were in?</td>
<td>9.0</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?</td>
<td>9.2</td>
<td>Best performing trusts</td>
</tr>
</tbody>
</table>

(Source: CQC Survey of Women’s Experiences of Maternity Services 2017)

We saw letters and cards of appreciation and positive comments about people’s experience displayed in the corridor. We noted there was no person identifiable information displayed.
We spoke with three women and two partners, all of whom spoke positively about their experience. Women told us they felt well cared for, the midwives were friendly and always introduced themselves. Women told us staff were always available if they needed them and staff introduced themselves. Women and partners described staff as “caring, supportive, professional, reassuring and compassionate”.

Partners were involved with the care and they had continuity of care in the community. Women and partners spoke positively of community midwives.

We observed staff reacted promptly to telephones and call bells in all areas we inspected.

Women could contact the unit or their community midwife if they had any concerns. We observed good interaction between midwives and women in all ward areas.

**Emotional support**

Staff valued and cared for families’ emotional needs in all departments we inspected.

The service provided a Patient Afterthoughts service, a listening service for women or families experiencing difficulties following any birth.

The delivery suite had a small quiet room set aside to use for bereaved families and had made plans for a bereavement suite, close to but separate from the main delivery suite, so women and their families needing a quiet place to sit had privacy. This room was shared with children’s services for use by parents of children in SCBU. The bereavement suite was being developed using donations of funds from bereaved families. The chaplaincy service could also provide support if requested.

Each main site had a bereavement midwife and they provided a link to the hospital bereavement team. There was a clear bereavement policy in place.

Perinatal mental health risk assessments took place at the booking appointment, throughout pregnancy and during the post-natal period. Women with a suspected mental health illness were cared for in partnership with the perinatal mental health team for further assessment and treatment.

**Understanding and involvement of patients and those close to them**

Women we spoke with said they felt involved in decisions about their care and had been provided with all the relevant information to help them make an informed choice about where to have their baby.

From patient records we reviewed we saw evidence of discussions of the risks and benefits of different birthing locations and discussions about birthing preferences.

The service told us midwives completed birth plans to support women with complex and difficult birth choices.

There were peer support volunteers to help new mothers with breastfeeding.
Is the service responsive?

Service delivery to meet the needs of local people

**Bed Occupancy**

From July 2016 to December 2017 the bed occupancy levels for maternity were generally lower than the England average. During the reported period the trust’s bed occupancy for maternity ranged from 53.7% (Q4 2016/17) to 44.5% (Q3 2017/18)

The chart below shows the occupancy levels compared to the England average over the period.

(Source: NHS England)

Partners could visit delivery suite at any time. On Honister ward partners and siblings could stay any time from 9am to 9pm. Other visitors were welcome on the ward from 3pm to 4pm and 7pm to 8pm.

Delivery suite facilitated, where possible, time for partners to spend on the ward with their partner and baby following the birth.

The service recorded babies born before arrival and if the ambulance service were called to a woman in labour there was an agreement in place to bring her direct to hospital. The service took part in a regional arrangement for babies born before arrival. The regional ambulance service was working with Trusts to develop a standard response to these calls.

The community staff worked out of local GP surgeries and a community hospital which helped women to receive antenatal and postnatal care closer to home. Community midwife teams were organised around geographical areas to ensure women had a responsive local service.

Women had the option to deliver at home, at Penrith Birthing Centre with midwifery led care, at...
West Cumberland Infirmary and on the delivery suite at Cumberland Infirmary.

There was fetal telemedicine clinic with the Royal Victoria Infirmary at Newcastle, this meant that women whose babies needed additional observation before birth would not need to travel to Newcastle for regular scans.

The trust website had a dedicated area about maternity services. In ward areas there was literature and leaflets supplied to women giving them information they might want to know about concerning their pregnancy.

**Meeting people’s individual needs**

The service treated women as individuals and strove to develop care plans that responded to their individual needs having taken into account any risk factors. Staff followed a process for supporting women who wished to birth outside of guidance.

Women we spoke with told us that they felt the service had listened to them and involved them in their care. Midwives told us they took time to listen to partners about their needs and wishes.

Specialist midwives were responsible for planning the care of and supporting vulnerable women such as those with addictions that could harm the baby. They also provided a source of expertise for all staff to draw on. Careful assessment supported staff in shaping the care plan to respond to the needs of the woman and their baby. This included referral to the perinatal mental health team where necessary.

Staff explained how, for vulnerable women such as those with learning difficulties, they would often offer longer appointment times.

Community staff supported women with healthy living and could signpost women to aqua aerobics.

The labour, delivery and recovery rooms were spacious and supported wheelchair access and had mostly en-suite facilities. Two out of ten rooms shared a bathroom.

While we did not see any leaflets that were not in English staff told us that leaflets could be produced and supplied in a different language. Staff also described how they could access translation services.

**Access and flow**

The service had systems and processes in place to monitor access and flow through the service to ensure that it remained responsive to the needs of women in its care.

Women could self-refer into the service and community midwives conducted the booking appointments at GP surgeries or appropriate venues throughout the local area that was served. All booking appointments were offered according to national guidelines.

Community staff could access electronic discharge summaries. This supported community staff in ensuring they visited the mother and baby within 24 hours of discharge.

The service had not closed to women in labour in the last year (May 2017-June 2018).

Women attended the ward for growth scans, amniotic fluid index (AFI) scans (to measure the amount of fluid was present around the baby before birth), and doppler scans (to measure the flow
of blood to the baby through the umbilical cord) in clinics on Monday and Thursday mornings and afternoons. Staff could complete extra sessions on Fridays when required.

Women could attend the maternity department with concerns or issues with their pregnancy. They could self-refer, or through their GP, or the emergency department. Midwives took calls and could give an approximate waiting time or a specific time to attend to minimise waiting in the department. One staff member on the ward worked within triage. Depending on capacity on the ward other midwives could support triage. Staff told us they tried to triage women within 30 minutes. However, they did not document triage waiting times.

Learning from complaints and concerns

Summary of complaints

From April 2017 to March 2018 there were seven complaints about maternity services. The trust took an average of 30 working days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be resolved within 30 working days. Six out of the seven complaints were resolved within the trust’s target timeframe. None of the seven complaints were re-opened.

There were two complaints about West Cumberland Hospital, both of which were regarding inpatient treatment or care and were partially upheld.

There was one complaint about other community settings, which was regarding patient treatment or care. This complaint was partially upheld.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

The service had a system in place to encourage complaints and compliments with a view to improving its service to women. Staff would seek to resolve a concern informally and staff we spoke with were not aware of any formal complaints.

The service advertised by notices displayed within the unit how to raise concerns and signposted women or their carers or relatives to the trust’s afterthoughts service for support in making a complaint.

This service had seen 61 women across the trust. Staff felt that this reduced the number of complaints and supported women to understand why some decisions were made. Women completed a questionnaire following the meeting to review whether the meeting had been valuable and useful. Any themes or trends about complaints were discussed at regular clinical and governance meetings as well as in other forums such as risk meetings. Staff told us one theme of concerns was women not receiving pain relief in a timely way following birth. Staff had trialled putting medicines in the locked cupboards next to the patient’s bed. The trial had worked well and this practice was implemented for all women.

Staff explained to us that they responded to complaints within the prescribed time limits but if, for any reason, they were unable to do so, they would keep the complainant informed about the revised timescales. The average time for closing complaints was 30 days.
Is the service well-led?

Leadership

The service sits within the trust’s Women and children’s care group. It had previously been part of the surgery care group. Staff we spoke with told us they now felt able to face challenges more positively. The service had a new leadership team led by an associate director of midwifery (ADM) who had been appointed in January 2018. There was a clinical midwifery manager in charge of maternity at Cumberland Infirmary and Penrith Birthing Centre.

The clinical director was appointed for the service in December 2017 with the support of a senior clinician from a separate trust to develop leadership skills and provide objective challenge and a lead consultant managed and led the medical team of consultants, middle grade doctors, including locums and junior doctors at West Cumberland Hospital.

The ADM reported to the associate operations manager for women and children’s services and directorate managers who together formed the leadership team at a local level.

We met the local leadership team who were new to post. Some of the team had worked within the service for many years but had recently changed roles. We noted that collectively the team was able to draw on skills and experience of running a maternity service.

Members of the local leadership team met regularly with the director of nursing or the medical director and through them they had ready and open access to the board. No individual board member was designated as a lead for maternity but the ADM had direct and open access to the board. The team also networked with midwives in local trusts in order to benchmark its service against their services and share good practice and learning.

The team were approachable and available and this was confirmed by staff we spoke with who also said they felt supported and listened to. The team met regularly in different forums to discuss issues of quality, finance and governance.

The leadership team were supported by a team of matrons and specialist midwives including a governance manager. A local systems and transformation manager led work on developing the service, working with consultant leads and community staff in discussions and joint decisions to keep women and staff safe.

Staff we spoke with told us said they felt the new leadership had already made positive changes to working within the service. Staff felt supported and were offered opportunities to step up into a more senior role. Healthcare assistants (HCA’s) told us the new maternity ward manager at Cumberland Infirmary had supported them in gaining regrading for HCA’s who had previously been midwives.

Vision and strategy

Senior leaders we spoke with told us there was no documented strategy for the service but they were looking at the options for provision for the future to ensure maternity services in the local region meet the needs of local people. The senior leadership team confirmed its vision was to provide the right care at the right time and in the right place.

Staff we spoke with told us they felt involved in plans for the future of the service. HCA’s we spoke with told us the maternity ward manager who was new in post had asked their opinions for unit improvements.
The proposal following internal and stakeholder consultation was that the service would be a continuity of caring model across the whole geographical area covered by the Trust. This would begin in the community and midwives would look after women across the whole pathway.

While the outcome of the planning of services to meet the needs of local people was not yet fully clear, staff did regularly review its local provision while preparing for any future changes.

**Culture**

All staff we spoke with told us they aimed to provide patient focussed care to women throughout their pregnancy journey.

Staff reported positive and negative aspects of culture within the department. Some staff felt supported within their own teams and were confident about raising concerns, although they did not always feel these would be addressed. Some staff told us they felt it was difficult to progress professionally within the department and explained that funding was lacking. However, other staff told us there were good progression pathways within the department.

We saw that staff were open and honest and we saw examples where duty of candour had been used.

HCA’s told us they received good support from doctors and midwives.

We did not come across any complaints or concerns about bullying or harassment.

Staff we spoke with told us the new ADM had provided some stability for the unit and kept staff informed. Staff received weekly emails and felt supported.

A quality midwife had been appointed to a temporary role to support the governance agenda. They described feeling part of an integrated team with midwives and doctors working together. The service aimed to make its risk processes more transparent and to develop more open governance culture and attitudes.

**Governance**

The service had a clear governance framework with staff assigned specific roles that ensured quality performance and risks were known about and managed.

Staff told us a weekly joint core risk group had been developed held where medical and midwifery staff met to discuss individual incidents and cases. These meetings were open to the whole team. Staff told us they took a summary from these meetings to management meetings.

Governance was the responsibility of the local leadership team which met regularly at clinical governance meetings to review a range of issues such as performance, risk, and quality measurement.

There was a lead consultant for governance and risk who was responsible for national clinical audit and identification of trends. There were three-monthly presentations at audit meetings with evidence of action plans implemented and progress checked.

The service had a governance lead midwife whose role was to work full time on reviewing risks posed to the service, oversee root cause analyses into serious incidents, and distribute learning. A quality midwife role had been developed and they supported this programme by carrying out audits, monitoring the maternity dashboard and presenting results at learning meetings. Staff confirmed that embedding of learning was ongoing regarding the never event in May 2018.
Management of risk, issues and performance

The service’s risk register supported the local leadership team in tracking risks and ensuring that staff were taking actions to reduce or extinguish the risk. We reviewed the service’s risk register and saw that each risk was given a unique identifier, a risk rate, a status, brief details, the review date, and the person who owned the risk. Each risk had an action plan and staff identified were responsible to manage the plan to completion.

The local leadership team had identified a range of policies that required updating. Tasks were allocated to consultants and lead midwives to review clinical guidelines and keep them up to date. However senior staff told us some staff had not met timeframes, some guidelines and policies had been updated and not yet ratified. There was a log of this information but did not seem to be any robust management of staff time or actions regarding the plan.

Information management

A new post had been developed and a midwife employed to ensure all staff at all levels were able to access and input information in a digital format which could be manipulated rapidly and used to provide effective patient care and help improve the service. They worked full time within the Trust’s IT department and provide advice, guidance and training to staff across all sites.

Engagement

Staff sought feedback and opinions of those who used the service. Friends and family cards which were distributed around the unit. Staff told us some family members had commented there were no public toilets to use on the unit and birth partners were having to leave the unit to find a toilet. Staff listened to this feedback and reported one toilet was changed into a visitors’ toilet. Staff requested feedback from women attending antenatal classes and discussed examples of changes made in response to feedback received.

Staff described feeling engaged by the service with the new leadership for the service and explained how the service engaged with the public to ensure their views helped to shape the service. Consultations were taking place for women and staff about restructure and plans for the future of the service.

The staff meeting schedule had slipped and no meeting had taken place for several months at the beginning of the year but staff reported there had been a meeting in June 2018 and a new meetings programme was scheduled. Staff were given specific roles such as leading on planning and execution of clinical reviews or audits. Staff took part in audit production and presentation. In addition to a newsletter staff described how the service used email to share lessons or pass on important messages. Team leaders had regular meetings and passed on information to staff at handovers. All staff had regular appraisals.

Staff told us they took part in fundraising initiatives and had raised funds towards a new bereavement suite. A large local company had provided funds for a second birthing pool which had been ordered but was not in place at the time of our inspection.
Learning, continuous improvement and innovation

The lead consultant at West Cumberland Hospital had taken on the role to provide education for all staff across the service at all sites. They organised learning sessions every Friday afternoon which all staff could attend. They used a video link to ensure staff at both main sites could benefit from these sessions.

Work was underway to provide improved facilities for postnatal women by expanding the ward area and updating facilities. Staff had lobbied for funds to expand and improve the ward area for women and plans would provide more space and privacy for women.

The service was working with a better births model to gain a more sustainable model of care to meet the needs of the population, the geographical difficulties and to ensure women were safe throughout their pregnancy.

New leaders had been appointed for medical and midwifery leadership and management. There had been significant changes in roles and the teams were adjusting and recognised early benefits to teamwork and provision of patient care. Staff supported and respected their new leaders. However, staff had been in post for a matter of months before our inspection and they recognised there was still work to be done to implement and sustain positive changes.
Services for children and young people

Facts and data about this service

West Cumberland Hospital and Cumberland Infirmary provide care for children and young people aged 0-16 years, extended to 19 years for patients who have special or more complex needs as well as those with life limiting disease. The units provide an on call 24-hour service for emergency admissions via the accident and emergency department and general practitioners catering for paediatric medicine, surgical, orthopaedic, trauma, dental, ENT, ophthalmology, gynaecology and child protection issues. The wards also accommodate day case surgery, medical admissions for further investigations and procedures and diagnostic procedures. Both wards are consultant led with a consultant on call system in place 24/7. The service provides an outpatient facility across North Cumbria with clinics in community and hospital sites.

The trust has 47 inpatient paediatric beds across two sites:

West Cumberland Hospital:
- Seven paediatric inpatient and seven assessment beds located within one ward
- Nine neonatal beds located within one ward.

Cumberland Infirmary:
- 16 paediatric inpatient and eight assessment beds located within one ward.
- Eight neonatal beds located within one ward

(Source: Routine Trust Provider Information Request (RPIR Acute) – Context tab)

The trust had 6,393 spells from February 2017 to January 2018.

Emergency spells accounted for 90% (5,759 spells), 7% (471 spells) were day case spells, and the remaining 3% (163 spells) were elective.

Percentage of spells in children’s services by type of appointment and site, from February 2017 to January 2018, North Cumbria University Hospitals NHS Trust.
Total number of children's spells by site, North Cumbria University Hospitals NHS Trust.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumberland Infirmary</td>
<td>4,272</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>2,121</td>
</tr>
<tr>
<td>This trust</td>
<td>6,393</td>
</tr>
<tr>
<td>England total</td>
<td>1,101,678</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The trust set a target of 95% for completion of mandatory training.

Trust level

A breakdown of compliance for mandatory training courses as at March 2018 at trust level for qualified nursing staff in children’s services is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>BLS (paediatrics)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Hand hygiene (non clinical)</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control level 1</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving &amp; handling level 1 non clinical (3 yearly)</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>58</td>
<td>57</td>
<td>98%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>58</td>
<td>57</td>
<td>98%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, trips and falls level 1</td>
<td>58</td>
<td>57</td>
<td>98%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>58</td>
<td>56</td>
<td>97%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk management</td>
<td>58</td>
<td>56</td>
<td>97%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Duty of candour</td>
<td>58</td>
<td>55</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Calculating drug doses</td>
<td>49</td>
<td>46</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>58</td>
<td>54</td>
<td>93%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Hand hygiene (clinical)</td>
<td>57</td>
<td>53</td>
<td>93%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>58</td>
<td>53</td>
<td>91%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management</td>
<td>54</td>
<td>49</td>
<td>91%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent level 1&amp;2</td>
<td>58</td>
<td>51</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
In children’s services the 95% target was met for ten of the 31 mandatory training modules for which qualified nursing staff were eligible. Four modules had completion rates of 100%, this however relates to only one member of staff for three modules and two staff members for the remaining module required to complete this training. Apart from the ten modules that met the 95% trust target a further five modules had completion rates above 90%.

A breakdown of compliance for mandatory training courses as at March 2018 at trust level for **medical staff** in children’s services is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information governance</td>
<td>13</td>
<td>11</td>
<td>85%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; handling level 1 clinical (3 yearly)</td>
<td>13</td>
<td>11</td>
<td>85%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Duty of candour</td>
<td>13</td>
<td>10</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>13</td>
<td>10</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>13</td>
<td>10</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety</td>
<td>13</td>
<td>10</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk management</td>
<td>13</td>
<td>10</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, trips and falls level 1</td>
<td>13</td>
<td>10</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health records management</td>
<td>13</td>
<td>9</td>
<td>69%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control level 2</td>
<td>13</td>
<td>9</td>
<td>69%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent level 1 &amp; 2</td>
<td>13</td>
<td>9</td>
<td>69%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Hand hygiene (clinical)</td>
<td>13</td>
<td>8</td>
<td>62%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>13</td>
<td>8</td>
<td>62%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Trust doctors patient safety programme</td>
<td>13</td>
<td>6</td>
<td>46%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>ALS (paediatrics)</td>
<td>9</td>
<td>4</td>
<td>44%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 02</td>
<td>13</td>
<td>4</td>
<td>31%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 04</td>
<td>13</td>
<td>4</td>
<td>31%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
In children’s services the 95% target was met for none of the 19 mandatory training modules for which medical staff were eligible. Information governance and moving & handling level 1 clinical (3 yearly) both had completion rates of 85%, although this relates to only two staff members not completing the training.

### West Cumberland Hospital children’s services department

A breakdown of compliance for mandatory training courses as at March 2018 for qualified nursing staff in the children’s services department at West Cumberland Hospital is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>BLS (adults)</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Hand hygiene (clinical)</td>
<td>17</td>
<td>17</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>17</td>
<td>17</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Slips, trips and falls level 1</td>
<td>17</td>
<td>17</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>17</td>
<td>16</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk management</td>
<td>17</td>
<td>16</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Calculating drug doses</td>
<td>14</td>
<td>13</td>
<td>93%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Duty of candour</td>
<td>17</td>
<td>15</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>17</td>
<td>15</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety</td>
<td>17</td>
<td>15</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health records management</td>
<td>17</td>
<td>15</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia</td>
<td>13</td>
<td>11</td>
<td>85%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>17</td>
<td>14</td>
<td>82%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines management</td>
<td>17</td>
<td>14</td>
<td>82%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent level 1&amp;2</td>
<td>17</td>
<td>14</td>
<td>82%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control level 2</td>
<td>17</td>
<td>13</td>
<td>76%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; handling level 2</td>
<td>17</td>
<td>12</td>
<td>71%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 01</td>
<td>13</td>
<td>7</td>
<td>54%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>4</td>
<td>2</td>
<td>50%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Understanding end of life</td>
<td>17</td>
<td>8</td>
<td>47%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 02</td>
<td>8</td>
<td>3</td>
<td>38%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk management (board and senior management)</td>
<td>6</td>
<td>2</td>
<td>33%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevention of suicide</td>
<td>4</td>
<td>1</td>
<td>25%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, trips and falls level 2</td>
<td>13</td>
<td>2</td>
<td>15%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>News</td>
<td>7</td>
<td>1</td>
<td>14%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 04</td>
<td>1</td>
<td>0</td>
<td>0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

At West Cumberland Hospital children’s services department, the 95% target was met for four of the 26 mandatory training modules for which qualified nursing staff were eligible. Apart from the four modules for which the trust target was met a further three modules had completion rates...
above 90%.

A breakdown of compliance for mandatory training courses from as at March 2018 for **medical staff** in the children’s services department at West Cumberland Hospital is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information governance</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving &amp; handling level 1 clinical (3 yearly)</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Duty of candour</td>
<td>5</td>
<td>4</td>
<td>80%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>5</td>
<td>4</td>
<td>80%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>5</td>
<td>4</td>
<td>80%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety</td>
<td>5</td>
<td>4</td>
<td>80%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control level 2</td>
<td>5</td>
<td>4</td>
<td>80%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent level 1&amp;2</td>
<td>5</td>
<td>4</td>
<td>80%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Risk management</td>
<td>5</td>
<td>4</td>
<td>80%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Slips, trips and falls level 1</td>
<td>5</td>
<td>4</td>
<td>80%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 02</td>
<td>5</td>
<td>3</td>
<td>60%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood safety 04</td>
<td>5</td>
<td>3</td>
<td>60%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Hand hygiene (clinical)</td>
<td>5</td>
<td>3</td>
<td>60%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health records management</td>
<td>5</td>
<td>3</td>
<td>60%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Trust doctors patient safety programme</td>
<td>5</td>
<td>3</td>
<td>60%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>5</td>
<td>2</td>
<td>40%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevention of suicide</td>
<td>5</td>
<td>2</td>
<td>40%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>ALS (paediatrics)</td>
<td>3</td>
<td>1</td>
<td>33%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

At West Cumberland Hospital children’s services department, the 95% target was met for three of the 19 mandatory training modules for which medical staff were eligible. A further eight modules had completion rates of 80%, although this relates to only one staff member not completing the training.

*(Source: Routine Provider Information Request (RPIR) –P40)*

The ward manager maintained a regular oversight of mandatory training for medical and nursing staff. At the beginning of each financial year, the mandatory training completion date returned to zero. At the time of the inspection visit, the service had already achieved 89% overall across both nursing and medical staff groups.

**Safeguarding**

The trust had a safeguarding children policy and had the necessary statutory staff in post, including the named nurse and named doctor. Staff we spoke with could explain what actions they would take if they had concerns about a child or young person.
Staff completed an information sharing form which alerted the safeguarding team and anyone reading it to the background of the child and any recommended treatments/actions going forward. The safeguarding team ensured they followed up the outcomes daily. The form was kept in the patient’s notes and uploaded into the electronic patient notes. We looked at one form for a child with learning disabilities. The form was completed fully with the reason for notification and contained all the required information such as consent, parental responsibility and history of attendances in the paediatric ED.

The Trust used the Child Protection - Information sharing project (CP-IS) to share information securely to better protect society’s most vulnerable children. Staff also used the hospitals internal patient record system to check for any internal alerts.

If there were alerts, the triage staff in the paediatric emergency department (ED) used the online CP-IS system to check the specific data relating to children (including unborn children) with a Child Protection Plan, or with Looked After Status. This was presented as a “flag” indicating the patient was a vulnerable child.

The CP-IS system was used trust wide and full access was only given to senior practitioners. Every time an alert was raised by the CP-IS the safeguarding team received an automatic email to make them aware. This mechanism ensured a consistent and safe approach to identifying vulnerable children.

The Children’s wards perform the check upon all admissions, including those from the paediatric ED, to ensure they have the current alerts.

There was a safeguarding team and structure in place across both sites with the main hub at Cumberland Infirmary. The team had dedicated roles in the safeguarding team such as a lead for children with learning disabilities, an independent domestic violence advisor (IDVA), a midwifery named nurse and dedicated administration support.

There was a safeguarding link nurse in all the children’s wards and recently an initiative had been put in place to have link nurses in the high-risk areas, such as the paediatric ED and maternity to look out for signs of domestic violence.

The safeguarding children leads were visible across both sites and within the wards and departments we inspected. Staff spoke highly of the availability and support they received from the safeguarding team and knew how to raise concerns using the correct forms.

The team stayed in contact via a bi-monthly teleconference across both sites, attending specific internal meetings such as the maternity safeguarding meetings and external meetings such as the Multi-Agency Risk Assessment Conference (MARAC), a coordinated community response to domestic abuse. Information from these meetings was shared across the safeguarding children team.

Consultants told us they usually undertook at least one child safeguarding medical examination a week. The findings are shared with the named doctor safeguarding children. In line with intercollegiate guidance (Third edition: March 2014), the named doctor chaired peer review meetings, which were held every six to eight weeks. One consultant spoke positively about the quality of peer review and told us the meetings included constructive challenge and debate.
The trust had a safeguarding children supervision guideline however this was out of date and had not been updated since 2014. Staff told us they had protected time for supervision, which supported practitioner’s reflection and learning in a supportive structured environment. Safeguarding formed part of the supervision and one-to-one discussions as well as being on the agenda at ward meetings.

The trust set a target of 95% for completion of safeguarding training.

**Trust level safeguarding training**

A breakdown of compliance for safeguarding training courses as at March 2018 at trust level for qualified nursing staff in children’s services is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 1</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 3 (specialist)</td>
<td>42</td>
<td>40</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>58</td>
<td>50</td>
<td>86%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>14</td>
<td>11</td>
<td>79%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In children’s services the 95% target was met for two of the four safeguarding training modules for which qualified nursing staff were eligible. Safeguarding children level 1 had a 100% completion rate, although this relates to only two staff members eligible to complete this training.

A breakdown of compliance for safeguarding training courses at March 2018 at trust level for medical staff in children’s services is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 3 (core)</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>13</td>
<td>10</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 3 (specialist)</td>
<td>11</td>
<td>8</td>
<td>73%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In children’s services the 95% target was met for one of the three safeguarding training modules for which medical staff were eligible. Safeguarding children level 3 had a 100% completion rate, although this relates to only two staff members required to complete this training. The remaining two modules had completion rates below 80%, although this relates to only three staff members for each module not completing this training.

**West Cumberland Hospital children’s services department safeguarding training**

A breakdown of compliance for safeguarding training courses at March 2018 for qualified nursing staff in the children’s services department at West Cumberland Hospital is shown.
At West Cumberland Hospital children’s services department, the 95% target was met for one of the three safeguarding training modules for which qualified nursing staff were eligible. Although safeguarding adults level 1 and safeguarding children level 2 did not reach the trust target it relates to only three staff members per module not completing the training.

A breakdown of compliance for safeguarding training courses at March 2018 for medical staff in the children’s services department at West Cumberland Hospital is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding adults level 1</td>
<td>5</td>
<td>4</td>
<td>80%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 3 (specialist)</td>
<td>5</td>
<td>4</td>
<td>80%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

At West Cumberland Hospital children’s services department, the 95% target was met for none of the two safeguarding training modules for which medical staff were eligible. Safeguarding adults level 1 and safeguarding children level 3 (specialist) both had completion rates of 80% although this relates to only one staff member per module not completing the training. (Source: Routine Provider Information Request (RPIR) – P40)

We reviewed the latest figures presented by the trust which showed they were on track to meet the 95% target in most cases. The overall compliance rates were:
- Safeguarding children 1 was 92%
- Safeguarding children 2 was 87%
- Safeguarding children 3 (core) was 76%
- Safeguarding children (specialist) was 91%

The ward manager in the children’s ward told us recent changes had meant that the Level 3 training had moved from a day’s face to face training to just a four-hour online course. This does not meet the guidance outlined in the ‘Safeguarding children and young people: roles and competences for health care staff intercollegiate document’. This states Level 3 training must be completed by ‘all clinical staff working with children, young people and/or their parents/ carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns’.

The intercollegiate document also states ‘training, education and learning opportunities should be multi-disciplinary and inter-agency, and delivered internally and externally. It should include
personal reflection and scenario-based discussion, drawing on case studies, serious case reviews, lessons from research and audit, as well as communicating with children about what is happening'.

We would expect that the method and expectations of training was properly designed, delivered and evaluated, and whilst there is room for some element of on-line training this is not a substitute for face to face training especially discussion of case studies and personal cases.

The ward manager was not aware of any other internal training but informed us there was external face to face training available via the Cumbria Local Safeguarding Children’s Board. The current safeguarding children policy (version 8) outlined the training levels required for each post, but did not outline how Level Three would be achieved.

There was confusion and discrepancy of how staff understood they would meet the Level 3 intercollegiate safeguarding guidance and many staff thought it was just via online training. There was no assurance that the trust had considered how they would ensure meeting the intercollegiate guidance going forwards.

We spoke with junior doctors who had only completed the online training for Level 3 and had deemed this to be sufficient for the Level 3 sign off.

The named nurse explained that they had moved to electronic learning for Level 3 at the end of December 2017. The safeguarding team told us they could provide bespoke safeguarding training to all the departments that may request this and they had some days planned in the future where they would hold training stalls for staff to attend and further their Level 3 training. However, this was in its infancy and staff on the wards were not aware of this service.

**Cleanliness, infection control and hygiene**

The children’s ward and special care baby unit were visibly clean.

There were handwashing facilities at the entrance of each clinical area and we observed staff and visitors using them appropriately upon entering and leaving the ward. Antibacterial hand gel dispensers were also available at various locations within each ward.

We saw personal protective equipment was readily available for staff to use and we observed staff using it appropriately. We also observed staff adhering to ‘bare below the elbow’ guidance, in line with national good hygiene practice.

Domestic and nursing staff followed cleaning schedules and updated cleaning logs. Tasks included the cleaning of examination equipment following use at the end of each clinic, such as blood pressure cuffs and specula for scopes.

Infection prevention and control (IPC) was part of the trust’s mandatory training programme and the compliance target was 95%. At March 2018, qualified nursing staff had achieved 76% and medical staff had achieved 80%.
The unit recorded no cases of clostridium difficile (C. diff), methicillin resistant staphylococcus aureus (MRSA) and methicillin sensitive staphylococcus aureus (MSSA) in the previous 12 months prior to the inspection.

Staff regularly took part in IPC audits. Hand hygiene audits showed staff from the children’s ward and SCBU consistently achieved 100%.

On the children’s ward, the play specialist was responsible for cleaning toys. They told us there was a toy cleaning protocol and they cleaned toys daily in line with the documented procedure.

We saw evidence of appropriate waste segregation and clinical waste disposal units. Staff were aware of the importance of and risks involved in handling of sharps.

In the CQC Children and Young People’s Survey 2016 the trust scored 8.70 out of ten for the question ‘How clean do you think the hospital room or ward was that your child was in?’ This was about the same as other trusts. (Source: CQC Children and Young People’s Survey 2016, RCPCH)

**Environment and equipment**

Access to the children’s ward and to the special care baby unit was restricted. Staff monitored visitors entering and leaving the respective unit and granted access and egress via a secure entry system.

The environment across all areas where children and young people accessed care and treatment was very child and young person-friendly. The children’s ward included a large playroom (which included sensory play equipment) for younger children and separate facilities for older children and young people.

The children’s outpatient department was located within the main outpatient department. There was a dedicated area for children within the main waiting room, which had a small number of appropriate toys and wall displays. Medical and nursing staff reviewed children in one of two dedicated examination rooms, which included toys and appropriate equipment suitable for children of different ages, such as various sizes in blood pressure cuffs. There was a paediatric ‘grab bag’, for immediate use in case of emergencies, and this was checked daily.

The trust’s medical electronics department was responsible for the maintenance of all devices and equipment. Equipment we checked had been safety tested. Staff we spoke with told us they knew who to contact if they needed to report any faults and felt confident the system was robust.

The environment across all areas where children and young people accessed care and treatment was very child and young person-friendly. The children’s ward included a large playroom for younger children and separate facilities for older children and young people. Since the last CQC inspection, the trust had installed Wi-Fi across the unit.

Resuscitation trolleys held appropriate equipment, which was suitable for the needs of children. Staff completed a daily log to confirm the daily resuscitation equipment check was completed. Staff had received training to use the equipment and their competency recorded.
The children’s ward was equipped with high flow oxygen machines, which reduced the number of transfers of babies suffering from bronchiolitis, a common illness of the respiratory tract, to the regional tertiary care centre for additional care and treatment.

**Assessing and responding to patient risk**

The children’s ward used the paediatric early warning scores (PEWS), an early warning assessment and clinical observation tool. This included a clinical observation chart, coma scale and additional information such as the pain score tools with an assessment table to assist clinical staff in determining what action nursing and medical staff should take for an ill child. We spoke with medical staff and nurses who demonstrated a clear awareness of how to assess patient risk and what action they would take in response. PEWS charts were audited every month and staff from the children’s ward achieved consistently high results, except for blood pressure checks. Both managers and staff told us they were taking appropriate steps to improve this.

The neonatal unit did not use a new-born early warning trigger and track (NEWTT) tool. However, nursing staff told us they were working with colleagues from the maternity unit to develop a new process. Through our observations and conversations with nurses, babies on the unit were closely monitored at all times.

Daily handovers took place and included discussions about patient safety as well as detailed information sharing about each child. Based on the SBAR principles (situation; background; assessment and recommendation), the meeting highlighted any risks and enabled medical and nursing staff to reinforce plans to monitor deteriorating patients, for example, increasing observations or 1:1 nursing care.

Clinicians transferred children who required paediatric intensive care to the regional tertiary care centre. In the event of a child deteriorating and, for example, requiring intubation, staff from the intensive care unit would stabilise the patient with support from a paediatrician (with or without paediatric nurse) until medical staff had secured appropriate retrieval or transfer arrangements to the tertiary hospital.

The trust had a transfer of patient policy with a designated section for the care and management of paediatric and neonatal patients. SCBU was part of the Northern Neonatal Network, which provided specific transfer guidelines for the movement of babies who required high dependency or intensive care. This included arrangements for baby retrieval, preparation for transfer, and transport requirements.

The trust had a policy for the management of sepsis and paediatric sepsis six pathway for children under the age of five and between the ages of five and 11. Staff we spoke with were clear about what actions they would take.

Managers confirmed there was a member of staff trained in paediatric life support on every shift on the children’s ward. In SCBU, there was not a neonatal life support (NLS) trained nurse on every shift but was confident that by the end of year, all staff will have received the appropriate training. One of the band 6 nurses was am NLS trainer and provided refresher training every six months. In an emergency, nurses contacted a doctor immediately.
Nursing and medical staff continued to express concerns about the care and management of children requiring assessment by an approved mental health practitioner (AMHP) from the child and adolescent mental health service (CAMHS). This was highlighted at the last CQC inspection. Staff identified these children to be an additional risk factor on the ward where they required additional support from nursing staff. Staff reported delays in securing CAMHS assessment (provided by another trust) and escalated this concern to unit managers.

Staff completed risk assessments on admission for children and young people with mental health issues and had taken steps to mitigate the environmental risks on the ward. Staff worked collaboratively with the CAMHS team to ensure all potential hazards were removed such as shower curtains, pull cord and suction equipment before the room was made safe for accommodation. Locks were appropriately installed on relevant rooms, including the exit from the ward. Patients and visitors were required to seek assistance from a member of staff upon leaving the ward. The ward had appropriate contingencies in place in the event of a power failure.

In the CQC Children and Young People’s Survey 2016 the trust scored 7.73 out of ten for the question ‘Were the different members of staff caring for and treating your child aware of their medical history?’ This was about the same as other trusts.

In the CQC Children and Young People’s Survey 2016 the trust scored 9.76 out of ten for the question ‘Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?’ This was about the same as other trusts.

### CQC Children and Young People’s Survey 2016 questions, safe domain, North Cumbria University Hospitals NHS Trust

<table>
<thead>
<tr>
<th>Question number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
<th>KLOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>How clean do you think the hospital room or ward was that your child was in?</td>
<td>0-15 adults</td>
<td>8.70</td>
<td>About the same as other trusts</td>
<td>S1</td>
</tr>
<tr>
<td>20</td>
<td>Were the different members of staff caring for and treating your child aware of their medical history?</td>
<td>0-15 adults</td>
<td>7.73</td>
<td>About the same as other trusts</td>
<td>S3</td>
</tr>
<tr>
<td>36</td>
<td>Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?</td>
<td>0-15 adults</td>
<td>9.76</td>
<td>About the same as other trusts</td>
<td>S4</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

### Nurse staffing

The trust reported the following qualified nursing staff numbers as at March 2018 and April 2018 for children’s services by site:
<table>
<thead>
<tr>
<th>Location</th>
<th>Mar-18</th>
<th>Apr-18</th>
<th></th>
<th>Mar-18</th>
<th>Apr-18</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
<td>Fill rate</td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
<td>Fill rate</td>
</tr>
<tr>
<td>West Cumberland Hospital</td>
<td>29.1</td>
<td>31.0</td>
<td>93.9%</td>
<td>31.0</td>
<td>29.1</td>
<td>106.5%</td>
</tr>
<tr>
<td>Cumberland Infirmary</td>
<td>34.2</td>
<td>33.9</td>
<td>100.9%</td>
<td>33.9</td>
<td>34.4</td>
<td>98.5%</td>
</tr>
<tr>
<td>Total</td>
<td>63.3</td>
<td>64.9</td>
<td>97.5%</td>
<td>63.5</td>
<td>64.9</td>
<td>102.2%</td>
</tr>
</tbody>
</table>

In April 2018 the service had a nursing staff fill rate of 102.2% due to West Cumberland being overstaffed by two WTE staff members. *(Source: Routine Provider Information Request (RPIR) – P16)*

The service used the Safer Nursing Care Tool (endorsed by National Institute for Health and Care Excellence) to assess safe staffing levels for the children. There was an escalation process in place should a shortfall occur. Ward managers advised they obtained support from the wider unit, asked existing staff to extend or work additional shifts, and requested staff from the nurse bank.

The service used the trust e-rostering system.

The children’s ward manager confirmed the ward was fully staffed and any gaps in the rota were covered by bank nurses. There was a senior nurse on every shift. We reviewed the children’s ward off-duty rota for the previous six weeks and noted there were no gaps.

We reviewed the current escalation plan which outlined actions to take when the demand for paediatric beds exceeded the capacity. According to the plan, the ideal staffing establishment for the children’s ward was:

- Early shift: three qualified nurses and one healthcare assistant
- Late shift: three qualified nurses and one healthcare assistant
- Night duty: two qualified nurses and one healthcare assistant

Information displayed on the Quality of Care board in the ward showed the actual levels met the planned establishment.

Information provided by the trust showed the bed occupancy rate on the children’s ward (July 2017 to June 2018) was 36%.

A paediatric nurse practitioner and two trainee advanced nurse practitioners supported the ward.

The ward manager worked Monday to Friday and had supernumerary time to fulfil management duties and responsibilities. They also supported the main nursing rota and provided cover on shifts when required, for example, if there was no band 6 nurse on duty.

The escalation plan also included SCBU and highlighted the same actions to take when the demand for special care baby cots exceeded the capacity. According to the plan, the ideal staffing establishment for the SCBU was:

- Early shift: two qualified nurses and one healthcare assistant
Late shift: two qualified nurses and one healthcare assistant
Night duty: two qualified nurses and one healthcare assistant (who also covered the children’s ward)

Information displayed on the Quality of Care board in SCBU showed the actual levels met the planned establishment.

The British Association of Perinatal Medicine (BAPM) recommends a staffing ratio of one neonatal nurse to four babies (1:4) in units providing level one special care. The unit met the standards.

The unit was fully staffed however, due to sickness absence and flexi-retirement (with no back-fill), the unit was reliant upon support from experienced paediatric nurses from the children’s ward or from the regular cohort of bank nurses.

SCBU had 14 qualified nurses, of which 10 were qualified in specialty (QIS). The unit had plans to train the remaining four nurses over the next 12 months.

Sickness absence meant there was not always a QIS nurse on duty. In addition to overtime and bank nurses, the matron and ward manager provided cover when required. The ward manager indicated this happened frequently and impacted upon the amount of non-supernumerary time they had to fulfil management duties.

We reviewed the off-duty rotas in SCBU. In April/June 2018, 5% of the shifts were unfilled. In May/June the rate was 5% and increased to 6% in June/July.

Staff told us the bed occupancy levels in SCBU were rarely above 50%. Information provided by the trust showed the bed occupancy rate (July 2017 to June 2018) was 39.2%.

The unit recorded neonatal nurse staffing levels twice daily on BadgerNet (a single record of care for all babies within neonatal services, and used widely across the country). The data was replicated onto the trust’s acuity tool which enabled managers to view actual staffing levels and patient numbers.

At the previous CQC inspection, we found that healthcare assistants (HCA) in the children’s outpatient department worked alone with no involvement from a registered children’s nurse. Although a children’s nurse was still not present during clinic time, they were supported by the nurse in charge of the children’s ward, with oversight from the ward manager. The registered nurses within the department had received paediatric life support training. Staff told us children who required a blood test or other procedures were sent to the children’s ward before returning to clinic. There were no paediatric outpatient clinics running at the time of our visit.

From April 2017 to March 2018, the trust reported a vacancy rate of 4.3% in children’s services at West Cumberland Hospital. This was lower than the trust target of 5.0%

A breakdown by site is shown below:
### Site Vacancy and Staff Establishment

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total vacancies (WTE)</th>
<th>Total number of staff establishment (WTE)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Cumberland Hospital</td>
<td>15.9</td>
<td>370.9</td>
<td>4.3%</td>
</tr>
<tr>
<td>Cumberland Infirmary</td>
<td>6.4</td>
<td>409.8</td>
<td>1.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22.3</strong></td>
<td><strong>780.7</strong></td>
<td><strong>2.9%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Vacancy tab)

From May 2017 to April 2018, the trust reported a turnover rate of 10.2% in children’s services at West Cumberland Hospital. This was lower than the trust target of 13.0%. The trust did not provide any data for Cumberland Infirmary Hospital.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total leavers (WTE)</th>
<th>Average number of staff establishment (WTE)</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Cumberland Hospital</td>
<td>3.0</td>
<td>29.4</td>
<td>10.2%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Between May 2017 and May 2018, the trust reported a sickness rate of 3.9% in children’s services at West Cumberland Hospital. This was lower than the trust target of 4.0%

A breakdown by site can be seen below:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total absence days</th>
<th>Total WTE days available</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Cumberland Hospital</td>
<td>414.4</td>
<td>10,698.9</td>
<td>3.9%</td>
</tr>
<tr>
<td>Cumberland Infirmary</td>
<td>273.2</td>
<td>12,431.6</td>
<td>2.2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>687.6</strong></td>
<td><strong>23,130.5</strong></td>
<td><strong>3.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

From April 2017 to March 2018, the trust reported a bank and agency usage rate of 88.6% in children’s services at West Cumberland Hospital. The wards used regular bank staff and no agency. Any external bank staff were required to undertake two induction shifts and a senior nurse completed a competency checklist as part of the assurance process.

A breakdown per site is shown below:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Bank shifts</th>
<th>Total shifts</th>
<th>Bank shifts as a proportion of total shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Cumberland Hospital</td>
<td>31</td>
<td>35</td>
<td>88.6%</td>
</tr>
<tr>
<td>Cumberland Infirmary</td>
<td>113</td>
<td>125</td>
<td>90.4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>144</strong></td>
<td><strong>160</strong></td>
<td><strong>90.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)
Medical staffing

The trust reported the following qualified medical staff numbers as at March 2018 and April 2018 for children’s services by site:

<table>
<thead>
<tr>
<th>Location</th>
<th>Mar-18</th>
<th>Apr-18</th>
<th>Fill rate</th>
<th>Mar-18</th>
<th>Apr-18</th>
<th>Fill rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
<td>Fill rate</td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
<td>Fill rate</td>
</tr>
<tr>
<td>West Cumberland</td>
<td>9.0</td>
<td>13.6</td>
<td>66.2%</td>
<td>6.0</td>
<td>13.6</td>
<td>44.1%</td>
</tr>
<tr>
<td>Cumberland Infirmary</td>
<td>12.0</td>
<td>13.2</td>
<td>90.9%</td>
<td>12.0</td>
<td>13.2</td>
<td>90.9%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>21.0</strong></td>
<td><strong>26.8</strong></td>
<td><strong>78.4%</strong></td>
<td><strong>18.0</strong></td>
<td><strong>26.8</strong></td>
<td><strong>67.2%</strong></td>
</tr>
</tbody>
</table>

In April 2018 West Cumberland Hospital had a fill rate of 44.1%; this indicates that the site had 7.6 less medical staff members in post than what was planned for. (Source: Routine Provider Information Request (RPIR) –P16)

The medical team at West Cumberland Hospital was comprised of 5.3 whole time equivalent (WTE) consultants, one of whom held a full-time substantive post, while the other was on a full-time fixed-term contract. There were three long-term locum consultants. The medical team also included six speciality doctors and two GP trainees. The paediatric nurse practitioners supported the junior medical rota.

Recruitment to substantive consultant posts was ongoing.

The medical team operated a ‘consultant of the week’ (COW) rota and each consultant provided cover one week in every five. Clinicians did not have any clinics during their COW week.

At the last CQC inspection, we found the service did not meet all the Royal College of Paediatric and Child Health (RCPCH) – Facing the Future: Standards for Acute General Paediatric Services.

Since our previous visit, the service had received external advice and support from a RCPCH consultant in relation to the development of a new medical staffing model. The service had undertaken an audit against of the standards and audit outcomes demonstrated an improvement:

- **Standard 2**: every child or young person who was admitted with an acute medical problem was seen by a health professional with the appropriate competencies within four hours of admission. Analysis provided by the RCPCH showed this was better than the national average of 79%.

- **Standard 3**: 60% of children and young people admitted to the paediatric department with an acute medical problem was seen by a consultant paediatrician within 14 hours of admission. Those children not seen by a consultant were reviewed by a middle-grade doctor. Some of the children included in the audit were short-stay patients while others were admitted. Analysis provided by the RCPCH showed this was better than the national average of 48%.
- Standard 5: every child with an acute medical problem who was referred for a paediatric opinion was seen by, or had their case discussed with, a clinician with the necessary skills and competencies before they were discharged. Analysis provided by the RCPCH showed this was better than the national average of 94%.

At least two consultant-led medical handovers took place every 24 hours on weekdays and once at a weekend (although verbal handovers took place as and when required). A multi-disciplinary grand round took place every Tuesday.

The service defined peak hours of activity as 4.00pm to 11.00pm weekdays, and 1.00pm to 11.00pm at weekends. Consultants were available between 9.00am and 5.00pm, Monday to Friday, and provided cover from 5.00pm to 9.00pm as required. Weekend cover was 9.00am to 12.00pm. Registrars were available from 9.00am to 9.00pm every day. However, this meant the unit did not meet the required RCPCH standard of consultant presence during peak times of activity. The service planned to establish a steering group to review all audit outcomes and develop an action plan.

Clinicians we spoke with were predominantly concerned about medical cover at night. There was only one consultant on call with one resident registrar on active duty Monday to Thursday, and one senior house officer (SHO) from Friday to Sunday. However, medical staff were confident the risk was mitigated due to the proximity of consultants to the hospital, as they could (and did) respond to a call within 10 minutes. Resident locum consultants remained on overnight. Clinicians we spoke with acknowledged the most appropriate solution to minimise risk was the recruitment of additional consultants (which was ongoing) however everyone we spoke with had confidence that the current situation worked well and ensured children and young people were safe. Nursing staff and junior doctors did not report any problems when accessing a consultant out of hours.

Consultants we spoke with told us their current job plans provided 10-11 programmed activities (PA) They no longer worked in excess of this, which was a concern identified at the previous inspection. A senior clinician explained the service had introduced an electronic job planning tool and told us the number of PAs for each consultant was around 12 (but pro-rated for part time staff). However, the built-in flexibility meant consultants had sufficient rest time in between shifts and periods of consecutive days off within the rota.

From April 2017 to March 2018, the trust reported a vacancy rate of 27.6% in children’s services at West Cumberland Hospital. This was higher than the trust target of 20%.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total vacancies (WTE)</th>
<th>Total number of staff establishment (WTE)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Cumberland Hospital</td>
<td>45.1</td>
<td>163.2</td>
<td>27.6%</td>
</tr>
<tr>
<td>Cumberland Infirmary Hospital</td>
<td>6.2</td>
<td>154.4</td>
<td>4.0%</td>
</tr>
<tr>
<td>Total</td>
<td>51.3</td>
<td>317.6</td>
<td>16.2%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

From May 2017 to April 2018, the trust reported a turnover rate of 39.3% in children’s services at West Cumberland Hospital. This was higher than the trust target of 13%. The high turnover rate
equates to 3.3 staff members leaving the trust out of an establishment figure of 7.5 WTE staff members.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total leavers (WTE)</th>
<th>Average number of staff establishment (WTE)</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Cumberland Hospital</td>
<td>3.3</td>
<td>8.4</td>
<td>39.3%</td>
</tr>
<tr>
<td>Cumberland Infirmary Hospital</td>
<td>1.0</td>
<td>6.6</td>
<td>15.2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4.3</strong></td>
<td><strong>15.0</strong></td>
<td><strong>28.7%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From May 2017 to May 2018, the trust reported a sickness rate of 1.6% in children’s services at West Cumberland Hospital. This was lower than the trust target of 4%.

A breakdown by site is shown below:

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total absence days</th>
<th>Total WTE days available</th>
<th>Annual sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Cumberland Hospital</td>
<td>48.0</td>
<td>2,978.2</td>
<td>1.6%</td>
</tr>
<tr>
<td>Cumberland Infirmary Hospital</td>
<td>71.0</td>
<td>2,385.0</td>
<td>3.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>119.0</strong></td>
<td><strong>5,363.0</strong></td>
<td><strong>2.2%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Sickness)

The trust was unable to provide bank and locum usage data broken down by site or core service, due to system restrictions under the previous recording method. (Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

In January 2018, the proportion of consultant staff reported to be working at the trust was slightly lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.

Staffing skill mix for the 18 whole time equivalent staff working in children’s services at North Cumbria University Hospitals NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>39%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>11%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>33%</td>
<td>45%</td>
</tr>
<tr>
<td>Junior*</td>
<td>17%</td>
<td>6%</td>
</tr>
</tbody>
</table>
Records

We reviewed 10 sets of care records. Overall, we saw notes were legible and staff completed them accurately and included appropriate information such as a documented diagnosis and management plan, input from the multi-disciplinary team and discussions with the family. Every child who was admitted with an acute medical problem was seen by a consultant paediatrician within 14 hours of admission and all notes were signed and dated appropriately.

The children’s ward and SCBU completed case note reviews as part of the NHS Litigation Authority (NHSLA) audit. Managers audited 10 case notes against 31 key indicators ranging from demographics to examination findings and treatment plans. The summary from an audit in SCBU highlighted areas of good practice, which included a full name, patient number and date of birth of every page. The two areas for improvement indicated the authors of entries should be identifiable by grade and bleep. Managers completed action plans to address shortfalls in audit compliance. The audit we reviewed was February 2018 however the action plan was incomplete.

We were unable to review a care record audit for the children’s ward. The trust advised they were in the process of developing a new health care record, with a schedule of audits throughout the year. A combined trust report, which included each speciality, would not be available until March 2019.

On the children’s ward, medical records were stored securely in the doctors’ office, away from the ward, which was kept locked when staff were not present. Nursing notes and charts were stored safely in folders behind the nurse’s station but were not in a locked storage unit. In SCBU, notes were stored in a locked filing cabinet.

Medicines

The trust had a policy for the administration and storage of medicines and staff we spoke with told us they followed standard procedures.

There was dedicated pharmacy support across the service. The paediatric pharmacist visited the unit during the week and there was appropriate out-of-hours support. Staff did not report any problems.

Medicines were securely stored and handled safely, and the medicines we reviewed were within the use-by date. Storage cupboards and fridges were tidy and locked.

Staff recorded and monitored the minimum and maximum fridge temperature appropriately, however, staff we spoke with could not tell us what the expected range should be or describe the escalation process.
We reviewed nine prescription charts. Overall, staff completed the charts accurately and the writing was legible. Staff recorded the date and their signature, allergies were documented, and antibiotics were prescribed as per guidelines. Staff also recorded the weight of the child.

**Incidents**

The trust had an incident reporting policy and staff reported incidents of harm or risk of harm using the risk management reporting system. Medical and nursing staff told us they felt confident reporting incidents and near misses, and received feedback from managers.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From June 2017 to May 2018, the trust reported no incidents classified as never events for children’s services. *(Source: Strategic Executive Information System (STEIS))*

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in children’s services which met the reporting criteria set by NHS England from June 2017 to May 2018. *(Source: Strategic Executive Information System (STEIS))*

There were 58 incidents reported between January and June 2018 relating to children’s services at West Cumberland Hospital. Most incidents (81%) resulted in no injuries or minor harm. There was no clear theme or trend although the majority (29%) related to the inappropriate admissions of children and young people who required specialist mental health care.

Staff could describe lessons learned from incidents. For example, discharge letters were not being filed in patient notes straight away. This practice has improved and letters were now completed at the time of discharge.

Staff we spoke with understood the duty of candour requirements. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

Managers held weekly risk meetings to review incidents, which included staff from the children’s ward and the special care baby unit (SCBU). Every month, managers reviewed emerging themes and trends from incidents at a unit governance meeting.

SCBU shared learning with colleagues from other trusts as part of the wider Northern Neonatal Network (NNN) at regional meetings held each quarter. The NNN aimed to improve outcomes for babies born and cared for across the network region, providing trusts with an opportunity to share good practice.

Medical and nursing staff discussed paediatric deaths at monthly mortality and morbidity meetings. Paediatric community deaths were reviewed in line with the Local Safeguarding Children’s Board recommendations and were discussed at the Child Death Overview Panel, attended by the named doctor for child protection.
Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, falls with harm or new urinary tract infections in patients with a catheter from April 2017 to April 2018 for children’s services. (Source: NHS Digital)

Quality of Care boards were displayed within each unit for patients, families and visitors to view. Information included planned and actual staffing levels for the day, infection prevention and control data, staff appraisal and mandatory training rates, and the number of days/months since a medication error.

Is the service effective?

Evidence-based care and treatment

Medical and nursing staff adhered to guidelines from the Royal College of Nursing (RCN), the Royal College of Paediatrics and Child Health (RCPCH), the National Institute for Health and Care Excellence (NICE), and other professional guidelines such as the British Association of Perinatal Medicine. Policies and guidelines were available on the trust intranet.

Policies and guidelines were accessible via the intranet and staff knew how to access them.

We saw evidence of appropriate evidence-based policies and care pathways, such as neonatal jaundice and sepsis, and diabetes. However, the service did not have an asthma management plan, only a viral wheeze plan. Care pathways for fever and respiratory conditions had been developed in conjunction with primary and community services.

Some pathways and guidelines had been produced by the regional tertiary care centre and the Northern Neonatal Network. We noted these were all up to date. However, some guidelines on the intranet, such as hypoglycaemia and meningitis, were due for review in 2017 and had not yet been updated.

Children’s services participated in national audits such as diabetes, seizures and epilepsy in children and young people, and the neonatal audit programme. We also saw evidence of local audit activity to assess compliance with quality standards. The audit plan for 2018/19 included NICE CG 29: intravenous fluid therapy in children and young people, and NICE CG149: management and treatment of neonatal sepsis on SCBU.
The neonatal unit (with maternity) had completed the UNICEF Baby Friendly Initiative stage two assessment. The unit had met almost all of the standards and planned to submit further audit result before the end of the year.

The neonatal unit was also working towards achieving accreditation with the Bliss Baby Charter, a scheme to ensure babies received the best neonatal care and treatment. The unit had received a ‘pledge of improvement’ certificate, demonstrating their commitment towards the scheme.

**Nutrition and hydration**

The children’s ward used the STAMP (Screening Tool for the Assessment of Malnutrition in Paediatrics) nutritional tool. It is a simple five-step tool to identify if a child’s condition has any nutritional implications, what the child’s nutritional intake is plus their weight and height. Based on the results from the first three steps, the overall risk of malnutrition is calculated and a care plan developed as appropriate.

There was a variety of food choices for children and young people, including those with allergies. Pictorial menus available for children to assist them in making their preferred choice of food.

A dedicated paediatric dietician met with families upon admission to discuss any special dietary needs. Dieticians also worked with the ward housekeeper to discuss requirements and make appropriate recommendations to meet the needs of the patients.

**Pain relief**

Children and young people had access to a range of pain relief if needed, including oral analgesia and patient-controlled analgesics. We saw evidence of a pain scoring system and completed pain assessments in the care records we reviewed.

Other non-pharmacological methods were also utilised by staff across the service. The children’s ward had a dedicated play specialist who told us they used age appropriate play and activities as a means of helping to prepare children for procedures.

Staff in the neonatal unit did not use a specific pain assessment tool and instead used oral sucrose analgesia, administered pre-procedure, for new-born infants undergoing painful procedures. The use of sucrose as an analgesia is common practice across the UK and the rest of the world. Staff recognised that sucrose, ‘non-nutritive’ sucking, breastfeeding and physical comfort all had a role to play in providing relief from the pain associated with certain procedures. The unit had also introduced the use of breast milk as a means of comforting babies.

**Patient outcomes**

Children’s services participated in national clinical audits to monitor and improve patient outcomes.

**Paediatric diabetes audit 2015/16**

HbA1c levels are an indicator of how well an individual’s blood glucose levels are controlled over time. The NICE Quality Standard QS6 states “People with diabetes agree with their healthcare
professional a documented personalised HbA1c target, usually between 48 mmol/mol and 58 mmol/mol (6.5% and 7.5%)”.

The data below shows that in the 2015/16 diabetes audit West Cumberland Hospital performance was similar to the England average.

Data for the proportion of patients receiving all key care processes annually were suppressed for both 2014/15 and 2015/16.

The average HbA1c value (adjusted by case-mix) at the hospital was 68.6% which was within the expected range, compared to a national aggregate of 68.3%, the previous year’s score was rated as within the expected range.

The median HbA1c value recorded amongst the 2015/16 sample was 60.0, which was better than the previous year’s median which was 66.5 and demonstrates a clinically significant improvement.

(Source: National Paediatric Diabetes Audit 2015/16)

Recently published data from the National Paediatric Diabetes Audit 2016/17 showed the average HbA1c value (adjusted by case-mix) at the trust was 69.%. This was within the expected range and similar to the national aggregate of 67.3%.

Recently published data from the National Paediatric Diabetes Audit 2016/17 showed the median HbA1c value recorded amongst the 2016/17 sample was 63.0%. Although this was worse than the previous year’s median of 60.0%, it was similar to the regional and national aggregates, which were both at 64.0%.

(Source: National Paediatric Diabetes Audit 2016/17)

A senior clinician told us patient outcomes were continuing to improve. The trust shared the latest (April 2018) Clinical Service Quality Measure (CSQM) outcomes for paediatric diabetes which indicated performance was ‘as expected and improving over time’.

A national diabetes peer review programme was in the process of being re-established (similar to the previous Diabetes Quality Improvement Network System – DQuIINS) and the trust had signed up to this new process.

National Neonatal Audit Programme

In the 2016 National Neonatal Audit West Cumberland Hospital performance was as follows:

**Do all babies < 1501g or a gestational age of < 32 week at birth undergo the first Retinopathy of Prematurity (ROP) screening in accordance with the current guideline recommendations?**

There were 13 babies born with a birth weight < 1501g or with a gestational age at birth < 32 weeks who were assigned to the unit for ROP screening. 100% of these babies were screened on time in accordance with the NNAP extended screening window*; this was above the national average, where 98% of eligible babies had their screening performed within the NNAP extended
screening window.

Results published in the Northern Neonatal Network quarterly reports showed the unit continued to maintain this performance throughout 2017/18.

**Is there a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission?**

There were 100 first episodes of care that were eligible for inclusion in this audit measure for the unit. Episodes of care lasting less than 12 hours have been excluded from analysis. The first consultation following admission occurred within 24 hours for 56% of the eligible episodes; this was below the national average, where 90% of eligible episodes had the first consultation within 24 hours of admission.

Managers confirmed that consultation with families did occur, however staff acknowledged this was not always documented appropriately. In response, the unit amended the clinician communication sheet and there was now a box at the top to record the date and time that they spoke to the parents.

**Are rates of normal survival at two years comparable in similar babies from similar neonatal units?**

There were nine babies born at < 30 weeks born between July 2013 and June 2014 who have been assigned to the hospital for two-year health assessment based on their final neonatal discharge. Data was entered for 55% of the babies assigned to the unit, whilst nationally data was available for 61% of babies born at < 30 weeks born between July and June 2014.

**What is the proportion of babies born <32 weeks who develop Bronchopulmonary Dysplasia?**

There were 24 babies born < 32 weeks in the hospital who were included in the analysis for Bronchopulmonary Dysplasia. Of these babies six were identified as having Significant BPD.

(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)

**Emergency readmission rates within two days of discharge:** the data shows that from December 2017 to November 2018 there was no readmissions for the under ones and no specialties had six or more readmissions for patients aged 1-17 years old following an elective admission.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>North Cumbria University Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>-----------</td>
<td>------------------</td>
<td>----------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>North Cumbria University Hospitals NHS Trust</td>
<td></td>
<td></td>
</tr>
<tr>
<td>England</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

There were no emergency readmissions after elective admission at this trust among patients in the under one age group over this time period.
Emergency readmissions within two days of discharge following elective admission among the 1-17 age group, by treatment specialty
(DECEMBER 2016 to NOVEMBER 2017)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>North Cumbria University Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmission rate</td>
<td>Discharges (n)</td>
<td>Readmissions (n)</td>
</tr>
</tbody>
</table>

No speciality at this trust had six or more readmissions.

The tables below show the percentage of patients (by age group) who were readmitted following an emergency admission. The tables show the three specialties with the highest volume of readmissions and only those specialties where six or more readmissions recorded are shown in the table.

The data shows that from December 2016 to November 2017 there was a higher percentage of under ones readmitted following an emergency admission compared to the England average and a higher percentage of patients aged 1-17 years old readmitted following an emergency admission compared to the England average.

Emergency readmissions within two days of discharge following emergency admission among the under 1 age group, by treatment specialty
(DECEMBER 2016 to NOVEMBER 2017)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>North Cumbria University Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmission rate</td>
<td>Discharges (n)</td>
<td>Readmissions (n)</td>
</tr>
</tbody>
</table>

No other speciality at this trust had six or more readmissions.

Emergency readmissions within two days of discharge following emergency admission among the 1-17 age group, by treatment specialty
(DECEMBER 2016 to NOVEMBER 2017)
Specialty & North Cumbria University Hospitals NHS Trust & England
& Readmission rate & Discharges (n) & Readmissions (n) & Readmission rate
Paediatrics & 3.4% & 3,613 & 122 & 2.8%
Paediatric trauma and orthopaedics & 3.0% & 265 & 8 & 1.2%
General surgery & 4.1% & 170 & 7 & 3.8%

(Source: Hospital Episode Statistics, provided by CQC Outliers team)

Rate of multiple emergency admissions within 12 months among children and Young people for asthma, epilepsy and diabetes: from January 2017 to December 2017 the number of patients under the age of one who had multiple readmissions for asthma, diabetes and epilepsy was too small to be included in the analysis.

The trust performed better than the England average for the percentage of patients aged 1-17 years old who had multiple readmissions for asthma and worse for patients who had diabetes or epilepsy.

<table>
<thead>
<tr>
<th>Long term condition</th>
<th>North Cumbria University Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Multiple admission rate</td>
<td>At least one admission (n)</td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1 to 17</td>
<td>9.8%</td>
<td>112</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1 to 17</td>
<td>15.4%</td>
<td>39</td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1 to 17</td>
<td>37.9%</td>
<td>29</td>
</tr>
</tbody>
</table>

Note - For reasons of confidentiality, numbers below 6 and their associated proportions have been removed and replaced with ‘*’.

(Source: Hospital Episode Statistics, provided by CQC Outliers team)

We spoke with staff and managers who all explained the ‘open door’ policy for children with chronic long-term conditions. This meant families were encouraged to return to hospital if they had
further concerns about their child and was a contributing factor to a higher than average readmission rate.

**Competent staff**

**Trust level appraisal rate**

From April 2017 to March 2018, 97.4% of staff within services for children and young people care at the trust received an appraisal compared to a trust target of 95% for nursing staff and 90% or higher for medical staff. Appraisal completion rates for both medical and nursing staff met the respective trust targets. Only one staff member for both staff groups did not receive an appraisal.

In the 2017 staff survey, quality of appraisals was within the worst 25% of trusts nationally. However, nursing staff spoke positively about the quality of the appraisal within children’s services and told us the process had improved over recent years.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required</th>
<th>Appraisals complete</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>64</td>
<td>63</td>
<td>98.4%</td>
</tr>
<tr>
<td>Medical &amp; dental staff</td>
<td>13</td>
<td>12</td>
<td>92.3%</td>
</tr>
<tr>
<td><strong>Grand total</strong></td>
<td><strong>77</strong></td>
<td><strong>75</strong></td>
<td><strong>97.4%</strong></td>
</tr>
</tbody>
</table>

**West Cumberland Hospital appraisals**

From April 2017 to March 2018, 100% of staff within services for children and young people care at the trust received an appraisal compared to a trust target of 95% for nursing staff and 90% or higher for medical staff.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required</th>
<th>Appraisals complete</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>29</td>
<td>29</td>
<td>100.0%</td>
</tr>
<tr>
<td>Medical &amp; dental staff</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>32</strong></td>
<td><strong>32</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Trust Provider Information Request – Appraisal tab)

Appraisals for locum consultants were completed by the relevant agency who provided the trust with the appropriate assurances. Long-term locums were also appraised locally by a consultant from a different service, not from paediatrics. The clinical director confirmed assurances in respect of competencies were sought from the appraisal process and there were no current concerns.

Nursing staff spoke positively about the quality of the appraisal and told us the process had improved over recent years.

Junior doctors we spoke with told us they had an educational supervisor and attended regular teaching sessions. All staff told us they felt supported in their role.

The ward manager told us some nursing staff had completed a clinical supervision course and
there was some group supervision at the weekly risk meetings.

Medical and relevant nursing staff had received paediatric life support training appropriate to their role and we noted there was at least one trained nurse on every shift. Healthcare assistants told us they had received training in basic paediatric life support.

Student nurses spoke positively about their placements and described a good support network to help develop their nursing knowledge.

**Multidisciplinary working**

Our observation of practice, review of records and discussion with staff confirmed effective multidisciplinary team (MDT) working practices were in place. Medical and nursing staff worked closely together and with other allied healthcare professionals such as dieticians, health visitors and GPs. Staff we spoke with also gave us positive examples of working with child and adolescent mental health services (CAMHS) and social services.

Staff spoke positively about the relationship with the local tertiary care centre. They gave examples of working and liaising with the bed manager and of arranging the transfer of children from one hospital to the other.

Medical and nursing staff told us relationships with obstetricians and midwives were very good. There were no reported problems.

The service held monthly meetings attended by healthcare professionals from the hospital, community and primary care services to monitor, review and improve the effectiveness of local unscheduled care services.

In the CQC Children and Young People’s Survey 2016 the trust scored 8.8 out of ten for the question ‘Did the members of staff caring for your child work well together?’ This was about the same as other trusts. *(Source: CQC Children and Young People’s Survey 2016, RCPCH)*

**Seven-day services**

Consultants were available out-of-hours and actively encouraged nursing and junior medical staff to contact them if the need arose. There were no reported problems accessing out-of-hours support.

Children’s services accessed diagnostic services such as the x-ray department, pharmacy and laboratory services during the weekend. Staff did not raise significant concerns over accessing these services.

**Health promotion**

Nursing staff worked to empower children and young people with mental health problems through building strong relationships with them and working together with the child and adolescent mental health service (CAMHS).
Children are involved in their own asthma management plan and diabetes nurses support children and young people to manage their condition.

Leaflets and posters were available in relation cyber-bullying and how to access drug and alcohol support teams.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

The trust had a ‘consent to examination and treatment’ policy and this included information specifically relating to children and young people. Staff we spoke with understood the Gillick competency guidelines and gave examples of how they had applied it in practice. Staff explained that the consent process actively encouraged young people to be involved in decisions about their care.

Staff we spoke with fully understood the Mental Capacity Act 2005 as it related to young people and consent to treatment. If they needed further advice, they told us they would contact the safeguarding team.

**Trust level Mental Capacity Act and Deprivation of Liberty training completion**

The trust reported that at March 2018 Mental Capacity Act (MCA) training was completed by 86% of staff within services for children and young people compared to the trust target of 95%. Nursing staff had a completion rate of 94%, just short of the 95% trust target.

A breakdown per staff group is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental staff</td>
<td>18</td>
<td>10</td>
<td>56%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>78</td>
<td>73</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Grand total</td>
<td>96</td>
<td>83</td>
<td>86%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

Note: The above figures include mental capacity level 1 and level 2 training.

Over the same period Deprivation of Liberty Safeguards training was completed by 87% of staff within services for children and young people compared to the trust target 95%.

A breakdown per staff group is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental staff</td>
<td>3</td>
<td>2</td>
<td>67%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>20</td>
<td>18</td>
<td>90%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Grand total</td>
<td>23</td>
<td>20</td>
<td>87%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

Although the trust target was not met by any of the staff groups, this relates to only one staff member for medical staff and two staff members for nursing staff not completing the training.
West Cumberland Hospital

West Cumberland Hospital reported that at March 2018 Mental Capacity Act (MCA) training was completed by 84% of staff in within services for children and young people to the trust target of 95%.

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental staff</td>
<td>10</td>
<td>7</td>
<td>70%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>28</td>
<td>25</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Grand total</td>
<td>38</td>
<td>32</td>
<td>84%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

Note: The above figures include mental capacity level 1 and level 2 training.

Although the overall completion rate is below the trust target it relates to only three medical and three nursing staff members not completing this training.

Over the same period Deprivation of Liberty Safeguards training was completed by 86% of staff within services for children and young people compared to the trust target 95%.

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental staff</td>
<td>3</td>
<td>2</td>
<td>67%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>11</td>
<td>10</td>
<td>91%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Grand total</td>
<td>14</td>
<td>12</td>
<td>86%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

The trust target was not met for medical or nursing staff, although this relates to only one medical and one nursing staff member not completing this training.

(Source: Trust Provider Information Request – P40)

Other CQC Survey Data

The trust performed better than other trusts for one question, worse than other trusts for no questions and about the same as other trusts for the remaining four questions relating to effectiveness in the CQC Children and Young People’s Survey 2016.

CQC Children’s Survey questions, effective domain, North Cumbria University Hospitals NHS Trust

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Did staff play with your child at all while they were in hospital?</td>
<td>0-7 adults</td>
<td>8.80</td>
<td>Better than other trusts</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)
Is the service caring?

Compassionate care

Medical and nursing staff, and those in non-clinical roles, were passionate about their job and were dedicated to making sure children and young people received the best patient and family-centred care possible. Throughout our inspection, we observed medical and nursing staff delivering compassionate and sensitive care that met the needs of children, young people, and families.

We observed members of staff who had a positive and friendly approach towards children and parents. Staff explained what they were doing and took the time to speak with them, offering reassurance and support.

Families we spoke with described care as ‘excellent’ and ‘exemplary’. One family told us they did not know how care could be improved and said they could give nursing and medical staff enough praise.

In addition to promoting interaction with children and young people through play and activity, the play specialist supported children who were anxious and distressed at outpatient clinics.

Services for children and young people participated in the national Friends and Family Test and the percentage of children, young people and families who would recommend the service was consistently above 95%. Of the 79 surveys returned in the recent quarter (April to June 2018), 100% of people were highly likely to recommend the service.

The service regularly gathered feedback from children, young people and families through a local patient experience survey. The monthly feedback, including FFT, was collated in a report and displayed on the ward. The scores (out of 10) were consistently high within the period June 2017 to June 2018. Children, young people and families said they were treated with respect, they felt safe, staff were kind and compassionate, and involved them in their own care.

The trust ran a ‘Glimpse of Brilliance’ scheme which encouraged members of the public to contact the trust with examples of outstanding care. Certificates were given to the staff who were nominated. For example, one family sent a message via social media to describe the excellent care their baby received in the neonatal unit whilst under the care of an ‘outstanding’ doctor.

Children, young people and families told us they saw medical and nursing staff regularly and they always introduced themselves by name.

The trust performed better than other trusts for one question, worse than other trusts for no questions and about the same as other trusts for the remaining nine questions relating to compassionate care in the CQC Children and Young People’s Survey 2016.

CQC Children and Young People’s Survey 2016 questions, compassionate care, North Cumbria University Hospitals NHS Trust

<table>
<thead>
<tr>
<th>Question</th>
<th>Question</th>
<th>Age</th>
<th>Trust</th>
<th>RAG</th>
</tr>
</thead>
</table>

20171116 900885 Post-inspection Evidence appendix template v3 Page 465
<table>
<thead>
<tr>
<th>Number</th>
<th>group</th>
<th>score</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>0-7 adults</td>
<td>9.27</td>
<td>Better than other trusts</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

**Emotional support**

Families told us they felt staff understood the impact the condition and treatment had on their children. Parents told us staff constantly offered reassurances and support throughout the treatment process. Medical and nursing staff kept families informed at every stage and children and parents felt empowered to ask questions.

Families also told us they felt very confident their children were receiving the best care possible. They felt confident leaving their child on the ward, reassured their child was safe, supervised, and cared for.

Staff understood the impact the condition and/or treatment had on children, young people and families. With support from a local charity, SCBU provided welcome packs on admission which included a diary/journal to encourage parents to record relevant interactions or interventions to help them retain the information and experience. In the parents’ absence, staff made appropriate entries. The pack also included a scent toy, one for the parents and one for the infant, bootees and a water bottle.

Families could access counselling and bereavement support.

Support was available for children with long-term health conditions. For example, all children and young people with diabetes had an annual assessment of their psychological well-being by the multi-disciplinary team responsible for their care.

The trust performed about the same as other trusts for all five questions relating to emotional support in the CQC Children and Young People’s Survey 2016. (Source: CQC Children and Young People’s Survey 2016, RCPCH)

**Understanding and involvement of patients and those close to them**

Families we spoke with felt well informed about their child’s condition and treatment. Medical and nursing staff communicated with children, young people and families openly and checked their understanding of the facts that were presented. For example, one family told us medical staff explained things to them using non-medical jargon, and in such a way to ensure their understanding.

Feedback from the children’s ward children and young people’s survey was positive in relation to patient involvement in decisions about care and treatment. Between April and June 2018, the score was 9.8 out of 10. The service scored a maximum 10 out of 10 from the question ‘did the staff listen and help you understand what was going to happen?’.
Medical and nursing staff actively involved families in caring for their children. Nurses from the neonatal unit described encouraging parents to undertake routine tasks to care for their baby as they would at home.

The trust performed about the same as other trusts for all questions relating to understanding and involvement of patients and those close to them in the CQC Children and Young People’s Survey 2016. No score was provided for one question. (Source: CQC Children and Young People’s Survey 2016, RCPCH)

Is the service responsive?

Service delivery to meet the needs of local people

The facilities and environment in the children’s ward and outpatient department were suitable for children and young people, with age appropriate facilities and play activities.

There were separate areas for teenagers. For example, the ward manager explained older children and young people, if not in a single room, could be located together in a dedicated bay.

There were appropriate facilities for parents and carers who chose to stay overnight. The children’s ward offered a fold away camp bed so parents could sleep beside their child while they were in hospital. There were also facilities for parents and carers to wash and dress.

Parent could stay overnight with their babies in SCBU. There was a dedicated parent’s room within the unit with appropriate facilities to help them feel comfortable. Parents could also remain by their child’s bedside on a fold away camp bed.

There was a play room on SCBU for siblings of babies being care for within the unit. A play specialist facilitated various activities and nursing staff told us they also participated where possible.

The children’s outpatient department provided a range of specialist clinics to meet the needs of children and young people. These included cystic fibrosis, rheumatology, respiratory medicine, ophthalmology, and diabetes. Clinicians also held diabetes outreach clinics in different venues across the county.

The play specialist was available five days a week. They also supported outpatient clinics for children with cystic fibrosis. we saw children interacting with them positively and confidently. The play specialist also ensured older children were included in all activities.

Medical and nursing staff spoke positively about working with GPs, the child and adolescent mental health services (CAMHS) and health visitors although acknowledged links with the children’s community nursing team could be stronger. Although the service did not have a link consultant for each local GP practice or group of GP practices, clinicians provided a minimum of two education and knowledge exchange sessions per year with GPs and other healthcare professionals who worked with children with unscheduled care needs.
The service facilitated a hospital and home tuition service which was provided by Cumbria County Council. Children and young people must be hospitalised for 15 school days to access the service. Young people who were undertaking their GCSE’s had direct access to the service to allow the exam process to continue if their health and wellbeing allowed. Children and young people with complex needs and already registered with the service also qualified for direct access. Children and young people who did not meet the criteria of the service often received homework from their local school. The play specialist also contributed to the patient’s education and development.

The service had introduced a local specialist epilepsy clinic, supported by a paediatrician with a specialist interest and a community paediatric epilepsy nurse specialist. The purpose was to improve services for children and families and meet epilepsy best practice standards.

Wi-Fi was readily available across the service which meant children and young people could keep in touch with family and friends whilst in hospital.

**Meeting people’s individual needs**

The trust classified children to be 0-18 years of age. All children and young people between these ages were seen in the paediatric emergency department (ED) and children up to the age of 16 are usually placed in the children’s wards, however, if it is deemed they may be mature and fit better in the adult wards then they are offered this opportunity.

Staff told us children and young people who were known to the service and had learning disabilities would be treated in the paediatric ED if it was felt they could be better accommodated. Staff from the children’s wards would assist those children if they were known to the service.

Nursing staff told us any children who were reaching 18 would undergo a transition process into the corresponding adult service. All children known to the service such as looked after children and those with mental health issues would still have some involvement from the child safeguarding team as required. The service was currently looking at creating a joint transition policy with Cumbria Partnership NHS FT, in line with the development of the care group.

Leaflets for children and families were widely available in the ward and outpatient areas. Staff knew how to access an interpreter and gave examples of when they had used the service.

There were arrangements to support children and young people with complex needs or who required psychiatric support. CAMHS services were provided by the local mental health trust, and was available during office hours only. Any patients requiring CAMHS outside of office hours were cared for on the ward until the service was open. Since May 2017 to April 2018 the service had cared for 278 CAMHS patients in the children’s ward, with their length of stay ranging from 30 hours to 10 days.

Managers told us they had seen an improvement since out last inspection, as CAMHS now provided a seven-day service, however this did not extend to out-of-hours.

The play specialist had received CAMHS training to enable her to understand and meet the needs of children and young people with mental health problems.
The children’s ward was a designated paediatric oncology shared care unit (POSCU). This meant children and young people who were receiving treatment for cancer could receive medication such as antibiotics at West Cumberland Hospital instead of travelling to the specialist regional centre in Newcastle. The lead consultant paediatrician and ward staff met with the regional POSCU team every month to discuss each child in their care. The medical and nursing team also cared for oncology patients who were in receipt of end-of-life-care. With support from the regional Paediatric Oncology and Outreach Nursing (POON) team, based in Newcastle, and local children’s community nurses, the team at WCH provided palliative and end of life care for children and young people with progressive malignant disease.

The trust performed better than other trusts for no questions, worse than other trusts for two questions and about the same as other trusts for the remaining 15 questions relating to responsiveness in the CQC Children and Young People’s Survey 2016.

CQC Children and Young People’s Survey 2016 questions, responsive domain, North Cumbria University Hospitals NHS Trust

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>71</td>
<td>Did a member of staff tell you who to talk to if you were worried about anything when you got home?</td>
<td>8-15 CYP</td>
<td>6.39</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>73</td>
<td>Did a member of staff give you advice on how to look after yourself after you went home?</td>
<td>8-15 CYP</td>
<td>7.48</td>
<td>Worse than other trusts</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Access and flow

Children and young people were admitted to the children’s ward through the paediatric emergency department or via a direct referral from a GP. Some children and young people were granted long-term open access to the ward or SCBU, particularly those suffering from chronic conditions or babies who had recently been discharged.

There was an escalation policy when the number of patients exceeded the number of available beds. Staff we spoke with could explain what actions they would take in such an event. Ward managers at both hospital sites also had regular contact with each other throughout each day to maintain oversight of bed capacity on each ward.

The service used a paediatric dashboard to monitor performance in relation to outpatient referrals, attendances, and did not attend (DNA) rates, emergency readmission rates and length of stay (elective and non-elective). The dashboard also included referral to treatment times (RTT).

Between April 2017 and March 2018, the number of new outpatient attendances was 3305 across both hospitals. Within the same time frame, there were 5418 review attendances. We did not see the figures for each individual site however, the service was consistently above the 92% trust target for RTT 18-week, ranging from 98% to 99%.
The DNA rate from April 2017 to March 2018 was 19.3%, which was worse than the 8% target. Staff could explain the process outlined in the DNA policy when a child or young person did not attend and told us what action they would take.

Cumbria Partnership NHS Foundation Trust provided community children’s nursing services across the local region. Some staff felt the current provision was limited in terms of the links with the hospital. However, a recent alliance between the community healthcare provider and North Cumbria University Hospitals NHS Trust indicates the relationship between the two organisations will become stronger going forward.

Specialist paediatricians were available for immediate telephone advice for acute problems within the trust or through a network. Specialties included gastroenterology, endocrinology, oncology, respiratory medicine, intensive care medicine, nephrology, paediatric cardiology and neurology. The unit maintained close working links with the local regional tertiary centre.

Discharge summaries were provided to GPs, other healthcare professionals and parents within 24 hours of discharge from hospital. As not all GP practices were set up to receive electronic communication, letters were sent directly to the relevant practice.

On all the records we reviewed, a consultant saw a child or young person within 14 hours of admission.

The trust has no neonatal critical care beds. The Special Care Baby Units (SCBUs) are level one, providing care for babies who require additional care post-delivery by the neonatal service, but do not require intensive or high dependency care. Both units engage with the Northern Neonatal Network, CNST and Developmental Care. At times, and during neonatal emergencies, the units are required to provide high dependency and intensive care, hence can provide short term intensive care for babies who are intubated, ventilated and awaiting transfer to the tertiary centre by the retrieval teams. Intensive care delivery requirements may be required for four to 2-hour periods, depending on the demands of the retrieval teams.

The SCBU initiates mechanical ventilation and stabilisation, but does not ventilate long term. Instead the Northern Neonatal Network will find a ventilator for the baby usually in the Northern Region and organise the baby to be transferred out by a neonatal transfer team.

(Source: Routine Trust Provider Information Request (RPIR Acute) – Context tab)

Learning from complaints and concerns

From April 2017 to March 2018 there were three complaints about children’s services. The trust took an average of 31 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be, responded to and closed within 30 working days. All complaints were about inpatient care and treatment. West Cumberland Hospital received one complaint and one complaint was not allocated to a specific site. One complaint was upheld, one partially upheld and one complaint refuted. (Source: Routine Provider Information Request (RPIR) – Complaints tab)

Parents we spoke with told us they felt they could raise concerns if they felt they wanted to and told us they knew how to make a complaint. There were posters and leaflets in visiting areas
about how people could raise concerns. Staff explained, in most cases, parents spoke to nurses on the ward and issues tended to be resolved informally.

**Is the service well-led?**

**Leadership**

There were clear lines of management and accountability across the service at all levels.

Staff spoke positively about leadership at ward, service and care group level. They felt they had the relevant skills, knowledge, experience, and integrity required. Managers were visible and approachable.

In respect of clinical leadership, staff told us the clinical directors for paediatrics and neonates were based at Cumberland Infirmary and did not maintain regular presence at West Cumberland Hospital. However, the lead consultant at the hospital undertook a leadership role within the medical team and staff spoke positively about their contribution.

The matron maintained a regular and visible presence in the unit. The matron and ward manager shad a one-to-one meeting every week to discuss concerns, risks and issues. The matron also held daily update meetings (morning and evening), either face-to-face if on site, or via telephone, to keep abreast of activity on the unit.

The neonates ward manager had not received any internal leadership training. We were informed the trust no longer provided this and it was difficult to source any external training. The ward manager from the children’s ward was providing peer support and the matron recognised the need for a preceptor. The matron was arranging internal human resources training and had good oversight of the training needs.

Consultants had job plans and these were reviewed annually as part of the appraisal process.

**Vision and strategy**

The trust had recently formed an alliance with Cumbria Partnership NHS Foundation Trust and senior managers continued to work collaboratively with the Cumbria Clinical Commissioning Group (CCG), Cumbria County Council, North West Ambulance Service, NHS England and neighbouring NHS Foundation Trusts to deliver a business case to remodel services for children and young people. The primary aim was to ensure services were safe by creating a one-team, sustainable, integrated service across both acute sites.

Managers continued to acknowledge the development of such an integrated model of care meant the service was better able to respond to the demands upon it. This included the needs of its population, geography, local infrastructure, and recruitment issues.

The trust, in alliance with Cumbria Partnership NHS Foundation Trust, had created a joint operational plan entitled ‘This is us’. Core objectives, aims and priorities for services for children and young people receiving acute and community across Cumbria were included with the strategy. The introduction of a paediatric short stay assessment unit at West Cumberland Hospital was
already in its first phase of development and had introduced a more rapid review of patients. Staff spoke positively about the changes and had felt involved in the process.

The child health business plan reflected the changing nature of childhood illness which meant fewer children require an inpatient hospital stay, while those who are admitted tend to have a shorter length of stay than in the past. This was reflected in the development of the short stay paediatric assessment units at both sites, and overnight beds for children with less acute, low risk illnesses at West Cumberland Hospital. Children and young people who needed more acute inpatient care would be transferred to Cumberland Infirmary.

Senior managers also recognised the need to look at a longer-term approach to the stabilisation of SCBU. This included developing a transitional care model and generating closer links with the maternity service. The associate director of midwifery, appointed in January 2018, worked closely with the matron and maintained oversight of SCBU.

Culture

The culture of the service was centred on the needs and experiences of children and young people. Feedback from patient experience surveys was widely shared across the units and staff demonstrated resilience and passion to ensure they delivered excellent care.

Medical and nursing staff spoke positively about good teamwork across the service. Our observations showed staff worked well together and there were positive working relationships between the multidisciplinary teams and other services involved in the delivery of care for children and young people.

Staff described a culture of openness and honesty, and told us they felt safe to challenge senior members of the team and express their own opinion. They were proud to work for the trust, and most staff felt valued and respected. Everyone we spoke with was aware of duty of candour and practitioners were encouraged to report incidents. Staff felt confident that if they raised a concern, managers would take appropriate action.

Governance

At previous inspection, services for children and young people was part of Surgical division. Children’s services were now currently part of the Women’s and Children’s Services Care Group which also included radiology, however managers felt it did not meet the governance needs of the service. In response, managers and service leads had resurrected child health unit governance meetings.

Managers and senior nurses described a governance structure that included regular meetings to discuss the performance, quality, and sustainability of the service.

There was a governance dashboard which included all reported incidents, complaints, PALS (patient advice and liaison service) enquiries, clinical audit activity, ongoing risks, and NICE exceptions.

Site governance meetings took place every Wednesday and cross-site governance meetings were held on the first Tuesday of every month. The ward manager also held bi-monthly ward meetings.
with staff. Information from governance meetings was shared with staff via email. The ward manager also maintained a governance folder which held up-to-date and relevant information such as minutes from governance and risk meetings. Staff were aware of the file and told us they regularly accessed it.

We reviewed the minutes from the previous three cross-site child health governance meetings, noted the regularity of meetings and the good representation from staff. They included the matron, business manager, ward managers, consultant paediatricians, and governance facilitator, plus the named nurse safeguarding children, and finance lead. The clinical director for paediatrics was unable to attend due to clinical responsibilities. There was a standard agenda which included operational issues, workforce updates, incident review, finance and risk.

Moving forward, the trust was in the process of establishing a cross-organisational Family Services Care Group with Cumbria Partnership NHS FT (CPFT). The current associate medical director for children and young people at CPFT, a consultant paediatrician, would have a leadership role within this.

**Management of risk, issues and performance**

There were 11 current risks relating to children’s services on the divisional risk register. Only one risk related specifically to West Cumberland Hospital, which was potential delays in outpatient follow-up. It had a current risk rating of eight and appropriate actions had been taken and were in place. Five other risks were cross-site while the other five were specific to Cumberland Infirmary.

Risks associated with both hospitals included lack of clarity around postcode divert when either hospital had reached capacity, inappropriate admissions of patients with mental health issues and nasogastric tube training and level of competency.

Managers reviewed the children’s services risk register every month.

Nursing and medical staff we spoke with had a good understanding of the risks within the service. Delays in appropriate care for children with mental health issues and medical staffing were the two main risks staff spoke about, although the latter issue did not feature on the divisional risk register. Managers had taken steps to mitigate some of the risks posed to children and young people with mental health problems through collaboration with the CAMHS team.

Staff could describe the escalation process in relation to risk. Staff escalated risks directly to the matron or paediatric clinical director. Escalation to the Board was via the medical director or director of nursing.

Performance was monitored through the paediatrics dashboard and reviewed at monthly governance meetings. In the event of a deterioration in performance, the business manager advised an action plan or recovery plan is created and monitored in governance meetings.

In respect of the service’s business continuity plans, the current plans required updating. A tabletop exercise was scheduled at the end of the month with the clinical commissioning group lead who was supporting the process.
Although there was a system of clinical and internal audit to monitor quality, the service did not have specific progress reports for audit action plans. Managers were currently developing a process to monitor and follow-up on action plans and had created an action plan escalation process with the governance facilitators for each Care Group. The new process included a spreadsheet that automatically sent out reminders for overdue action plans. This had only been developed very recently and the service had not used it yet. As part of this work managers also told us they also planned to develop progress reports.

Managers and staff from both sites completed a detailed '15 Steps' safety and quality assessment to monitor ward compliance against the CQC’s five key questions. We reviewed the latest report from the latest assessment that took place in May 2018. The assessment team included staff from Cumberland Infirmary. The report highlighted good practice within each domain plus any concerns and learning. Good practice included medicines, incident awareness, governance arrangements, and good teamwork. Areas for development were mostly in relation to the ‘safe’ domain. The report noted that barrier nursing signs were not on the doors of cubicles where barrier nursing was taking place, and mandatory training compliance. A 15 Steps safety and quality action plan detailed the actions taken and progress updates.

**Information management**

Staff we spoke with told us they could access the information they needed to ensure they provided safe and effective care to patients. This included policies and standard operating procedures. The intranet was available to all staff and contained links to guidelines, policies, safeguarding information and contact details for colleagues within the trust. This meant staff could access advice and guidance easily. All staff we spoke with knew how to access the intranet and the information contained within.

Managers could access governance and performance dashboards that provided relevant data about the service. This was discussed at ward and governance meetings.

The information accessed by managers was stored in line with data security standards, for example, confidential and personal information pertaining to staff was protected through the use of smart cards, issued only to staff with line management responsibilities.

**Engagement**

The service proactively engaged with children, young people and their families and sought feedback through patient experience surveys. Feedback was displayed on boards in the children’s ward and SCBU. Recognising that some children were too poorly to put their thoughts in writing, staff also engaged with them face-to-face to capture their views.

The service displayed ‘You Said, We Did’ boards within each unit, demonstrating that the service listened to and took appropriate action in response to feedback.

Medical and nursing staff engaged daily with the children and young people in their care and ensured parents were included. We saw evidence of positive and caring interactions between staff of all grades with the children and their families.
Staff told us they felt informed about the current plans for children’s services at West Cumberland Hospital, particularly in respect to the development of the paediatric short stay assessment unit.

The trust communications team distributed regular bulletins and newsletters via email, and uploaded trust information onto the intranet for staff to access.

**Learning, continuous improvement and innovation**

Managers and staff demonstrated continuous improvement through the plan to re-model children’s services at West Cumberland Hospital, and the paediatric short stay assessment unit.

Staff were proud of their achievements in relation to BLISS and the Baby Friendly Initiative.

In SCBU, staff spoke of their family integrated care approach. Due to the regular presence of parents on the unit, staff encouraged them to proactively engage in the care of their child. The ward manager explained the aim was to empower parents to look after their baby and staff promoted initiative such as skin to skin contact for a sustained period. Representatives from the service had been involved in discussions at the local neonatal network and had implemented the practice within the unit.
Acute services

Penrith Hospital

Evidence appendix

Penrith Birthing Centre
Penrith Hospital
Bridge Lane
Penrith
CA11 8HX

Tel: 01768 245555
http://www.ncuh.nhs.uk

Date of inspection visits:
12 - 13 July 2018
28 – 30 August 2018

Maternity

Facts and data about this service

Penrith Birthing Centre is a midwifery led unit. Between May 2017 and June 2018 there were 18 births at the birthing centre.

Staff within the unit also provided community based care and were based within the East Cumbria rural community service. The team covered rural areas and were split into geographical areas such as Penrith, Brampton, Appleby and Wigton. Overall the team was known as Eden. The neighbouring midwife team covered Carlisle. Both teams worked across the geographical area out of hours and weekends.

The trust provides consultant led maternity care and midwifery led units at both Cumberland Infirmary Hospital and West Cumberland Hospital. This includes a day assessment centre, antenatal and postnatal inpatient beds, maternity theatre, delivery suite and a number of outpatient clinics on each site.

Services available on both sites include:

- Elective and emergency caesarean sections
- Epidural service
- Bereavement service
- Scanning, diabetic clinics and early pregnancy assessment clinics

At West Cumberland Hospital there is a fetal telemedicine clinic with the Royal Victoria Infirmary at Newcastle. Antenatal clinics are also undertaken in the community which covers the remote rural areas of North Cumbria.
There is an active maternity voices partnership.

(Source: Trust Provider Information Request (RPIR) AC1 Context - description of all acute services)

The trust has 41 maternity beds. There are 23 maternity beds at Cumberland Infirmary Hospital, all of which are on the Aspen maternity ward. There are 17 maternity beds at West Cumberland Hospital, six of which are on the delivery suite and 11 are on Honister ward. There is one maternity bed at the Penrith birthing centre.

(Source: Trust Provider Information Request (RPIR) P2 Sites)

From January 2017 to December 2017 there were 2,763 deliveries at the trust.

A comparison of the number of deliveries at the trust and the national totals during this period is shown below.

Number of babies delivered at North Cumbria University Hospitals NHS Trust – comparison with other trusts in England

(Source: Hospital Episode Statistics)
A profile of all deliveries and gestation periods from January 2017 to December 2017 can be seen in the tables below.

### Profile of all deliveries (January 2017 to December 2017)

<table>
<thead>
<tr>
<th></th>
<th>North Cumbria University Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Single or multiple births</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>2,371</td>
<td>98.8%</td>
</tr>
<tr>
<td>Multiple</td>
<td>32</td>
<td>1.2%</td>
</tr>
<tr>
<td>Mother's age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 20</td>
<td>108</td>
<td>3.9%</td>
</tr>
<tr>
<td>20-34</td>
<td>2,238</td>
<td>81.0%</td>
</tr>
<tr>
<td>35-39</td>
<td>352</td>
<td>12.7%</td>
</tr>
<tr>
<td>40+</td>
<td>65</td>
<td>2.4%</td>
</tr>
</tbody>
</table>

**Total number of deliveries**

<table>
<thead>
<tr>
<th></th>
<th>North Cumbria University Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total</td>
<td>2,763</td>
<td></td>
</tr>
</tbody>
</table>

*Note: A single birth includes any delivery where there is no indication of a multiple birth.*

### Gestation periods (January 2017 to December 2017)

<table>
<thead>
<tr>
<th></th>
<th>North Cumbria University Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Gestation period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 24 weeks</td>
<td>No deliveries at the trust had a valid gestation period recorded.</td>
<td>0.1%</td>
</tr>
<tr>
<td>Pre term 24-36 weeks</td>
<td></td>
<td>7.9%</td>
</tr>
<tr>
<td>Term 37-42 weeks</td>
<td></td>
<td>91.8%</td>
</tr>
<tr>
<td>Post Term &gt;42 weeks</td>
<td></td>
<td>0.2%</td>
</tr>
</tbody>
</table>

**Total number of deliveries with a valid gestation period recorded**

<table>
<thead>
<tr>
<th></th>
<th>North Cumbria University Hospitals NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)
The number of deliveries at the trust by quarter for the last two years can be seen in the graph below.

**Number of deliveries at North Cumbria University Hospitals NHS Trust by quarter**

There was a reduction in the number of deliveries for each quarter in 2017 compared to the equivalent quarter in 2016. However, the quarterly trend in 2017 follows the same trend when compared to 2016.

(Source: HES - Deliveries (January 2016 - December 2017))

**Is the service safe?**

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

**Mandatory training**

**Mandatory training completion rates**

The trust set a target of 95% for completion of mandatory training.

**Trust level**

Nursing and midwifery staff in maternity services had an overall mandatory training compliance rate of 81.1% for April 2017 to March 2018 which was below the trust target. A breakdown of completion of mandatory training courses for nursing and midwifery staff in maternity services is shown below:
<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced life support (adults)</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Basic life support (adults)</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Dementia</td>
<td>14</td>
<td>14</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Slips, trips and falls level 1</td>
<td>174</td>
<td>171</td>
<td>98%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Risk management</td>
<td>174</td>
<td>169</td>
<td>97%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>174</td>
<td>166</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Duty of candour</td>
<td>174</td>
<td>164</td>
<td>94%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Intensive life support (paediatrics)</td>
<td>16</td>
<td>15</td>
<td>94%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Information governance</td>
<td>174</td>
<td>158</td>
<td>91%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>174</td>
<td>155</td>
<td>89%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Medicines management</td>
<td>174</td>
<td>155</td>
<td>89%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Prevent level 1 and 2</td>
<td>174</td>
<td>155</td>
<td>89%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Calculating drug doses</td>
<td>174</td>
<td>153</td>
<td>88%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Health and safety</td>
<td>174</td>
<td>153</td>
<td>88%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Blood safety 04</td>
<td>16</td>
<td>14</td>
<td>88%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Fire safety</td>
<td>174</td>
<td>149</td>
<td>86%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Hand hygiene (clinical)</td>
<td>174</td>
<td>147</td>
<td>84%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>PROMPT</td>
<td>144</td>
<td>121</td>
<td>84%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Health records management</td>
<td>174</td>
<td>140</td>
<td>80%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Infection control level 2</td>
<td>174</td>
<td>135</td>
<td>78%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Moving and handling level 2</td>
<td>174</td>
<td>124</td>
<td>71%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>NEWS</td>
<td>10</td>
<td>7</td>
<td>70%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Maternity professionals issues day</td>
<td>144</td>
<td>100</td>
<td>69%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Blood safety 02</td>
<td>174</td>
<td>109</td>
<td>63%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Blood safety 01</td>
<td>158</td>
<td>98</td>
<td>62%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>162</td>
<td>99</td>
<td>61%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Slips, trips and falls level 2</td>
<td>15</td>
<td>8</td>
<td>53%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Understanding end of life</td>
<td>174</td>
<td>92</td>
<td>53%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Risk management (board and senior management)</td>
<td>39</td>
<td>16</td>
<td>41%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Prevention of suicide</td>
<td>16</td>
<td>5</td>
<td>31%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

The maternity service met the trust’s mandatory training target in six out of the 30 modules for which nursing and midwifery staff were eligible, however for two of these modules only a small number of staff were eligible to complete the training (nine eligible staff for adults advanced life support and five staff for adult’s basic life support). A further three training modules had a completion rate of over 90%, which was just below the trust target.

For four of the modules the compliance rate was less than 60%, however for two of these modules only a small number of staff were eligible to complete the training (15 eligible staff for slips, trips and falls level 2 and 16 eligible staff for prevention of suicide).

There was no data available specifically to the Penrith Community Hospital in relation to mandatory training.
Safeguarding

A system was in place on the computer system to raise any safeguarding issues or incidents.

A safeguarding supervision audit was currently being completed and was due to be completed by the end of September 2018.

The trust set a target of 95% for completion of safeguarding training.

Trust level

Nursing and midwifery staff in maternity services had an overall safeguarding training compliance rate of 86.2% for April 2017 to March 2018 which was below the trust target. A breakdown of completion of safeguarding courses for nursing and midwifery staff in maternity services is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 2</td>
<td>14</td>
<td>13</td>
<td>93%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 3 (specialists)</td>
<td>160</td>
<td>145</td>
<td>91%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>174</td>
<td>142</td>
<td>82%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Maternity services did not meet the safeguarding training trust target for any of the three modules for which nursing and midwifery staff were eligible. However only one member of staff (out of 14) did not complete the safeguarding children level 2 training module, and over 90% of staff had completed two out of the three modules.

The community midwifery teams based had an overall safeguarding training compliance rate of 95% for April 2017 to March 2018 which met the trust target.

The midwives were moving onto online training for level three safeguarding and told us they understood this was the only route available to them for level three training. The community midwives carried out case reviews when they raised safeguarding issues.

The trust had policies, systems and processes in place to protect children and adults from neglect or abuse. Staff we spoke with had undertaken safeguarding training so that safeguarding was everyone’s business. Staff we spoke with understood their responsibilities in identifying and reporting any safeguarding concerns.

Staff could give us examples of safeguarding referrals made including domestic abuse, child protection, and female genital mutilation (FGM). The lead consultant at West Cumberland Infirmary was also the FGM lead for the whole service.

Midwives told us they undertook FGM and child sexual exploitation (CSE) training as part of their mandatory training. Staff told us they were not aware of any women who had presented with this. However, staff told us that any case would be shared with the community teams, GP, and health visitors.
There was a clear referral pathway via the community midwives if there were any identified safeguarding issues with expectant mothers, for example mothers who may have had children removed previously, those living with drug and alcohol abuse, and domestic violence. Staff attended a regular core group meeting where all the professionals met to discuss the mothers and plan any further action that may be required. We looked at two cases with safeguarding issues and found that adequate risks had been assessed and recorded. If there was any risk of the mother absconding due to safeguarding issues, the unit was part of a network and would put alerts out to warn other maternity units nationally. The midwives told us mothers were involved in any decisions about their care and staff would ensure any plans of action would be made clear.

Staff set an alert in the patient administration system in maternity and staff put a red divider in patient paper records to ensure all staff were aware of safeguarding issues for a mother. We saw red cards used in patient records to identify any patient with a reported safeguarding concern. We saw evidence to show the team identified babies at risk at birth due to social issues. Staff told us an alert would also show on any electronic record.

Once the mother was discharged home, staff would tick a box in the perinatal notes to alert any health visitors of risks such as safeguarding.

The midwives referred women into the safeguarding HUB and received feedback when required from the social workers.

**Cleanliness, infection control and hygiene**

We found that the environment was visibly clean and that systems and processes were in place to control infection and promote hygiene. However, we did not see evidence of cleaning audits in the unit and results were not displayed. We did not find evidence staff complied with the Health and Safety Executive guidance to run the hot water in the birthing pool for five minutes daily to reduce the risk of legionella. There was no checklist for cleaning of the birthing pool so staff were not aware of what was expected of them.

We found checklists for cleaning patient bed areas following discharge. This was placed on the top of the bed and filed in the patent records when the bed was occupied. Domestics held cleaning rotas for public areas.

Staff followed best practice with infection control and prevention principles, in relation to the management of clinical waste.

We saw clinical waste and domestic waste was appropriately segregated and disposed of correctly in accordance with trust policy. Separate utility areas were designated for clean and dirty use. Separate bins for clinical and domestic waste were evident.
Environment and equipment

The environment was spacious, there were two clinic rooms one, which, was used for antenatal and postnatal checks and the other could be used for antenatal classes.

The premises and facilities at the birth centre were appropriate for the services provided there. The centre had one birthing suite which contained a birthing pool. This contained a star projector to relax pregnant women. The service provided birthing balls and mats for women to promote active birth.

The delivery room had dimmable lighting and an iPod dock for parents to take their own music to listen to during labour.

Assessing and responding to patient risk

There was a robust midwifery led care policy, which identified the criteria for women being able to deliver within the unit and at home. Women were reviewed throughout their pregnancy to identify if they still met the criteria. Staff informed us if they assessed any woman was at risk and needed to be transferred to hospital they called for an emergency response ambulance immediately. Women would be transferred to Cumberland Infirmary in Carlisle which was approximately 23 miles away. The midwife would travel with the patient to Cumberland Infirmary.

Midwives completed risk assessments at booking to identify women with any medical, obstetric, psychological or lifestyle risk factors. This determined if an individual was high or low risk. High risk women were referred to consultant led antenatal clinics. Women referred by their GP or the emergency department attended the ward for assessment.

Midwifery and nurse staffing

The centre was midwifery led and consisted of a lead midwife, community midwives, healthcare assistants and administration staff.

The total caseload for the Eden team in January 2018 was 957. This was split into four caseload sizes with the largest in Penrith of 346. The smallest caseload was 140 in Appleby. Lead midwives reviewed the size of caseloads and supported staff as well as having their own caseloads. We asked midwives about their caseload who told us they felt they were manageable.

At weekends and out of hours, staff worked across the region with two community midwives providing cover from both the Eden and Carlisle teams. Two further midwives were accessible who worked in West Cumbria. If a patient needed to access the centre both midwives would attend the centre.

The lead midwife told us that there was one vacancy within the Eden team at the time of our inspection.

At times we saw that midwives were required to attend the acute maternity units as part of the maternity staffing escalation plan. This meant staff were unable to provide care at the birthing centre out of hours on 10 occasions. In 2017 we saw that the centre was closed on 45 occasions in total due to staffing. On 10 occasions this was due to midwives being required to work at
Cumberland Infirmary in Carlisle. On 20 occasions this was due to sickness and no cover was available. The remaining 15 were due to only one midwife being available. In 2018 staff recorded incidents to identify there was no midwife cover for dates in February, March and April 2018.

**Vacancy rates**

From April 2017 to March 2018, the trust reported an over-establishment of 4.1% with 63.4 more WTE staff in post than planned. The trust target for vacancy rate is 5%.

Vacancy rate for the Penrith birthing centre was 23.3% (underfill)
(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

From April 2017 to March 2018, the trust reported a turnover rate of 7.2% in maternity which was lower than the trust target of 13.0% for voluntary turnover (excluding corporate services, junior doctors and FTCs)

Turnover rate for the Penrith birthing centre was 7.2%.
(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**

From May 2017 to May 2018, the trust reported a sickness rate of 5.2% in maternity which was above the trust target of 4.0%.

Sickness rate for the Penrith birthing centre was 6.3%.
(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Bank and agency staff usage**

From April 2017 to March 2018, the trust reported a bank usage rate of 8.6% in maternity.

The trust was unable to provide comparable data for agency and shifts left unfilled, due to system restrictions.

The breakdown by site is shown in the table below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Bank shifts</th>
<th>Total shifts</th>
<th>Bank shifts as a proportion of total shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Penrith Birthing Centre</td>
<td>28</td>
<td>41</td>
<td>68.3%</td>
</tr>
<tr>
<td>Total</td>
<td>72</td>
<td>833</td>
<td>8.6%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)
Midwife to birth ratio

From January 2017 to December 2017 the trust had a ratio of one midwife to every 23.7 births. This was similar to the England average of one midwife to every 25.5 births and similar to the trust’s previous performance (November 2015 to October 2016) of one midwife to every 24.4 births.

(Source: Electronic Staff Records – EST Data Warehouse)

The service performed better than national benchmark for midwifery staffing set out in the Royal College of Obstetricians and Gynaecologists guidance (Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour) with a ratio of 1:24 against the recommended 1:28. The service had previously used the Birthrate Plus® midwifery acuity tool, however, at the time of inspection the service was working towards the continuity of carer model advocated in Better Births (2017). This meant that the acuity tool would be more appropriate following the implementation of the new way of working.

Medical staffing

There were no medical staff based at the maternity unit. However, staff informed us if they were concerned they were able to contact a consultant at the Cumberland Infirmary for advice.

Records

Patient records were a mix of electronic and paper patient notes (for instance, inpatient notes and nursing care plans were paper based). Paper records were stored securely away from patient areas and maternity used an electronic record so data could be shared with community services.

Women carried their own hand-held records throughout their pregnancy. These were shared with community midwives and GPs. Results from antenatal tests were documented in these records. Antenatal risk assessments were completed at booking to identify any medical, obstetric, or psychological risk factors. Midwives we spoke with told us risk assessments were repeated at each antenatal visit.

Information relating to discharge was communicated using the SBAR tool to ensure timely communication on discharge from the maternity unit. Information was sent by post to women, GPs and health visitors. Community midwives could access the information electronically. Staff said if a woman had complex needs they would contact the relevant professional in addition.

All staff could access test results using the trust electronic system.

Staff we spoke with told us and we saw senior midwives undertook a monthly spot check record audit of records. Any trends or good practice were disseminated to clinical areas.
Medicines

Transport of gases for home births was provided by a company and delivered to each woman’s address at 36 weeks gestation.

We found some medicines that were not stored appropriately in a locked cupboard. We highlighted this with staff during our inspection and this was immediately dealt with. We found that each community midwifery team had a different process for the management and carrying of emergency medicines. This meant that there was a risk that staff who may have provided support to a different team may not have had the appropriate medicines required for a homebirth.

Incidents

The trust had a clear policy for the reporting of incidents, near misses and adverse events. Staff were encouraged to report incidents using the trust’s electronic reporting system. The staff we spoke with described the process of incident reporting and understood their responsibilities to report safety incidents including near misses. Staff told us they received a copy of the closure of any incident they reported from the electronic reporting system.

Staff told us of an incident that resulted in a serious investigation at one of the maternity units. Staff at the centre told us that they were informed of incidents and learning that had occurred in the acute maternity units. We saw examples of the ‘message of the week’ which highlighted key messages and lessons learnt from incidents.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From June 2017 to May 2018, the trust reported one incident which was classified as a never event for maternity. This was a retained foreign object post procedure and occurred in May 2018.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported nine serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from June 2017 to May 2018 including one never event.

The types of incident reported were:

- Maternity/obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant) with six (66.7% of total incidents)
- Maternity/obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant) with one (11.1% of total incidents)
• Maternity/obstetric incident meeting SI criteria: mother only with one (11.1% of total incidents)

• Surgical/invasive procedure incident meeting SI criteria with one (11.1% of total incidents)

There were no serious incidents reported at Penrith community hospital.

(Source: Strategic Executive Information System (STEIS))

Safety Thermometer

Staff did not collate safety thermometer data at the Penrith Birthing Centre.

Is the service effective?

Evidence-based care and treatment

The trust had systems and processes in place to ensure that care was given by the service according to published national guidance such as that issued by National Institute for Health and Care Excellence (NICE) and Royal College of Obstetricians and Gynaecologists (RCOG). All staff we spoke with could access on the trust's intranet, guidelines, policies and procedures relevant to their role.

On a review of clinical pathways and guidelines we found some maternity guidelines and procedures had an author and were within their review date. However, there were many maternity guidelines that were beyond their published review date. We found that of 20 maternity guidelines we reviewed, 17 were out of date, some by up to two years. We spoke with the midwife lead responsible for governance, along with the ADM, to ensure that clinical guidelines were updated in accordance with NICE or RCOG guidelines. Staff told us guideline reviews were underway but there were various reasons for delays including lack of clinical input. There was no clear process or timeline for updating maternity guidelines and staff reported the Trust ratification process was responsible for some of the delays in publishing clinically agreed guidelines.

There was limited evidence of audit activity undertaken within the Birthing Centre itself.

Nutrition and hydration

We found the service met the needs of women having babies, babies and visitors, carers or relatives.

There was specialist midwife for infant feeding who worked across all sites, who led on the implementation and training associated with the implementing United Nations Children’s Fund (UNICEF) Baby Friendly Initiative standards.

The trust had implemented United Nations Children’s Fund (UNICEF) Baby Friendly Initiative standards. The birthing centre was awarded stage two UNICEF baby friendly accreditation in October 2017.

There was no site-specific breastfeeding initiation rate for deliveries that took place in the birthing centre. The breastfeeding initiation rates for deliveries that took place in the trust between June 2017 and May 2018 were reported between 56.8% (October 2017) and 67.1% (July 2017).
Pain relief

Within the community any relevant pain relief medicines were prescribed by the doctor and kept at the patient’s home.

Women received information of the pain relief options available to them, which included Entonox, piped directly into the delivery room.

The birth centre had had one birthing pool. There was equipment to support active labour. Pharmacological pain relief options were limited to Diamorphine. Women who required additional pain relief for example epidural analgesia were transferred to the Cumberland Infirmary. The trust did not undertake pain relief audits or collect this data.

The service did not actively promote alternative therapies for example hypnobirthing. However, we were told they supported women who chose this method of pain relief and one staff member had been trained.

Patient outcomes

The birth centre had 100% normal vaginal delivery rate, which was better than the national average of 60%.

The number of women who required transfer to the Cumberland Infirmary was six between May 2017 and June 2018, however, two of these were from the Penrith Birthing centre. We were told each transfer was discussed, however, there was no formal audit of themes or record of the discussion.

Information regarding the centre was incorporated into the maternity dashboard to monitor key maternity indicators.

The use of the birthing pool at the centre was audited including the percentage of women who delivered in the pool. In 2017, 18 women used the birthing pool with 15 delivering within the pool.

Competent staff

Staff told us they completed specific training for maternity known as ‘skills drills’. This included training on obstetric emergency situations where scenarios and reflection were discussed. We spoke with staff who had completed the training and felt competent in completing these procedures.

A preceptorship programme was in place for all new staff within the trust. As part of the programme specific core skills and competencies for midwives were included. We saw that newly qualified midwives attended the sessions and there was a log of staff’s competencies. Staff attended the relevant courses to be up to date with the most current and relevant information. For example, staff who managed the antenatal classes attended regional antenatal seminars to ensure they were providing up to date information. Staff told us of examples where they had changed the classes to reflect the learning from the courses.
Community midwives were required at times to attend the labour suite as part of Cumberland Infirmary midwifery staffing escalation plan.

Evidence provided by the trust showed the practical obstetric multi-professional training (PROMPT) training completion rate for the community midwifery teams was 86.1% between April 2017 and March 2018, this was worse than the trust target of 95% completion.

Evidence provided by the trust showed the new-born life support training completion rate for the community midwifery teams was 68.6% between April 2017 and March 2018, this was worse than the trust target of 95% completion.

Evidence provided by the trust showed the cardiotocograph (CTG) training completion rate for the Penrith community midwifery team was 91.5% between April 2017 and March 2018, this was worse than the trust target of 95% completion.

From April 2017 to March 2018 100% of staff within maternity services at Penrith Community Hospital received an appraisal compared to a trust target of 95%. A breakdown of staff appraisal completion is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Individuals required</th>
<th>Appraisals completed</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing midwifery staff (Qualified nurses)</td>
<td>9</td>
<td>9</td>
<td>100%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>2</td>
<td>2</td>
<td>100%</td>
</tr>
</tbody>
</table>

Both of the two staff groups met the trust target for completion of appraisals with 100% completion rate.

We spoke with staff who confirmed that they had appraisals completed. They felt their managers listened and acted on information within their appraisal.

**Multidisciplinary working**

We saw evidence of multidisciplinary working. Midwives liaised and discussed women on their caseloads with medical staff when required. Obstetric consultants also attended regular meetings.

Education sessions and joint core governance meetings were open meetings so if any staff member wished to attend they were welcome to do so.

Staff also liaised with GP services to follow up any care needs required.

Specialist midwives worked closely with GPs, social workers, health visitors, and support workers, to ensure that vulnerable women and those with long term conditions received effective care. Staff told us they had good links with the perinatal mental health team who could provide assessment and treatment as necessary.

Staff worked with the perinatal mental health team in the local mental health trust for women with specific needs.
The midwife teams worked closely together and staff from other teams would attend the centre. The team liaised with the acute maternity unit and would support women when they were transferred there.

For women that had multiple services involved, the midwives completed joint appointments with the relevant services when required. Staff told us of various services they were involved with and would inform women of additional antenatal programmes that other services were providing so they can access them.

**Seven-day services**

The centre was open daily between 8.30am and 4.30pm. Out of hours if the centre was required to be accessed for a delivery, women would contact labour ward in the Cumberland infirmary who would contact the on-call midwife. The midwife on call would contact the patient and review the need to attend the centre.

At times the centre was closed out of hours when adequate cover could not be maintained or midwives were required to attend Cumberland Infirmary in Carlisle.

Community midwives provided seven-day cover. They provided antenatal clinics in community settings and postnatal visits took place in the home.

**Health promotion**

Various information was provided to women, these included breastfeeding, smoking cessation, importance of taking supplements and a balanced diet. Women told us that staff provided them with health promotion during their consultations.

As part of the antenatal classes, health promotion advice was given. This included information on breastfeeding, immunisations and reducing the risk of sudden infant death syndrome.

We saw various displays and leaflets around the centre providing women with health promotion information and advice.

There was no location specific data, however, between January 2018 and May 2018, the service reported the trust-wide rate of women smoking at booking appointment was 10.5% (March 2018) and 19.3% (February 2018); this was worse than the target of less than 11%.

There was no location specific data, however, between January 2018 and May 2018, the service reported the trust-wide rate of women smoking at delivery was 11% (March 2018) and 17.4% (February 2018), this was worse than the target of less than 11%.

It was identified there was an increased rate of women not completing the smoking cessation programme. As a result, the service looked at how they could manage the programme differently. Staff were now available when women attended their consultations so they could receive advice, treatment and therapy before leaving the centre.

The service had a public health midwife manager whose portfolio included Vaccinations, obesity pathways, infant nutrition, smoking cessation, substance misuse and teenage pregnancy. Each workstream had a specialist midwife lead.
Women could access free referrals to local slimming groups if they met certain criteria. Staff told us that women would access this service. Women had access to aqua aerobics classes.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust set a target of 95% for completion of mental capacity act (MCA) and deprivation of liberty safeguarding (DoLS) training.

There was no location specific MCA and DoLs specific training data however at a trust wide level nursing and midwifery staff in maternity services had an overall MCA and DoLS training compliance rate of 94.8% for April 2017 to March 2018 which met the trust target. A breakdown of completion of MCA and DoLS courses for nursing and midwifery staff in maternity services is shown below:

<table>
<thead>
<tr>
<th>Module</th>
<th>Required</th>
<th>Completed</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Target met</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental capacity level 2</td>
<td>37</td>
<td>36</td>
<td>97%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Mental capacity level 1</td>
<td>174</td>
<td>169</td>
<td>97%</td>
<td>95%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Deprivation of liberty</td>
<td>37</td>
<td>30</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

Maternity services met the training trust target for two of the three modules for which nursing and midwifery staff were eligible.

Staff told us that they had received training on mental capacity and asked women for consent. We spoke to women who told us that staff asked for their consent and informed them of any investigations or procedures they were completing.
Is the service caring?

Compassionate care

Friends and Family test (FFT) performance

Friends and family test performance (antenatal), North Cumbria University Hospitals NHS Trust

From March 2017 to March 2018 the trust's maternity FFT (antenatal) performance (% recommended) was generally similar to the England average. In three of the reported months 100% of patients recommended the trust for antenatal care. Note that no data was published by NHS England for November 2017.

Friends and family test performance (birth), North Cumbria University Hospitals NHS Trust

From March 2017 to March 2018 the trust's maternity FFT (birth) performance (% recommended) was generally similar to the England average. In five of the reported months 100% of patients recommended the trust for care during birth. Note that no data was published by NHS England for November 2017.

Friends and family test performance (postnatal ward), North Cumbria University Hospitals NHS Trust
From March 2017 to March 2018 the trust’s maternity FFT (postnatal ward) performance (% recommended) was generally better than the England average. The trust scored between 97% and 100% each month compared to the England average of between 94% and 95%. Note that no data was published by NHS England for November 2017.

Friends and family test performance (postnatal community), North Cumbria University Hospitals NHS Trust

From March 2017 to March 2018 the trust’s maternity FFT (postnatal community) performance (% recommended) was generally similar to the England average. In nine of the reported months 100% of patients recommended the trust for care during birth. Note that no data was published by NHS England for November 2017.

(Source: NHS England Friends and Family Test)

CQC Survey of women’s experiences of maternity services 2017

The trust performed better than other trusts for six out of 16 questions in the CQC maternity survey 2017

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>9.4</td>
<td>Best performing trusts</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>8.8</td>
<td>Best performing trusts</td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>9.7</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>8.8</td>
<td>About the same</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>9.3</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>8.6</td>
<td>Best performing trusts</td>
</tr>
<tr>
<td></td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>8.9</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth,</td>
<td>9.6</td>
<td>About the same</td>
</tr>
</tbody>
</table>
were you spoken to in a way you could understand? | same
---|---

If you needed attention during labour and birth, did a member of staff help them within a reasonable amount of time? | 9.3 About the same

Thinking about your care during labour and birth, were you involved enough in decisions about your care? | 9.1 Best performing trusts

Thinking about your care during labour and birth, were you treated with respect and dignity? | 9.6 About the same

Did you have confidence and trust in the staff caring for you during your labour and birth? | 9.3 About the same

Care in hospital after the birth

Looking back, do you feel that the length of your stay in hospital after the birth was appropriate? | 8.0 About the same

Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed? | 8.8 Best performing trusts

Thinking about your stay in hospital, how clean was the hospital room or ward you were in? | 9.0 About the same

Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding? | 9.2 Best performing trusts

(Source: CQC Survey of Women’s Experiences of Maternity Services 2017)

Women told us that staff were friendly and provided compassionate care. They felt that they were treated with respect and their privacy was maintained.

Around the centre we saw thank you cards from women and families. They expressed their thanks and gratitude in the staff’s support.

**Emotional support**

Around the centre was information regarding certain myths in pregnancy and birth. Information identified if these were correct and provided the correct information.

Women told us that they felt the midwives had provided them with emotional support. Staff supported women with breastfeeding.

The service provided an Afterthoughts service, a listening service for women or families experiencing difficulties following any birth. Staff discussed one issue where a woman had previously had a forceps delivery. The patient had not understood why this was necessary and they were very anxious that the same issues would occur in the current pregnancy. A staff member had used a model to show and explain what would have occurred and why forceps would have been needed.

Perinatal mental health risk assessments took place at the booking appointment, throughout pregnancy and during the post-natal period. Women with a suspected mental health illness were cared for in partnership with the perinatal mental health team for further assessment and treatment.
Understanding and involvement of patients and those close to them

Women were encouraged to complete their pregnancy notes identifying their own preferences for the birthing plan and how they were preparing for parenthood.

Women told us that they felt included with their pregnancy and staff valued their thoughts and opinions.

We spoke with midwives who told us that they supported women to breastfeed, however they were aware that not all women decided to breastfeed and they would respect the patient’s choice.

Is the service responsive?

Service delivery to meet the needs of local people

The centre was accessible to women who lived in the local area, however women from other areas could also access the centre. We were told of women from outside of the local had attended the centre to see if they would prefer to use the birthing suite.

At the last inspection in May 2014 we found that the Maternity Service Liaison Committee had not met for two years. Following the recommendations of Better Births (2017) the service now had an active maternity voices partnership. Staff told us the group attended various meetings and felt it to be beneficial.

The service recorded babies born before arrival and if the ambulance service were called to a woman in labour there was an agreement in place to bring her direct to hospital. took part in a regional arrangement for babies born before arrival. The regional ambulance service was working with Trusts to develop a standard response to these calls.

The community staff worked out of local GP surgeries and a community hospital which helped women to receive antenatal and postnatal care closer to home. Community midwife teams were organised around geographical areas to ensure women had a responsive local service.

Women had the option to deliver at home, at Penrith Birthing Centre with midwifery led care, at West Cumberland Infirmary and on the delivery suite at Cumberland Infirmary.

The trust website had a dedicated area about maternity services. In ward areas there was literature and leaflets supplied to women giving them information they might want to know about concerning their pregnancy.

Meeting people’s individual needs

Staff within the centre had devised their own leaflet which provided information to women regarding the centre. It also provided information on why women may need to be transferred and the support they would receive.

Midwives discussed with women’s choices throughout the pregnancy where they could choose to give birth. Specific criteria were required to be met to allow women to give birth at the centre. The
information was reviewed and a risk assessment completed at 36 weeks to identify if they still met the criteria.

Interpreting services were available and interpreters would often attend for the first visit due to the amount of information that was required from the patient. Staff could also use interpreting lines which they told us that they could access easily.

Information within the patient’s pregnancy notes booklet identified if individuals required further assistance and support, these included communication and learning disability needs.

Specialist midwives were responsible for planning the care of and supporting vulnerable women such as those with addictions that could harm the baby. They also provided a source of expertise for all staff to draw on. Careful assessment supported staff in shaping the care plan to respond to the needs of the woman and their baby. This included referral to the perinatal mental health team where necessary.

Staff explained how, for vulnerable women such as those with learning difficulties, they would often offer longer appointment times.

Community staff supported women with healthy living and could signpost women to aqua aerobics.

**Access and flow**

Patient could access appointment clinics in the centre between Monday and Friday 9 am to 4 pm and the centre was open on weekdays until 4.30 pm. Weekend appointments were also available plus two days within the week where late appointments could be made. We saw that the clinic was flexible with their accessibility, during our inspection we spoke with one patient who had missed their appointment the previous day. They confirmed that they had rang the centre who accommodated them easily with another appointment.

Post-natal checks were normally undertaken in the woman’s home; however, community midwives were unable to give appointment slots when the midwife would visit.

Women could also drop in to the centre and refer themselves once they had become pregnant. We spoke with women who told us that they referred themselves or their GPs advised them to contact the centre. However, the centre did not collate the number of extra women they may have seen through women dropping in.

There had been six births at the centre since January 2018 with an additional three home births. We saw that 20 pregnant women had been booked in to give birth at the centre between January 2018 and June 2018. Some women had changed their birthing plan to give birth in an alternative location due to various reasons.

Staff had submitted incidents when no midwife cover was available at the centre for dates in February, March and April 2018. This was due to increased capacity in the consultant led maternity units and the on-call midwives were called in to support, therefore the birthing centre was not accessible out of hours on those dates.
Community staff could access electronic discharge summaries. This supported community staff in ensuring they visited the mother and baby within 24 hours of discharge.

**Learning from complaints and concerns**

Staff were aware of the complaints policy and process to follow. We saw complaints leaflets within the centre. There were no complaints received regarding the centre.

The afterthoughts service had seen 61 women across the trust. Staff felt that this reduced the number of complaints and supported women to understand why some decisions were made. Women completed a questionnaire following the meeting to review whether the meeting had been valuable and useful. Any themes or trends about complaints were discussed at regular clinical and governance meetings as well as in other forums such as risk meetings.

**Is the service well-led?**

**Leadership**

The service sits within the trust’s Women and children’s care group. It had previously been part of the surgery care group. Staff we spoke with told us they now felt able to face challenges more positively. The service had a new leadership team led by an associate director of midwifery (ADM) who had been appointed in January 2018. There was a clinical midwifery manager in charge of maternity for Cumberland Infirmary and Penrith Birthing Centre. A lead consultant managed and led the medical team of consultants, middle grade doctors, including locums and junior doctors. The clinical director was new to post and was supported in his clinical director role by a local clinical director from another trust. The ADM reported to the associate operations manager for women and children’s services and directorate managers who together formed the leadership team at a local level.

We met the local leadership team who were new to post. Some of the team had worked within the service for many years but had recently changed roles. We noted that collectively the team was able to draw on skills and experience of running a maternity service.

Members of the local leadership team met regularly with the director of nursing or the medical director and through them they had ready and open access to the board. No individual board member was designated as a lead for maternity but the ADM had direct and open access to the board. The team also networked with midwives in local trusts in order to benchmark its service against their services and share good practice and learning.

The leadership team were supported by a team of matrons and specialist midwives including a governance manager. A local systems and transformation manager led work on developing the service, working with consultant leads and community staff in discussions and joint decisions to keep women and staff safe.

Staff we spoke with told us said they felt the new leadership had already made positive changes to working within the service. Staff felt supported and were offered opportunities to step up into a more senior role.
Trust-wide team meetings were in place and staff told us they could contribute to the items discussed within the meeting. We saw minutes from the last meeting held in June 2018 which included the sharing of information, these included safeguarding and ambulance transfers. Staff told us they had meetings with their manager. However these were more informal and were not recorded. Staff felt that because the teams were small, discussions took place regularly where they supported each other.

**Vision and strategy**

Senior leaders we spoke with told us there was no documented strategy for the service but they were looking at the options for provision for the future to ensure maternity services in the local region meet the needs of local people. The senior leadership team confirmed its vision was to provide the right care at the right time and in the right place.

Staff we spoke with told us they felt involved in plans for the future of the service.

The proposal following internal and stakeholder consultation was that the service would be a continuity of caring model across the whole geographical area covered by the Trust. This would begin in the community and midwives would look after women across the whole pathway.

While the outcome of the planning of services to meet the needs of local people was not yet fully clear, staff did regularly review its local provision while preparing for any future changes. The ADM recognised the birthing centre was underutilised.

- 2017 – 20 births
- 2016 – 37 births
- 2015 – 41 births

Staff were actively promoting the centre and the trust had run articles on the centre including a recent one in relation to international women’s day. Plans were being developed to utilise the birthing centre in line with the Better Births (2017) recommendations this was in line with the trust objective in providing the right care in the right place.

**Culture**

All staff we spoke with told us they aimed to provide patient focussed care to women throughout their pregnancy journey.

Staff felt supported within their own teams and were confident about raising concerns, although they did not always feel these would be addressed. We did not come across any complaints or concerns about bullying or harassment.

The birthing centre team was small but all the staff we spoke with felt they were supported and valued.
Governance

The service had a clear governance framework with staff assigned specific roles that ensured quality performance and risks were known about and managed. However, we found community teams each worked in different ways and processes such as for medicines management were not standardised.

Staff told us a weekly joint core risk group had been developed held where medical and midwifery staff met to discuss individual incidents and cases. These meetings were open to the whole team. Staff told us they took a summary from these meetings to management meetings.

Governance was the responsibility of the local leadership team which met regularly at clinical governance meetings to review a range of issues such as performance, risk, and quality measurement. However, staff at Penrith Birthing Centre did not carry out compliance audits to check cleanliness or provide staff with checklists to ensure they knew what was expected.

The service had a governance lead midwife whose role was to work full time on reviewing risks posed to the service, oversee root cause analyses into serious incidents, and distribute learning. A quality midwife role had been developed and they supported this programme by carrying out audits, monitoring the maternity dashboard and presenting results at learning meetings.

Staff confirmed that embedding of learning was ongoing regarding the never event in May 2018. The birthing centre collated data which included the number of women planned to deliver in the birthing centre, and the number of women who actually delivered at the centre and the themes identified.

Management of risk, issues and performance

The service’s risk register supported the local leadership team in tracking risks and ensuring that staff were taking actions to reduce or extinguish the risk. We reviewed the service’s risk register and saw that each risk was given a unique identifier, a risk rate, a status, brief details, the review date, and the person who owned the risk. Each risk had an action plan and staff identified were responsible to manage the plan to completion. We saw the risks were specific for the birthing centre and included lone working within the community and access to the unit.

The local leadership team had identified a range of policies that required updating. Tasks were allocated to consultants and lead midwives to review clinical guidelines and keep them up to date. However senior staff told us some staff had not met timeframes, some guidelines and policies had been updated and not yet ratified. There was a log of this information but did not seem to be any robust management of staff time or actions regarding the plan.

Information management

A new post had been developed and a midwife employed to ensure all staff at all levels were able to access and input information in a digital format which could be manipulated rapidly and used to provide effective patient care and help improve the service. They worked full time within the Trust’s IT department and provide advice, guidance and training to staff across all sites.

Computer systems were in place to alert staff to certain areas of concerns such as safeguarding.
Engagement

The maternity voices partnership was active within the service and met monthly. We saw the chair and lay representatives on the maternity voices partnership attended meetings within the trust.

Staff sought feedback and opinions of those who used the service. Friends and family cards which were distributed around the unit. Staff told us some family members had commented there were no public toilets to use on the unit and birth partners were having to leave the unit to find a toilet. Staff listened to this feedback and reported one toilet was changed into a visitors’ toilet.

Staff requested feedback from women attending antenatal classes and discussed examples of changes made in response to feedback received.

Staff described feeling engaged by the service with the new leadership for the service and explained how the service engaged with the public to ensure their views helped to shape the service. Consultations were taking place for women and staff about restructure and plans for the future of the service.

Learning, continuous improvement and innovation

Plans were in place to provide a scan list from the birthing centre in the future.

The trust had completed a project for early pregnancy loss to support women. A patient complained that they felt they did not see anyone to discuss their experience following a miscarriage. Following the project, a proposal was submitted with Cumbria learning improvement collaborative to continue the work to be able to support women who were grieving.